

PATIENT INFORMED CONSENT FOR AT-HOME TOOTH WHITENING

Patient Name: _____

Phone Number: (_____) _____

GENERAL INFORMATION:

WHITE & BRITE CARBAMIDE PEROXIDE GEL is intended for use only in a professionally prescribed course of treatment under the supervision of a dentist. Follow all instructions by your dentist and carefully read your Patient Instructions.

SIDE EFFECTS:

There are no known lasting side effects associated with the use of this material. The most common discomforts you may experience are sore gums or tooth sensitivity to hot and cold foods and liquids. Should you experience such discomforts, do not delay in contacting your dentist. Your dentist may prescribe certain actions to alleviate your discomfort. Also, you may use aspirin or ibuprofen to help reduce discomfort. Although there is no evidence of adverse effect on pregnancy, consult your physician prior to treatment.

EXPECTED RESULTS:

While it is not possible to accurately predict how much brighter your teeth will be upon completion of treatment, you can reasonably expect a two or three shade change. Whitening treatment will take approximately two to three weeks. Good oral hygiene habits, regular professional cleanings, and periodic touch-up whitening treatments will help maintain tooth brightness and prevent the recurrence of stains. Stains caused by tetracycline, fever, or minerals may prolong your treatment time. Carbamide peroxide will not brighten or lighten crowns, tooth-colored restorations or bonding.

PATIENT RESPONSIBILITY:

I understand this information and the instructions, both written and verbally, given to me by my dentist. It is my responsibility to follow the instructions as given and to keep all follow-up appointments. I understand that to do otherwise could result in unsatisfactory whitening results and/or damage or irritation to my teeth, gums, and soft tissue. I have been given the opportunity to ask questions about the treatment and products involved, and my dentist has provided me with satisfactory answers. I have been instructed and I understand how to apply the product, and the number of hours per day I am to keep the whitening tray in place in my mouth. I consent to treatment, to the fee for this treatment and to the keeping of treatment records if this procedure.

Patient Signature

Date

Witness Signature

Date