DR. KRYSTYNA

CONSENT FORM FOR TOOTH WHITENING

The tooth whitening is a state of the art procedure designed to whiten the teeth to their optimum natural brightness. The amount of whitening varies from patient to patient and cannot be predicted exactly. In general, yellow or brown teeth, teeth with extrinsic staining from tea, coffee or red wine, and darkened monochromatic teeth are easier to whiten.

Alternatives to tooth whitening?

• Scale and polish, or air abrasion. This will only remove surface staining.
• Veneers and crowns. This involves shaving of tooth enamel but can change shape as well as colour of smile.

Tooth whitening awareness

• Transient tooth sensitivity may develop after treatment and will normally resolve within 24 hours.
• Temporary inflammation or white spots on your gum or lips may be caused by the whitening procedure.
• These can cause short lived discomfort which resolves within a few hours.
• Porcelain restorations such as crowns or veneers as well as white fillings will not change colour and you may prefer replacement

Responsibilities

• Avoid tobacco, tea, coffee and teeth staining foods such as tomato paste, food colourants and deeply coloured toothpastes
• Use mouthwashes for 2 days after the whitening procedure.
• Proper oral hygiene must be maintained including regular visits to hygienist in order to maintain optimum whiteness of the teeth. • Keep your recall appointments with your dentist

Guarantees

• There are no guarantees to the degree of tooth whitening.
• The amount of teeth whitening depends on the individual and the reason for discolouration.

I have had the tooth whitening procedure fully explained to me and have had the opportunity to ask questions. I have read this information sheet. I consent to treatment and assume responsibility for the risks described above. I also consent to photographs being taken. I understand that they may be used for documentation/education/portfolio/marketing and illustration of my whitening treatment.

If required in your case, thank you for consenting for clinical photographs to be taken as part of your personal treatment planning & education. You cannot be identified through your photos. Please sign if you consent for images to be used for potential academic, portfoilio, marketing, educational & open publication purposes.

NAME _____ Signature _____

Dentist_____

Date _____

Date: _____