



Informed Consent **Request for Removal of Amalgam Fillings**

I have requested the removal of my amalgam (silver) fillings. I know that this treatment is completely elective on my part. I understand that the removal of my amalgams could result in structural damage to the teeth including, but not limited to:

- Nerve damage or inflammation, possibly requiring endodontic treatment (root canal therapy).
- Cracked cusps requiring full coverage crowns
- Possible tooth loss

I understand that alternative fillings to replace my amalgams may be more costly and even less durable.

I understand that any medical condition I have may not be improved or may not lessen as a result of the removal of my amalgam fillings, and have not been told by Dr. _____ that any medical symptom I have will be improved or lessened. I understand that the replacement of dental amalgam in a non-allergic patient does not indicate that Dr. _____ is of the opinion that amalgam is a health hazard.

I have had ample opportunity to discuss with Dr. _____ and his/her staff my concerns about amalgam, and have had all of my questions answered fully.

I have read and understand the above information concerning the replacement of amalgam fillings. I have been informed of the treatment, any alternatives (including doing nothing), and the benefits, fee(s), and risks involved.

Patient Signature _____ Date _____

Witness _____