ENDODONTIC EXCELLENCE
WHERE CARING IS OUR SPECIALTY

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INFORMED CONSENT FOR INTERNAL BLEACHING (SINGLE TOOTH WHITENING)

TOOTH #_____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

The purpose of internal bleaching is to lighten or whiten the cosmetic appearance of a single discolored tooth. Internal bleaching is a biological procedure and therefore there is no guarantee or warranty relating to the cosmetic outcome. Internal bleaching may require multiple office visits. Therefore, the patient must return for all additional appointments at the time specified by the doctor. The patient's failure to return for appointments or complete treatment within the specified period may result in an undesirable cosmetic outcome, loss of the tooth or other problems or complications that may require additional treatment with additional fees at the patient's sole expense.

RISKS AND COMPLICATIONS

I understand that the most common risks and complications related to internal bleaching include, but are not limited to: External resorption

- Internal resorption
- Reaction to bleaching agent
- Over whitening or under whitening
- Recurring discoloration
- Pain or tenderness of the tooth following treatment due to possible complications or normal post operative response.

These complications may require additional endodontic intervention or extraction of the tooth.

ALTERNATIVE PROCEDURES

Alternative treatment choices include no treatment or other dental procedures such as crowns or veneers to achieve cosmetic outcomes.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with internal bleaching. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I

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also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

Patient Name: _____Signature of Patient or Legal Guardian:_____ Date: _____