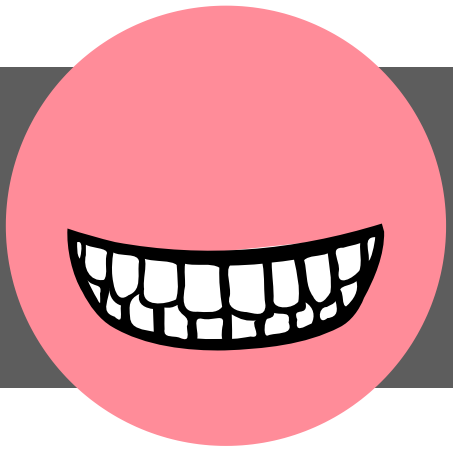


Teeth Whitening Consent

Start Shade:_____ **End Shade:** _____

INFORMED CONSENT FORM IN-OFFICE TOOTH WHITENING TREATMENT

INTRODUCTION

_____This information has been given to me so that I can make an informed decision about having my teeth whitened. I may take as much time as I wish to make my decision about signing this informed consent form. I have the right to ask questions about any procedure before agreeing to undergo the procedure. I would like to have my teeth lightened via the "in-office" technique.

DESCRIPTION OF THE PROCEDURE

_____In-Office Whitening is a procedure designed to lighten the color of my teeth using a hydrogen peroxide gel. The In-Office Whitening treatment involves using the gel to produce maximum whitening results in the shortest possible time.

_____ During the procedure the whitening gel will be applied to my teeth for two or three 20-minute sessions, with an optional fourth 20-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 ensure they are not exposed to the gel.

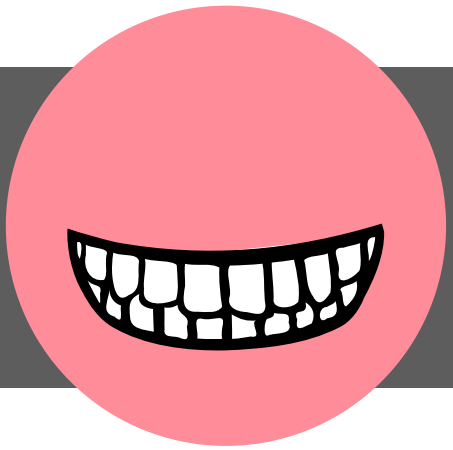
_____Lip balm may also be applied as needed and I will be provided protective eyewear for my eyes. After the treatment is completed, the retractor and all gel and tissue coverings will be removed from my mouth. Before and after the treatment, the shade of my upper-front teeth will be assessed and recorded.

RISKS OF TREATMENT

_____I understand that In-Office whitening treatment results may vary or regress due to a variety of circumstances. I understand that almost all natural teeth can be lightened from In-Office Whitening treatment. I understand that In-Office Whitening treatments are not intended to lighten artificial teeth, caps, crowns, veneers or porcelain, composite or other restorative materials and that people with stained teeth.

_____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 at all. I understand that teeth with many fillings, cavities, chips or cracks may not lighten and are usually best treated with other non-bleaching alternatives.

_____I understand that the results of my In-Office Whitening cannot be guaranteed.



Teeth Whitening Consent

_____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:

_____Tooth Sensitivity is normal and is usually mild, but it can be worse in susceptible individuals. Usually, tooth sensitivity or pain following a whitening treatment subsides after a few days, but it may persist for longer periods of time in susceptible individuals. People with existing sensitivity, recession, exposed dentin, exposed root surfaces and large wear facets (severely worn teeth), damaged or missing enamel, cracked teeth, cavities, leaking fillings, or other dental conditions that cause sensitivity or allow penetration of the gel into the tooth may find that those conditions increase or prolong tooth sensitivity or pain after whitening treatment.

_____After the whitening treatment, it is natural for teeth that underwent the whitening treatment to regress somewhat in their shading after treatment. This is natural and should be very gradual but it can be accelerated by exposing the teeth to various staining agents. Treatment usually involves wearing a take-home tray or repeating the whitening treatment.

_____I understand that the results of the whitening treatment are not intended to be permanent and secondary, repeat or take-home treatments may be needed further to maintain the tooth 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 48 hours after treatment. These substances include coffee, teas, and sodas, ALL tobacco products, mustard or ketchup, red wine, soy sauce, berries, berry pie, and red sauces.

Since it is impossible to state every complication that may occur as a result of whitening treatments, the list of complications in this form is incomplete. The basic procedures of whitening treatments and the advantages and disadvantages; risks and known possible complications of alternative treatments have been explained to me by my technician and my technician has answered all my questions to my satisfaction. In signing this informed consent I am stating I have had this informed consent (or it has been read to me) and I fully understand it and the possible risks, complications and benefits that can result from the whitening treatment and that I agree to undergo the treatment as described by my technician and/or their staff.

SIGNATURES By signing this document in the space provided I indicate that I have read and understand the entire document and that I give my permission for the In-Office whitening treatment to be performed on me.

Patient: _____ Date:_____

Witness: _____ Date: _____