INFORMED CONSENT DISCUSSION FOR TOOTH WHITENING (BLEACHING)

Patient Name:_____ **Date of Birth:**_____

Facts for Consideration

Patient Initials
Required

_____ **I understand** yellow and brown stains usually lighten better than gray or blue stains. Some stains return after treatment is discontinued. Retreatment may be required. Teeth with multiple colorations, bands, or spots due to tetracycline use or fluorosis (discoloration of tooth enamel) do not whiten well and may need multiple treatments or may not whiten at all.

_____ **I understand** that teeth with many fillings may not lighten and are usually best treated with other non-whitening alternatives.

_____ **I understand** that whitening treatments only lighten the natural tooth structure and cannot lighten crowns, veneers, composite, or other restorative materials.

_____ **I understand** professional in-office whitening may require more than one office visit. Most whitening treatments will result in teeth lightening one-to-two shades on a dental shade guide.

_____ If I choose to participate in an at-home whitening program, **I understand** there are specific instructions that I must follow. Dr. _____ has given these instructions to me, and **I understand** my responsibility when using these products.

Benefits of Whitening, Not Limited to the Following:

_____ **I understand** that participating in whitening treatments can whiten my teeth, giving me a healthier-appearing smile.

Risks of Whitening, Not Limited to the Following:

_____ **I understand** tooth whitening is unpredictable and there are no guarantees that tooth whitening will work.

_____ **I understand** tooth whitening may cause teeth to become sensitive. Should sensitivity occur and persist for any length of time, I will notify Dr. _____.

_____ **I understand** that the gums and/or soft tissue in my mouth may be exposed to the various agents used in whitening procedures which may cause an allergic response or inflammation. This could also be due to an inadvertent exposure of a small area of those tissues to the whitening gel or ultraviolet light. If this happens, I will contact Dr. _____.

_____ **I understand** it is impossible to place a specific time frame on how long the lightened appearance of whitened teeth will maintain the lightened shade. These time periods may vary depending on conditions that exist from my habits and circumstance (For example, daily coffee drinking, smoking, or genetics) which may be internal, external, or both.

_____ **I understand** that prolonged exposure to whitening products can wear away tooth enamel. Additionally, any existing sensitivity, recession, exposed dentin, or other dental conditions that cause sensitivity or allow penetration of the whitening product into the tooth may require additional treatment.

_____ **I understand** that professional application of whitening products can result in my mouth being open for extended periods of time. If my jaw becomes sore, I will notify Dr. _____ immediately. Also, my lips may become dry or chapped. This can be treated by application of lip balm, petroleum jelly, or vitamin E cream.

Consequences if no Treatment is Administered, Are Not Limited to the Following:

_____ **I understand** if I do not participate in whitening procedures, my tooth color will remain the same or continue to discolor further.

Alternatives to Tooth Whitening, Are Not Limited to the Following:

_____ **I understand** that depending on the reason I have my teeth whitened, alternatives may exist including, but not limited to, bonding, crowns, and veneers. I have asked my dentist about them and their respective expenses. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits, and costs.

Alternatives discussed: _____

No guarantee or assurance has been given to me by anyone that the proposed treatment will cure or improve the conditions(s) listed above. I have had my questions answered to my satisfaction.

- ☐ I consent to the whitening treatment as described above by Dr. _____.
- ☐ I refuse to give my consent for the proposed treatment as described above.
- ☐ I have been informed of and accept the consequence if no treatment is administered.

_____ _____
Patient's Signature (or Patient's Representative) Date

I attest that I have discussed the risks, benefits, consequences, and alternatives of whitening with _____(patient's name), who has had the opportunity to ask questions, and I believe my patient understands what has been explained.

_____ _____
Dentist's Signature Date

_____ _____
Witness' Signature Date