Polanica-Zdrój, on _____

PATIENT'S CONSENT TO TEETH WHITENING

I. PATIENT DATA:

Patient's first name and surname: _____
Personal Identification Number PESEL: _____

II. DETAILS OF THE HEALTHCARE PROFESSIONAL WHO PERFORMS THE PROCEDURE: _____

III. DESCRIPTION OF THE SCHEDULED PROCEDURE, POSSIBLE COMPLICATIONS AND ADVERSE REACTIONS:

This informed consent form concerns the following medical procedure:

1. TEETH WHITENING:

Tray whitening – performed at home by the patient – involves using individually prepared trays which, following application of a special bleaching product thereon, are placed on the teeth. This activity is repeated several times (usually 10 to 14 times), until a desirable effect is achieved. **In-office whitening** – is limited to one visit, sometimes two visits, during which a high concentration bleaching agent is used, whose activity is triggered by a special lamp or diode laser. We also use a combined method – **home-office whitening**, which combines these 2 above-mentioned methods. Non-vital teeth require using a different method – so called internal whitening of a single tooth from inside out – the procedure is performed by the doctor during one or two visits. Only natural teeth can be whitened. Fillings, crowns, veneers and other restorations, including dentures, are not bleached. In order to adjust their colour to the colour of the whitened teeth, it may be necessary to replace them. During the procedure and within 7 days after the procedure, a transient teeth sensitivity to thermal and chemical stimuli may occur, as well as tenderness and irritation of the oral mucosa. Whitening a single tooth from inside out may involve a risk of tooth root resorption (root dissolution, resulting, in rare cases, in tooth extraction). An allergic reaction to the materials/tools used during the procedure may also develop.

Contraindications to teeth whitening (excluding whitening of a single tooth from inside out):

- patient under 18 years of age,
- mechanical injuries or decay of teeth,
- large number of fillings, crowns, bridgework or veneers in front teeth,
- tooth hypersensitivity,
- poor oral hygiene with concomitant gingivitis,
- pregnancy and breast-feeding,
- smoking.

2. ANESTHESIA:

This procedure of internal whitening of a single tooth from the inside out may be performed under local anesthesia, at the patient's request, in which case a pharmacological agent is administered to the tissue within the oral cavity to block the nerves within the target area. After administration of anesthesia, adverse reactions or complications may occur, depending on the patient's individual sensitivity. **Common but less dangerous complications include:** sensitivity of the injection site, tissue hematoma (bruising), swelling, dizziness, lip and cheek biting, increased blood pressure and increased heart rate. **Rare complications include**: fainting, partial paralysis of the sensory nerve, post-injection infection, allergic reaction.

3. X-ray/CBCT:

It may be necessary to perform an X-ray (radiological examination) during the procedure of whitening of a single tooth from the inside out referred to in this form. This is an imaging diagnostic procedure performed using X-rays, which have an adverse effect on the human body; as a result, the dose of radiation is reduced to the minimum necessary to obtain technically correct images (test results). This examination may include: tooth/teeth x-ray in the target area, dental panoramic radiograph, and X-ray tomography. **Radiological examinations are absolutely contraindicated during**

pregnancy. If you are a woman, please make sure to tell your doctor if you are or may be pregnant before the X-ray. If you are correctly receiving any oncological treatment, please make sure to tell your doctor about it before the X-ray.

Like any other medical procedure, this procedure is also associated with a risk of complications and/or adverse reactions, also if all precautions are followed by the medical staff engaged in this procedure. We make every effort to minimize the risk of any complications and/or adverse reactions; however, their occurrence cannot be ruled out or prevented by any medical professional or healthcare center.

Other remarks:
……

IV. PATIENT'S STATEMENT:

I confirm that:

1) I have not been legally incapacitated;
2) I have provided complete and true information about my health to the best of my knowledge, and in accordance with my medical history;
3) I agree to notify my doctor in writing without delay of any changes in my health status;
4) I have been fully informed in an understandable manner:
   a. about my health;
   b. about the nature, method and purpose of the medical procedure concerned;
   c. about the technique of the procedure and I have been extensively advised about the course of the procedure;
   d. that I need to follow post-treatment medical recommendations, specifically the oral hygiene recommendations;
   e. In particular, I have been informed that:
      - during the whitening procedure and 7 days afterwards, a so-called "white diet" must be used, i.e. I must not consume food and drink having an intense colour, e.g. tea, coffee, beetroot, carrots, red wine, etc. and I must not smoke
      - the final effect of whitening is difficult to predict and depends on numerous factors, such as e.g. mineral composition of the tooth enamel, oral hygiene, and diet – a negative effect may be exerted by consumption of high amounts of tea, coffee, red wine, smoking and medications;
      - durability of the whitening procedure effects depends on my compliance with the recommendations regarding lifestyle, including diet and oral hygiene, as well as the frequency of prophylactic procedures;
      - I shall be required to pay check-up visits, at terms recommended by the doctor and/or dental hygienist, at least every 12 months;
   f. that I have the right to refuse to consent to this procedure, and I was made aware of the resulting consequences;
   g. that there is a risk of adverse reactions and complications during and after the whitening procedure, which are described in detail in section III of this informed consent form;
   h. about the importance of reporting any alarming symptoms to my doctor, including any complications and adverse reactions;
   i. that I have the right to ask questions and voice concerns about the procedure to the medical staff;
5) I reported to the medical staff all my concerns and asked all my questions concerning the procedure, and I had all my concerns addressed and the questions answered to my satisfaction and in an understandable manner;
6) I understand that, as with any general medical and dental procedures, the positive outcomes of the medical procedure concerned are not guaranteed;
7) I am aware that I can withdraw my consent to this procedure any time;
8) I have read and fully understood this document, and do not report any reservations.

V. PATIENT'S CONSENT

I confirm that I consent to have the following medical procedure:

(please insert an X as appropriate)*

[ ] teeth whitening with the use of the following methods: home-office, in-office, tray, internal

[ ] anaesthesia

[ ] X-ray/CBCT

....
doctor's signature, stamp and date patient's legible signature and date

VI. INFORMATION ON THE CONDITIONS OF DELIVERING HEALTHCARE SERVICES

1) ESTIMATED COSTS OF THE PROCEDURE: ……..

2) PAYMENT CONDITIONS: Payment will be made after the whitening procedure is performed.

3) PATIENT'S STATEMENT:

I hereby confirm that:

1. I have been informed about the terms of payment, which I fully acknowledge and accept;
2. I acknowledge and accept that the costs of travel to/from the healthcare center shall not be reimbursed;
3. I understand that, in the event of a change in the scope of the performed procedure, the amount of the pre-determined expected costs of the procedure (section VI item 1) may be modified accordingly;
4. I am aware that the success and outcomes of the procedure depend to a large extent on my compliance with the doctor's recommendations, which I agree to follow, including by attending regular check-ups and hygienization visits.

……..
(patient's signature and date)

VII. CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Acting on my own behalf, I hereby confirm that I consent to the disclosure of confidential medical information concerning the medical procedure referred to hereinabove, in the form of X-ray/CBCT images and photographs to be presented or published, without disclosing any personally identifiable information, for the purposes of: educating other patients (presenting medical records for illustrative purposes only), staff training, and marketing (informing about the health services delivered). I confirm I shall not be entitled to make any claims in this respect. I am aware that I can withdraw my consent at any time, without any negative consequences.

……..
(patient's signature and date)