TEETH WHITENING

NAME: ______________________ **BIRTHDAY:** ______________

EMAIL: ______________________ **PHONE #:** ______________

HOW DID YOU HEAR ABOUT US? ______________________

(IF REFERRED BY ANOTHER CLIENT, PLEASE PROVIDE THEIR FIRST AND LAST NAME)

DO WE HAVE PERMISSION TO USE ANY PHOTOS OR VIDEOS TAKEN FOR MARKETING PURPOSES? ☐ **YES** ☐ **NO**

CLIENT CONSENT

GENERAL

I acknowledge that I am purchasing a self-administered Teeth Whitening Kit that is designed to whiten the color of my teeth. I am asking for assistance in the use of my kit and I understand that I will be allowed to use a specifically designed LED lamp in order to accelerate the whitening process.

RESULTS GUARANTEE

Although most natural teeth can benefit from a teeth whitening treatment, I understand that everyone's teeth are different and the results will vary. I understand that people with yellowish teeth generally get the best results and if my teeth had spots due to tetracycline (grayish tint) or fluorosis, these will be difficult to whiten. Also, if I have artificial teeth, caps, crowns, veneers, porcelain, composite, or other restorative materials, I shouldn't expect dramatic results from this treatment because the peroxide gel will not whiten (nor damage) artificial dental work. Also, I am aware that my teeth will never be whiter than the color my genes naturally allow.

POTENTIAL RISKS

Although whitening treatments are generally safe, I understand that some of the potential complications of this treatment include, but are not limited to:

GUM/LIP IRRITATION: Whitening gel that comes in contact with gum tissue or the lips during the treatment may cause inflammation or whitening of these areas. This is due to the inadvertent exposure of small areas of those tissues to the whitening gel. The inflammation and/or whitening of the gums/lips is transient, and the color change will reverse within 30 minutes. I may feel a stinging and tingling sensation on these soft tissues during the treatment if the gel comes in contact with them.

TOOTH SENSITIVITY: Although uncommon, some customers can experience some tooth sensitivity during the first 24 hours after the treatment. People with existing sensitivity, recently cracked teeth, micro-cracks, open cavities, leaking filling, exposed roots, or other dental conditions that cause sensitivity may find that those condition increase or prolong sensitivity following treatment.

SPOTS OR STREAKS: Some customers may develop white spots or streaks on their teeth due to CALCIUM DEPOSITS that naturally occur in teeth. These spots are NOT caused by the gel. The gel brings the already existing calcium deposits out and makes them visible again.

RELAPSE: After the treatment, it is natural for teeth color to regress somewhat over time. This is natural and should be very gradual, but it can be accelerated by exposing teeth to various staining agents such as coffee, tea, tobacco, red wine, colas, etc. I realize that I should not eat or drink anything except water for 60 minutes after the treatment because the gel opens the pores of my enamel and makes my teeth very vulnerable to staining agents. If I purchase a touch-up pen, I realize that my pores will remain open for as long as I use it so I should refrain from staining agents until I stop using the pen. Only 24 hours after I conclude the touch-up pen treatment I can resume my normal habits. I understand that the results of the treatment are not intended to be permanent and that secondary, repeat or touch-up treatments may be needed for me to maintain the color I desire for my teeth.

ELIGIBILITY

I UNDERSTAND THIS TREATMENT CANNOT BE USED BY PREGNANT OR LACTATING WOMEN, PEOPLE UNDER THE AGE OF 14, PEOPLE WITH GUM DISEASE, OPEN CAVITIES, LEAKING FILLINGS, OR OTHER DENTAL CONDITIONS OR PEOPLE WITH A KNOWN ALLERGY TO PEROXIDE AND/OR TO ALOE VERA. PEOPLE THAT HAVE HAD BRACES REMOVED SHOULD WAIT SIX MONTHS FOR THE CEMENT RESIDUE TO WEAR OFF BEFORE GETTING A TEETH WHITENING TREATMENT AND PEOPLE WITH A PIERCING OR OTHER METAL OBJECTS IN THE ORAL CAVITY SHOULD REMOVE THEM BEFORE THE TREATMENT AS THEY MAY TURN BLACK. IF I FEEL A SHARP PAIN ON A PARTICULAR TOOTH DURING THE TREATMENT, I SHOULD STOP THE TREATMENT AND CONTACT MY DENTIST SINCE THIS COULD BE A SIGN OF AN OPEN CAVITY.

BY SIGNING BELOW, I INDICATE THAT I AM NOT INELIGIBLE AS PER THE CRITERIA LISTED ABOVE, THAT I HAVE READ AND FULLY UNDERSTAND THIS FORM IN ITS ENTIRETY INCLUDING THE POSSIBLE RISKS, COMPLICATIONS AND BENEFITS THAT CAN RESULT FROM THE TREATMENT, AND THAT I AM PERFORMING THIS TREATMENT UNDER MY OWN RESPONSIBILITY. I CERTIFY THAT I HAVE HEALTHY TEETH AND GUMS.

SIGNATURE: ______________________ **DATE:** ______________