INFORMATION & INFORMED CONSENT · RESTORATIVE DENTISTRY

CD-C17

Fissure Sealants

Please read this form carefully before your treatment. It explains what is involved, the benefits, the risks and your options. Ask your dentist about anything you do not understand. You do not have to sign until you are ready.

PATIENT DETAILS

PATIENT NAME (CHILD) _____

DATE OF BIRTH _____

TEETH TO BE SEALED _____

TREATING DENTIST _____

CLINIC _____

01 About the treatment

Fissure sealants are a thin protective coating of resin or glass ionomer painted into the deep grooves of back teeth, where decay often starts. The tooth is cleaned and dried, the sealant is applied and set with a curing light. No drilling or injection is usually needed. Sealants are most often placed on children's new adult molars.

EXPECTED BENEFITS

- Reduces the risk of decay in the grooves of back teeth
- Quick, painless and non-invasive

ALTERNATIVES

- No treatment, relying on brushing, diet and fluoride
- Fluoride varnish

02 Risks and possible complications

All dental treatment carries some risk. Most complications are uncommon and manageable, but you should know about them before deciding. Risks specific to you, including those relating to your medical history, have been discussed with you.

- **Sealants wear or come away** over time and need checking and occasionally re-applying.
- **Not complete protection.** Sealants protect the biting surface only; decay can still form between teeth.
- **Bite.** The sealed tooth may feel slightly high for a day or two.
- **Allergy** to resin materials is very rare.

03 Your acknowledgement

Tick each box to confirm you understand and agree.

- ☐ I have read this form, or it has been read to me, and I understand it.
- ☐ The dentist has explained the proposed treatment, why it is recommended, the expected benefits, the material risks and the reasonable alternatives, including no treatment.
- ☐ I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.
- ☐ I understand that dentistry is not an exact science and that no guarantee has been given about the outcome or how long treatment will last.

- [ ] I have given the dentist a complete and accurate medical history, including medicines, supplements, allergies and pregnancy (if applicable), and I will tell the clinic of any changes.
- [ ] I understand that unforeseen findings during treatment may require a change in plan, and that the dentist will discuss this with me where practical.
- [ ] I have received a written estimate of fees. I understand that fees may change if the treatment plan changes, and that health fund rebates are my responsibility to confirm.
- [ ] I consent to clinical photographs, X-rays and scans being taken and kept in my record. These will not be used for any other purpose without my separate written consent.
- [ ] I understand that I may withdraw my consent at any time before or during treatment.

04 Financial consent

ESTIMATED FEE ($) _____ ITEM NUMBERS / QUOTE REFERENCE _____

05 Consent

I, the undersigned, consent to **Fissure Sealants** as described above for the child named above, and to the administration of any local anaesthetic or other medicines needed for this treatment.

Parent / legal guardian

FULL NAME _____ SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT _____

Dentist

I have explained the treatment, risks, benefits and alternatives, and answered the patient's questions.

NAME _____ SIGNATURE _____ DATE _____

Interpreter (if used)

NAME / LANGUAGE _____ SIGNATURE _____ DATE _____