

Amalgam Removal Informed Consent

1/2017

I UNDERSTAND that treatment of my dentition for which I desire dental procedure to be performed may entail certain risks and possible unsuccessful results, with even the possibility of failure to achieve the results which may be desired or expected. I agree to assume those risks, possible unsuccessful results and/ or failure associated with, but not limited to the following : (even though care and diligence is exercised in this subject treatment, there are no guarantees of anticipated or desired results nor of the longevity of the treatment.

I _____ (Please print name) request that my dentist, **Dr. David S. Peterson, DDS**, and those associated with him, remove dental amalgam fillings and or other non-precious metals from my teeth and replace them with dental materials presently considered more biocompatible based on existing scientific research. These materials include: posterior composite resins, ceramic, porcelain, and gold.

It has been explained to me that although the signs and symptoms of mercury toxicity. Outlined in the scientific literature may reflect signs or symptoms that I presently have, there is no scientific evidence that removing amalgam fillings from my teeth will cause the cure or amelioration of any health problems or conditions. Furthermore, my dentist has made no representation that replacing my amalgam fillings/non-precious metals will affect or cure any specific symptoms or medical problems I may have.

If a posterior composite resin is the material chosen to replace dental amalgam and other non-precious materials, the advantages and disadvantages of the material chosen has been explained to me including the fact that it is not known if posterior composites will last as long as dental amalgam and therefore may have to be replaced more frequently than amalgam.

As might occur with the placement of amalgam, gold, or any other dental material, I understand that there are situations beyond the control of my dentist that may necessitate endodontic (root canal) treatment and or removal of an existing tooth despite precautions taken and proper procedures utilized. Also the premature need for full crowns increases as large amalgam restorations are removed. My questions concerning the treatment plan have been fully answered and I have read this statement and fully understand it.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of Mercury Removal procedure(s) and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Peterson and/or his associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Patient's name (please print)
representative

Signature of patient, legal guardian or authorized

Witness to signature

Date