TEETH WHITENING

Teeth whitening is a treatment designed to lighten the color of teeth.

I understand that I am receiving the following treatment option *(please check one)*:

_____ ***Power Whitening:*** There are several options for power whitening. All power whitening options include the use of a bleaching or whitening agent applied to the teeth. A rubber dam or protective gel may be placed over the gums before the whitening agent is applied to reduce gum irritation. One option also includes the use of heat, a special light, or laser light directed at teeth to accelerate the process. Whitening may be achieved in one visit or may require multiple visits, depending on how my teeth respond to the whitening gel. The advantages of power whitening include completing the process in the office, which takes less time than bleaching my teeth at home. The disadvantages include the normal inconveniences of any dental treatment, such as having to keep my mouth open for the duration of the appointment and the increased costs compared to home whitening.

_____ ***Home Teeth Whitening:*** This process, which may be completed anywhere and anytime, involves wearing a custom-made bleaching tray (which looks like a thin, transparent night guard) filled with a mild bleaching agent. The advantages of home whitening include being able to perform the treatment when it is convenient and the lower cost. The disadvantage to home bleaching is that the success of the treatment is entirely based on my commitment to wearing the whitening tray for the time period prescribed.

_____ ***Other (Insert type, advantages, and disadvantages):***

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SAMPLE

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Patient's Initials

_____ I understand that while anyone may be a candidate for teeth whitening, results may vary depending on the preexisting colors (shades) of my teeth, the type of prior dental work that I have had, and the way that I care for my teeth after the treatment.
_____ The details of the procedure, including the anticipated benefits and material risks, have been explained to me in terms I understand.
_____ My mouth has been carefully examined. Alternative methods and therapies and their benefits, material risks, and disadvantages have been explained to me.
_____ I understand and accept that the most likely material risks and complications of ____ are not limited to:
(Procedure Name)

___ *Tooth sensitivity*
___ *Gum irritation*
___ *Restaining or "bleaching relapse"*

_____ I understand that tooth-colored fillings will not whiten, and mismatched shading may result. I should, therefore, be prepared to have any fillings in my front teeth replaced after the treatment.
_____ I understand that open cavities should be filled or badly leaking fillings should be refilled prior to bleaching.
_____ I understand that bleaching may cause tooth-colored fillings to become softer and may make them more susceptible to staining.
_____ I understand that it is my responsibility to:

- Keep my appointments.
- Follow my treatment plan.
- Communicate any problems or issues to my dentist.

_____ I understand that no guarantees about results of the procedure have been made.
_____ I understand that treatment is optional and that my alternative to treatment is to decline.
_____ I understand my teeth whitening treatment. The information has been explained to me, and all of my questions have been answered.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct ____, DDS/DMD/MD, with
(Dentist Name)
associates or assistants of his or her choice, to perform the procedure of _____________________ on
(Procedure Name)
____at___________________________________.
(Patient Name) *(Facility Name)*

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I further authorize the dentist(s) and any assistants to perform any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

____	___________________________
Patient or Legal Representative Signature/Date/Time	*Relationship to Patient*
____	___________________________
Print Patient or Legal Representative Name	*Witness Signature/Date/Time*

I certify that I have explained to the patient or the patient's legal representative the nature, purpose, anticipated benefits, material risks, possible complications, and alternatives to the proposed procedure/treatment and the risks and consequences of not proceeding. I have answered all questions fully, and I believe the patient/legal representative *(circle one)* fully understands what I have explained.

____

Dentist Signature/Date/Time

_____ Copy given to patient
Initials

_____ Original placed in patient's chart
Initials

SAMPLE

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