# Internal Tooth Bleaching Consent Form

1. Complete and accurate disclosure of medical information about the patient is necessary for proper diagnosis and treatment and to minimize unnecessary complications related to root canal treatment and internal teeth whitening.
2. The purpose of internal bleaching is to lighten or whiten the cosmetic appearance of the tooth. Internal bleaching is a biological procedure therefore there is no guarantee or warranty relating to the cosmetic outcome.
3. Internal bleaching may require multiple office visits. Therefore, you must return for all additional appointments at the time specified by the dentist. 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 expense.
4. I understand that the most common risks and complications related to internal bleaching include, but are not limited to:

   a. External resorption

   b. Internal resorption

   c. Reaction to bleaching agent

   d. Over whitening or under whitening

   e. Pain or tenderness of the tooth following treatment due to possible complications or normal post-operative response.
5. These complications may require additional root canal treatment, extraction or follow-up of the tooth. Alternative treatment choices include no treatment or other dental procedures such as crowns or veneers to achieve cosmetic outcomes.
6. I understand that a new permanent restoration will be needed to seal the access (hole) created to perform this procedure
7. I have been informed of the possible risks and complications involved and have had the opportunity to discuss any concerns that I have.

I HAVE READ AND UNDERSTAND EVERYTHING WRITTEN ABOVE.

I, _____ (print name), consent to internal tooth bleaching and confirm that I have read and understood the contents of this document. I have had the opportunity to ask questions and understand I can ask further questions should they arise at any point.

Signature _____ Date _____

To be completed by the clinician(s) providing information to the patient: I, _____ (print name), confirm that I have explained the treatment to the patient, along with the significant risks and the possible alternatives. I also confirm that I have the necessary competence to provide this information.

Signature _____ Date _____