Consent Form: Bleaching of Vital Teeth

Bleaching of teeth is a cosmetic procedure that lightens the color of the tooth. The treatment is performed by the dentist at his clinic or by wearing a guard at home (home bleaching). The chemical reaction may be accelerated using an energy source such as visible light, blue light, laser beam. To improve the in-office whitening result, the patient is required to continue the treatment at home for a period of two to five weeks, according to the treating dentist's instructions.

Name of patient: _____ _____ _____
Last Name First Name I.D.

I declare and confirm that I received a detailed verbal explanation from:

Dr. _____ _____
Last Name First Name

regarding bleaching of teeth in the upper jaw / lower jaw/ both jaws (Hereinafter: the "Principal Treatment").

I was informed that the results of the treatment are personal and depend on my teeth structure, that in every person, the original color of all the teeth in the arch and in each individual tooth may not be uniform. Therefore, the color of different teeth might be different at the end of the treatment. Furthermore, the color of **existing restorations (fillings), crowns and bridges would not be changed as a result of the treatment**. It would be possible to replace fillings and crowns at the end of the treatment so that they blend in and more closely match with the whitened teeth, but such replacements are not a part of the bleaching treatment. I was also informed that in the course of the time, teeth undergo natural processes, changing their color, in which case it might be necessary to preserve the whitening effect that was achieved by repeating the bleaching process once every few months or as may be recommended by the treating dentist.

I was also informed of the side effects of the Principal Treatment, including: Temporary tooth sensitivity and gum irritation for several days.

Furthermore, I was informed and I understand that should several treatments be required, it would be important to persevere with the treatment in order to achieve the desirable result. I am aware that the treating dentist will not be responsible for the treatment or its results, should I fail to persevere with the treatment.

I am aware of the importance of providing accurate information regarding my health condition and of following all the instructions given to me by the treating staff and/or dentist, including the need to maintain oral hygiene.

I hereby give my consent to the Principal Treatment.

_____ _____
Date Patient's Signature

_____ _____
Name of Guardian (Relationship) Guardian's Signature
(When patient is legally or mentally incompetent, a minor or mentally ill)

I confirm that I explained to the patient/the patient's guardian all of the aforementioned in detail, as required, and that he/she signed the consent form before me, after I had satisfied myself that he/she have fully understood my explanation.

_____ _____ _____
Name of Physician Signature License No.