

Informed Consent for In-Office Teeth Whitening

___ I understand that teeth whitening is a procedure designed to lighten the color of my teeth. The whitening treatment involves using gel to produce maximum whitening results in the shortest possible time.

___ I understand that teeth whitening treatment results may vary.

___ I understand that almost all natural teeth can be lightened from in-office whitening treatment.

___ I understand that teeth whitening treatments are not intended to lighten the following types of teeth:

- Artificial teeth
- Caps
- Crowns
- Veneers
- Porcelain
- Composite
- Other restorative materials

___ I understand that teeth with the following may not lighten and are usually best treated with other non-bleaching alternatives.

- Multiple fillings
- Cavities
- Chips
- Cracks

___ I understand that teeth with the following may not whiten as well and may need multiple treatments or may not whiten at all.

- Multiple colorations
- Bands
- Splotches
- Spots due to tetracycline use
- Fluorosis

___ I understand that the results of my whitening are not guaranteed and results vary.

___ I understand that although my technician has been trained in the proper use of the in-office whitening system, the treatment is not without risk. I understand that some of the potential complications of this treatment include, but are not limited to:

- Slight tingling
- Tooth Sensitivity
- Minor discomfort
- Toothache

___ I understand that while some tooth sensitivity is normal and should only last for a few days, the following may make my teeth more sensitive after the treatment and may make the sensitivity last longer:

- Existing sensitivity

- Tooth recession
- Exposed dentin
- Exposed root surfaces
- Severely worn teeth
- Damaged or missing enamel
- Cracked teeth
- Cavities
- Leaking fillings

___ I understand that this procedure should not be administered on me if I am pregnant, nursing, have not seen a dentist in two years, have unfilled holes in my teeth, have a temporary crown, or have untreated gum disease.

___ I understand that it is natural for teeth that underwent the whitening treatment to regress somewhat in their shading posttreatment. I understand that this is natural and should be very gradual but it can be accelerated by exposing the teeth to various staining agents such as dark colored liquids (coffee, tea, dark soda), all tobacco products, mustard or ketchup, red wine, soy sauce, berries, berry pie, and red sauces like tomato sauce.

___ I understand that the results of the whitening treatment is not intended to be permanent.

___ I understand that repeat or take-home treatments may be needed further to maintain the shade I desire for my teeth.

___ I understand that after treatment, I will be required to refrain from consuming any substances that could discolor my teeth for the first 24 hours after treatment. These substances include: dark colored liquids (coffee, tea, dark soda), all tobacco products, mustard or ketchup, red wine, soy sauce, berries, berry pie, and red sauces like tomato sauce.

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me. I understand and acknowledge that there are risks involved with the treatment I will be receiving. Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications, and I have had the opportunity to ask questions regarding these risks and other possible complications.

Printed Name

Signature

Date

Witness Name

Signature

Date
