

Informed consent form for Zoom! tooth whitening treatment

Please read the following information and fill out the required fields previous to receiving the *Zoom!* treatment.

Introduction:

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 my make my decision about signing the informed consent form. I have the right to ask questions about any procedure before agreeing to undergo the procedure. My dentist has informed me that my teeth are discolored and could be treated by in-office whitening (also known as “bleaching”) of my teeth.

Description of the Procedure:

Zoom! in-office tooth whitening is a procedure designed to lighten the color of teeth using a combination of a hydrogen peroxide gel and a specially designed ultraviolet lamp. The *Zoom!* treatment involves using the gel lamp 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 and my teeth will be exposed to the light from the *Zoom!* lamp for three (3), 20-minute sessions. During the entire treatment, a plastic retractor will be placed in my mouth to help keep it open and the soft tissues of my mouth (i.e. lips, gums, cheeks and tongue) will be covered to ensure they are not exposed to either the gel or light. Lip balm (SPF 30+) may also be applied as needed and I will be provided an ultraviolet light filter for my eyes. After the treatment is completed, the retractor and all the gel and tissue coverings will be removed from my mouth. Before and after the treatment, the shade of my upper front teeth will be assessed and recorded.

Alternative Treatments

I understand I may decide not to have *Zoom!* treatment at all. However, I should decide to undergo the treatment, I understand there are alternative treatments for whitening my teeth for which my dentist can provide additional information to me.

These treatments include:

- Whitening Toothpastes/Gels
- Take-Home Whitening Kits
- Other In-office Whitening Treatments

Cost

I understand that the cost my *Zoom!* treatment is determined by my dentist. I understand that my dentist will inform me if there are other costs associated with my *Zoom!* treatment.

Risks of Treatment

I also understand that *Zoom!* treatment results may vary or regress due to a variety of circumstances. I understand that almost all natural teeth can benefit from *Zoom!* whitening treatment and significant whitening can be achieved in most cases. I understand that *Zoom!* 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 flourosis do not whiten as well, may need multiple treatments or may not whiten at all. I understand that teeth with many fillings, cavities, chips or cracks may not lighten and are usually best treated with other non-bleaching alternatives. I understand that provisionals or temporanes made from acrylics may become discolored after exposure to *Zoom!* treatment.

I understand that *Zoom!* treatment is not recommended for pregnant or lactating women, light sensitive individuals, patients receiving PUV A (psoralen + UVA radiation) or other photochemotherapeutic drugs or treatment, as well as patients with melanoma, diabetes or heart conditions. I understand that the *Zoom!* Lamp emits ultraviolet radiation (UVA and UVB) and that patients taking any drugs that increase photosensitivity should consult with their physician before undergoing *Zoom!* treatment.

I understand that the results of my *Zoom!* treatment cannot be guaranteed.

I understand that in-office whitening treatments are considered generally safe by most dental professionals. I understand that although my dentist has been trained in the proper use of the *Zoom!* 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 *Zoom!* treatment, many 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 a *Zoom!* treatment subsides after a few days but it may not persist for longer periods of time in susceptible individuals. People with existing sensitivity, recession, exposed dentin, exposed root surfaces and occlusal wear facets (severely worn teeth), damaged or missing enamel, 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 *Zoom!* treatment.

Gum/Lip/Cheek inflammation- Whitening may cause inflammation of your gums, lips or cheek margins. This is due to the inadvertent exposure of a small area of those tissues to the whitening gel or the ultraviolet light. 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 and the ultraviolet light.

Dry/Chapped lips- The *Zoom!* treatment involves three, 20-minute sessions during which the mouth is kept open continuously for the entire treatment by 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 intended for the outside of the teeth, except for patients who have already undergone a root canal procedure. If any open cavities or fillings that are leaking and allow gel to penetrate the tooth present, significant pain and damage to the tooth could result. I understand that if my teeth have these conditions, I should have my cavities filled or my filling re-done before undergoing the *Zoom!* treatment.

Cervical Abrasions/Erosion- These are conditions which affect the roots when the gums recede and they are characterized by grooves, notched and/or depressions, that 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. Even if these areas are not currently sensitive, they can allow the whitening gel to penetrate the teeth, causing sensitivity, pain and possible damage to the nerve. I understand that if my teeth have these conditions, I should not undergo the *Zoom!* treatment.

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

Relapse- After the *Zoom!* treatment, it is natural for teeth that underwent the *Zoom!* treatment to regress somewhat in their shading after treatment. It is natural and should be gradual, but it can be accelerated by exposing the teeth to various staining agents. Treatment usually involves wearing a take-home tray or repeating the *Zoom!* treatment. I understand that the results of the *Zoom!* treatments are not intended to be permanent and secondary, repeat or take home treatments may be needed for me to maintain the tooth shade I desire for my teeth.

I understand that after treatment, I will be required to refrain from consuming any substances that could discolor my teeth for the first **48 hours** after treatment.

These substances include: coffee, teas, colas, **all** tobacco products, mustard or ketchup, red wine, soy sauce, berry pie, and red sauces. I understand that there are other substances that could discolor my teeth which I should avoid during the first 48 hours after treatment. If I have any questions regarding any such substance, I understand that I can discuss the potential stain with my dentist.

The safety, efficacy, potential complications and risks of *Zoom!* treatment can be explained to me by my dentist 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 *Zoom!* the list of complications in this form is incomplete.

Photoreactive Drug Information:

The following medications are commonly considered to be photoreactive and may cause an adverse condition if used in conjunction with the *Zoom* system. If you are currently taking any of these medications, please consult your physician before going through the *Zoom!* procedure. To check photoreactive properties of any medications not listed below, please consult the most recent edition of the Physician’s Drug Reference (PDR).

<u>Generic Name</u>	<u>Trade Names</u>
Chlorthalazide	Aldocior, Diupies, Diuril
Hydrochlorothalazide	Aldactaride, Aldoril, Capozide, Dyazide, Hydrodiuril, Lopressor, Orotic, Modurecic
Chlorthalldone	Combipres, Tenoretic, Hygroton
Naprosyn	Naproxen
Cocaprozin	Daypro
Nabumetone	Reiafen
Piroxicam	Feldene
Doxycycline	Vibramycin, Doryx
Ciprofloxacin	Cipro
Ofloxacin	Floxin
Psoraiens	Methoxsaien, Trisoraien
Demociocycline	Deciomycin
Norfloxacin	Chlbroxin, Noraxin
Sparfloxacin	Zagan
Suilndac	Clinoril, Sulinoac
Tetracycline	Achromycin
St. John’s Wart	

Patient Acknowledgement:

I have read the list above and understand that the medications listed, if taken, can have an adverse reaction when used with the *Zoom!* System. I also acknowledge that I do not currently take any of the prescribed medications.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

The basic procedures of *Zoom!* treatment and the advantages and disadvantages, risks and known possible complication of alternative treatments have been explained to me by my dentist and my dentist has 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 *Zoom!* treatment and that I agree to undergo the treatment as described by my dentist.

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

Patient's Signature: _____ Date: _____

Patient's Name (Printed): _____ Date: _____

Dentist's Signature: _____ Date: _____

Dentist's Name (Printed): _____ Date: _____