Teeth Whitening Client Consent Form

Full Name:_____ Starting Shade:_____
Ending Shade:_____

Date:_____

Do you have sensitive teeth? (Yes) (No)

Initial the following:

____ I understand that Teeth Whitening is a procedure designed to lighten the color of my teeth using a hydrogen peroxide gel. This treatment involves using the gel to produce maximum whitening results in the shortest possible time

____ I understand that during the procedure, the whitening gel will be applied to my teeth for two 30-minute sessions, with an optional third 30-minute session. During the entire treatment, a plastic retractor will be placed in my mouth to help keep it open and the soft tissues of my mouth (i.e. my lips, gums, cheeks, and tongue) will be covered to unsure they are not exposed to the gel.

____ I understand, during, the whitening procedure may cause or result in (i) inflammation of your gums, lips or cheek margins due to the exposure of a small area of those tissues to the whitening gel or (ii) a chemical burn due to whitening gel coming in contact with soft tissue. The inflammation or burn is temporary and will subside in a few days. In rare instances, it may persist longer and may result in swelling of lip, or white patch on gums. It will subside in a couple of days. To avoid this, we ask that you DO NOT TALK during this procedure, to help avoid any complications. If you happen to feel any thin going during the treatment, let you tech know right away.

____ I understand that lip balm may also be applied as needed and I will be provided protective eyewear for my eyes. After the treatment is completed, the retractor and all gel and tissue coverings will be removed from my mouth. Before and after the treatment, the shade will be assessed and recorded.

____ I give my permission to allow before and after picture to be taken. (Circle) YES or NO

____ I understand that teeth with bonding, veneers or caps can only lighten to original shade. I understand that teeth with multiple colorations, bands, splotches or spots due to tetracycline use or fluorosis do not whiten as well and may need multiple treatments or may not whiten.

____ I understand that the results of my teeth whitening cannot be guaranteed. Not everyone whitens the same.

____ I understand that the results of the whitening treatment are not intended to be permanent. That after a period, without proper maintenance they will revert to original shade. I understand after the treatment, I will be required to refrain from consuming any substances that could discolor my teeth for the first 48 hours after treatment. These substances including coffee, teas, red wines, ALL tobacco products, mustard or ketchup, soy sauce, berries, berry pie and red sauces. DO NOT use any charcoal powders, blue mouthwash or colored toothpastes. ***Please ask your technician if you have any other questions about aftercare within 48 hours***

____ I agree that I read and fully understand this consent form in its entirety.

____ I am of sound mind and capable of executing this waiver for myself.

____ I have read and completed the Teeth Whitening Client Agreement & Consent Form in its entirety and have answered everything to the best of my knowledge. I have been informed of potentially harmful or negative side effect that may be caused by the application.

Printed Full Name:_____

Signature:_____

Date:_____