



HOME TOOTH WHITENING INSTRUCTIONS AND CONSENT FORM

Patients Name: _____

Date: _____

We are planning to whiten your teeth using carbamide peroxide solution.

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY:

The active ingredient is carbamide peroxide in a glycerine base. If you know of any allergy or are aware of an adverse reaction to this ingredient, please do not proceed with this treatment.

As with any treatment there are benefits and risks. The benefit is that teeth can be whitened fairly quickly in a simple manner. The risk involves the continued use of the peroxide solution for an extended period of time. Research indicates that using peroxide to bleach teeth is safe. There is new research indicating the safety for use on the soft tissues (gingivae, cheek, tongue, throat). The long-term effects are as yet unknown. Although the extent of the risk is unknown, acceptance of treatment means acceptance of risk.

The amount of whitening varies with the individual. Most patients achieve a change within 2 - 5 weeks. Try to reduce the amount of tea, coffee, red wine or eating berries or curries during or after treatment for at least 1 month.

This type of treatment has been done on some patients over 40 years ago. During that time, nobody needed a root canal treatment or damaged a tooth following home bleaching treatment.

It is advisable not to smoke during the course of bleaching treatment for at least 5 - 8 weeks.

Sensitivity may result after a few days. This is usually slight and temporary. If this should occur, refrain from using the bleaching treatment for 3 - 4 days.

Do not use bleaching treatment if you are pregnant. There have been no adverse reactions, but long-term clinical effects are unknown.

Wear the tray overnight for a minimum of two hours or as instructed.

It may be necessary to do a top-up treatment in 18-24 months depending on the amount of staining.

I have read the above information and agree to return for examination after treatment begins and at any recommended time afterwards. I have read and received a copy of this information sheet. I consent to treatment and assume the risks described above.

I consent to photographs being taken. I understand that they may be used for documentation and for illustration of my treatment.

Signature of Dentist: _____

Signature of Patient: _____

Date: _____