



Consent for In-Office Teeth Whitening

You have a right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

1. I _____ understand that I will undergo In Office Teeth Whitening treatment(s) using a in office tooth whitening solution
2. I understand that multiple treatments may be necessary to achieve desired results. Treatments can take from 30 minutes up to one hour. Additional treatments may be necessary to maintain desired results. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. Results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment.
3. **Possible Side Effects can include but are not limited to:** Allergic reaction to the gel solution, tooth sensitivity and irritation of the soft tissues (particularly the gums). Repeated teeth whitening may damage teeth.
4. I am aware that I should be examined by a dentist prior to treatment. I will advise the hygienist if I had/have any cavities or other dental work in my mouth.
5. I understand that if I have veneers, porcelain, or other dental materials in my mouth, that these materials cannot get any whiter than their original color.
6. I understand I am not a good candidate for this procedure if I have significant periodontal disease, fillings that may be breaking down, unfilled cavities, or chipped or worn teeth. I understand if I have any of these conditions I will advise my hygienist.
7. If I am pregnant I understand that I may receive the In Office Teeth Whitening service, however; I must first consult with my family physician.
8. If I am provided with a home whitening treatment kit, I will follow the instructions provided by my Hygienist/Dentist. I will not use the product more than instructed.
9. I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of side effects and complications as listed above.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement.

Patient/Parent/ or Guardian signature

Date

Doctor's signature

Signature of witness

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