Discussion and Informed Consent for Tooth Whitening (Bleaching)

Patient Name: _____ Date: _____

Diagnosis: _____

Treatment: _____

Facts for Consideration

Patient's initials required

_____ I understand yellow and brown stains usually lighten better than gray or blue stains. Some stains return after treatment is discontinued. Re-treatment 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 nonwhitening 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 lighten the color my teeth, giving me a whiter 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 caused by my habits (for example, daily coffee drinking, smoking) and circumstance 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, 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, 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.

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.

Check the boxes below that apply to you:

Consent

☐ I have been informed, both verbally and by the information provided on this form, of the risks and benefits of the proposed treatment.

☐ I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition.

☐ I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr. to do whatever he/she deems necessary and advisable under the circumstances.

☐ I consent to have the above-mentioned treatment.

☐ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

or

Refusal

☐ I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

_____ _____

Patient or Patient's Representative Date

_____ _____

Witness Signature Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

_____ _____

Dentist Signature Date