



All-In-One Dental Innovations

CONSENT FOR IN-OFFICE BLEACHING

PATIENT NAME _____

We provide this information to give you insight into Zoom Advanced Teeth Whitening system. Your cooperation and understanding of the material is necessary as we strive to achieve the best results for you. The safety of Zoom Advanced Teeth Whitening in general is very high. Like all professional health care there are limitations and risks, and absolute success is variable and cannot be guaranteed.

EXPECTATIONS:

Significant Whitening can be achieved in many cases, but there is no definite way to predict how light your teeth will get. Candidates with Yellow or Yellow/Brown teeth tend to whiten better and quicker than people with Gray or Gray/Brown teeth. Teeth discolored by antibiotics, decalcification (white spots), root canal therapy, or trauma do not always respond as quickly or predictably, and may require additional treatment. On the other hand, if your teeth are already a light shade of white, for example-shade A-1/B-1 of the Vita Shade Guide, your whitening results could be minimal. The level of whiteness varies with each individual; therefore, you may or may not achieve a higher degree of whitening.

MAINTENANCE:

It may appear that there is a slight change in the shade of your teeth within 24-48 hours. This is due to the reformation of saliva coating. Also, through the normal staining process of a day-to-day eating and drinking, you may experience a slight regression of shade. This will depend on the frequency of your use of:

TOBACCO, COFFEE, TEA, RED WINE etc

This can generally be managed by using a maintenance program at home.



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POTENTIAL RISK/PROBLEMS:

Teeth Whitening have some risks and limitations. Complications that can occur in Zoom Advanced Teeth Whitening are generally infrequent and are usually minor in nature.

- a.) **Tooth Sensitivity:** You may experience some teeth sensitivity. The sensitivity is usually mild if your teeth are not normally sensitive. If your teeth are normally sensitive, you can experience **EXTREME** sensitivity. We cannot eliminate this risk. In some cases, we may suggest taking an Ibuprofen 400 mg before beginning the procedure. Please let us know if you experience any discomfort during the procedure. If your teeth become or stay sensitive following the procedure, Tylenol, Ibuprofen or Advil will usually be effective in helping you feel comfortable. This sensitivity generally goes away in 12-24 hours. If this persists for more than 24 hours, please contact our office.
- b.) **Gum and soft tissue irritation:** Temporary inflammation of the gums and other soft tissues of the mouth can occur during the procedure. This is generally the result of the whitening gel coming in contact with these tissues. Protective materials are placed in the mouth to prevent this, but despite our efforts, it can still occur. Usually, this will go away within 1-2 hours following the procedure. The irritation is generally short in duration and is very mild. If discomfort persists for more than 24 hours, please contact our office.
- c.) **Fillings and other Dental Restorations:** Tooth colored fillings (composite), Composite Veneer/Bonding, Porcelain Crowns, and/ or Porcelain Veneers will not whiten at all. We may be able to remove certain stains (tobacco) from the surface of the restorations. All Dental restorations that show when you smile may need to be replaced at your expense. Please be sure to discuss this with the Dentist prior to beginning treatment.

YOUR TREATMENT RESPONSIBILITIES:

- a.) **Follow all Directions:** Please take time to read all written instructions, and listen carefully to all oral instructions. You are welcome and encouraged to ask us any questions you may have.
- b.) **Communications:** If you do not understand something communicated to you during the consultation, exam, in any printed material given to you, or after the procedure, please feel free to ask us.



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CONFIDENTIALITY AND USE OF INFORMATION:

Your signature below is your confirmation that you understand that the information which is obtained in this form will be treated as privileged and confidential and will consequently not be released or revealed to any person without your expressed written consent. You do, however, agree to the use of any information for research or quality control purposes.

AUTHORIZATION AND RELEASE

The information that I have provided on this form is accurate and complete to the best of my knowledge, information and belief. I certify that I have thoroughly read and understand the above information. I have had all my questions answered to my satisfaction. Furthermore, the above questions have been accurately answered. With this understanding, I authorize DR.

_____ the affiliated Dentist to perform Whitening Procedure on me. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

Signature of Patient/Parent/Legal Guardian

Date

Signature of Dentist

Date

Signature of Witness

Date