



## **INFORMED CONSENT FOR BOOST WHITENING TREATMENT**

This information has been given to me so that I can make an informed decision about having my teeth whitened. I may take as much time as I wish to make my decision about signing this informed consent form. I have the right to ask questions about any procedure before agreeing to undergo the procedure. My dental hygienist has informed that my teeth are discolored and could be treated by in-office whitening (also known as "bleaching") of my teeth.

### **DESCRIPTION OF THE PROCEDURE**

BOOST in-office tooth whitening is a procedure designed to lighten the color of my teeth using a combination of 40% hydrogen peroxide gel and activator. The BOOST treatment involves using the gel activator in conjunction with each other to produce maximum whitening results in the shortest possible time. During the procedure, the whitening gel will be applied to my teeth for up to two 20 minute procedures. During the entire treatment, a plastic retractor will be placed in my mouth to help keep it open and cotton rolls, gauze, and isolation materials will be used to protect the soft tissue in my mouth. After the treatment is completed, the retractor and all gel and tissue coverings will be removed from my mouth. Before and after treatment, the shade of my upper-front teeth will be assessed and recorded.

### **ALTERNATIVE TREATMENTS**

I understand I may decide not to have the BOOST treatment at all. However, should I decide to undergo the treatment, I understand there are alternative treatments for whitening my teeth for which my dental hygienist can provide me additional information. These treatments include:

\*Whitening toothpastes/Gels, other in-office whitening treatments, and take-home whitening kits.

### **COST**

I understand that my dental professional determines the cost of the BOOST treatment. I understand that they will inform me if there are any other costs associated with my BOOST Treatment.

## RISK OF CONSENT FOR TREATMENT

I also understand that BOOST treatment results may vary or regress due to a variety of circumstances. I understand that almost all natural teeth can benefit from BOOST. I understand that whitening treatments are not intended to lighten artificial teeth caps, crowns, veneers or porcelain, composite or other restorative materials and that people with darkly stained yellow or yellow-brown teeth frequently achieve better results than people with gray or bluish-gray teeth. I understand that teeth with multiple colorations, bands, splotches or spots due to tetracycline use or fluorosis do not whiten as well, may need multiple treatments and/or may not whiten at all. I understand that teeth with many fillings, cavities may not lighten and are usually best treated with other non-bleaching alternatives. I understand that provisionals or temporaries made from acrylics may become discolored after exposure to BOOST treatment. I understand that BOOST treatment is not recommended for pregnant or lactating women.

**I understand that the results of my BOOST treatment cannot be guaranteed.** I understand that in-office whitening treatments are considered generally safe by most dental professionals. I understand that although my dental hygienist has been trained in the proper use of the BOOST whitening system, the treatment is not without risk. I understand that some of the potential complications of this treatment include, but are not limited to:

**Tooth Sensitivity/Pain:** During the first 24 hours after BOOST treatment, some patients can experience some tooth sensitivity or pain. This is normal and is usually mild, but it can be worse in susceptible individuals. Normally, tooth sensitivity or pain following BOOST treatment subsides within 24 hours, but in rare cases can persist for longer periods of time in susceptible individuals. People with existing sensitivity, recession, exposed dentin, exposed root surfaces, recently cracked teeth, abfractions (micro-cracks), open cavities, leaking fillings, or other dental conditions that cause sensitivity or allow penetration of the gel into the tooth may find that those conditions increase or prolong tooth sensitivity or pain after BOOST treatment.

**Gum/Lip/Cheek Inflammation:** Whitening may cause inflammation of your gums, lips or cheek margins. This is due to inadvertent exposure of a small area of those tissues to the whitening gel. The inflammation is usually temporary which will subside in a few days but may persist longer and may result in significant pain or discomfort, depending on the degree to which the soft tissues were exposed to the gel.

**Dry/Chapped Lips:** The BOOST treatment involves four, 10-15 minute sessions during which the mouth is kept open continuously for the entire treatment by a plastic retractor. This could result in dryness or chapping of the lips or cheek margins, which can be treated by application of lip balm, petroleum jelly, or Vitamin E cream.

**Cavities or Leaking Fillings:** Most dental whitening is indicated for the outside of the teeth, except for the patients who have already undergone a root canal procedure. If any open cavities or fillings that are leaking and allowing gel to penetrate the tooth are present, significant pain could result. I understand that if my teeth have any of these conditions, I should have my cavities filled or my fillings redone before undergoing the BOOST treatment.

**Cervical Abrasion/Erosion:** These are conditions, which affect the roots of the teeth when the gums recede and they are characterized by grooves, notches and/or depressions, which appear darker than the rest of the teeth, where the teeth meet the gums. These areas appear darker because they lack the enamel that covers the rest of the teeth, causing sensitivity. I understand that if cervical abrasion/erosion exists on my teeth, these areas will be covered with a dental dam prior to my BOOST treatment.

**Root Resorption:** this is the condition where the root of the tooth starts to dissolve either from the inside or the outside. Although the cause of this is still uncertain, I understand that there is evidence that indicates the incidence of root resorption is higher in patients who have undergone root canals followed by whitening procedures.

**Relapse:** after the BOOST treatment, it is natural for the teeth that underwent the BOOST treatment to regress somewhat in their shading after treatment. This should be very gradual, but exposing the teeth to various staining agents can accelerate it. Treatment usually involves wearing take-home trays or repeating BOOST treatment. I understand that the results of the BOOST treatment are not intended to be permanent, secondary, repeat or take-home treatments may be needed to maintain the tooth shade I desire for my teeth. My dental professional can explain the safety, efficacy, potential complications and risks of BOOST treatment to me and I understand that more information on this will be provided to me upon my request. Since it is impossible to state every complication that may occur as a result of BOOST treatment, the list of complications in this form is incomplete. The basic procedures of BOOST

treatment and the advantages and disadvantages, risks and known possible complications of alternative treatments have been explained to me by a dental professional and they have answered all my questions to my satisfaction. In signing this informed consent I am stating I have read this informed consent (or it has been read to me) and I fully understand it and the possible risks, complications and benefits that can result from the BOOST treatment and that I agree to undergo the treatment as described by the dental professional.

### Signatures

By signing this document in the space provided I indicate that I have read and understand the entire document and that I give my permission for BOOST treatment to be performed on me.

\_\_\_\_\_ I am not pregnant and/or breastfeeding.

\_\_\_\_\_ If applicable, I am aware that my anterior restorations, fluorosis, and tetracycline stains will not be affected by the Opalescence Boost procedure.

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**Patient's Name (Signature)**

**Date**

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**Patient's Name (Printed)**

**Date**

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**Dental Professional's Signature**

**Date**