Tooth Whitening Treatment ZOOM! ®

Patient Information and Consent Form

Dr. Karla Macias-Diaz

INTRODUCTION This information has been given to me so that I can make an informed decision about having my teeth whitened. I may take as much time as I wish to make my decision about signing this informed consent form. I have the right to ask questions about any procedure before agreeing to undergo the procedure. I have attended for a Whitening Consultation at Denttist Pro Med Spa and have been informed that my teeth are discolored and could be treated by Zoom! Tooth Whitening.

DESCRIPTION OF THE PROCEDURE Zoom! Tooth Whitening is a procedure designed to lighten the color of my teeth using a combination of a hydrogen peroxide gel and a specially designed light to produce maximum whitening results in the shortest possible time. During the procedure, the whitening gel will be applied to my teeth and my teeth will be exposed to the light from the Zoom! light for three (3), four (4), 15-minute sessions during my appointment. Before and after the treatment, the shade of my teeth will be recorded and photographed.

ALTERNATIVE TREATMENTS There are alternative Teeth Whitening Options I can perform by using At-Home Teeth Whitening. I have decided on Zoom Whitening, because At Home Whitening will take too long, and I didn't want to apply the gel two times a day for two weeks. Alternatively I could leave my teeth as they are and have no whitening treatment.

INFORMATION ABOUT AND POSSIBLE RISKS OF ZOOM TREATMENT It has been explained that Zoom Treatment results and effects will vary, and the following areas apply directly to my treatment:

- Zoom Treatment is not suitable for: Pregnant or Breast-feeding Women; Light-Sensitive Individuals and Patients on Light Sensitive Medications; Melanoma.
- Existing Fillings, Crowns, Veneers will not whiten, and may need replacement after Zoom Whitening is completed. Active Decay, Exposed Dentine and gum disease needs to be treated before proceeding with Whitening, or further damage to the teeth could be caused. There can be no guarantee to the success of the whitening result as it is dependent on many factors including the existing tone/shade of my teeth, diet, habits and past whitening experience. Already White Teeth cannot whiten as much as darker shades of teeth.
- Patches may become more noticeable. These areas are usually due to decay, gum recession, fluorosis, tetracycline and developmental defects in teeth will not disappear during whitening treatments, and may be more noticeable during the first few days after whitening. Root Surfaces of teeth will not be whitened.
- Tooth Sensitivity/Pain – In the first 24 hours after Whitening Treatment, you can experience some tooth sensitivity or pain. This is normal and is usually mild, but it can be worse in some patients.
- Gum/Lip/Cheek Inflammation – Whitening may cause inflammation of your gums, lips or cheek margins. This is due to inadvertent exposure of a small area of those tissues to the whitening gel or the light. The inflammation is usually temporary which will subside in a few days but may persist longer and may result in significant pain or discomfort, depending on the degree to which the soft tissues were exposed to the gel or light.

Relapse –It is natural for the teeth that undergo Teeth Whitening to relapse somewhat in their shading after treatment. This is natural and should be very gradual, but it can be accelerated by exposing the teeth to various staining agents such as Coffee, Tea, Smoking, Red Wines, dark fruits etc. Using At Home Whitening Trays with Day or Nite-White Gel is required on a six (6) monthly basis to maintain the effectiveness of my whitening result.

The safety, efficacy, potential complications and risks of Zoom! Tooth Whitening Treatment have been explained to me and I understand that more information can be provided to me upon my request.

By signing this document in the space provided I indicate that I have read and understand the entire document and that I give my permission for Zoom! Tooth Whitening Treatment to be performed on me.

Signature (patient or parent/guardian)_____

Please Print Name_____ Date_____