AS4U0716- WHITENING FOR LIFE

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WHITENING FOR LIFE PROGRAM

STAGE I
Zoom-professional chairside whitening system

The following medications are commonly considered to be photo reactive 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.

Aldoclor, Diupres, Diuril, Aldacteride, Aldoril, Capozide, Dyazide, Hydrodiuril, Lopressor, Orotic, Moduretic, Combipres, tenoretic, Hygroton, Naproxen, Daypro, Relafen, Feldene, Vibramysin, Doryx, Cipro, Floxin, Methoxsalen, Trisoralen, Declomycin, Chibroxin, Noroxin, Zagan, Clinoril, Sulindac, Achromycin, Accutane, Retin A.

STAGE II
POLA Night Advance Whitening System

Indications for use: Whitening of discolored vital teeth and non-vital teeth.

Composition: 22% Wt Carbamide peroxide, less then 47 % additives, 30% Glycerol, 20% wt water, and 0.1% Flavour.

Treatment Guidelines: 22% POLA Night 1x a day for 1 hour a day
1. Remove the syringe cap and insert an application tip twisting it securely onto the syringe.
2. Place a small drop of gel into every compartment of the tray for the teeth undergoing treatment.
3. Seat the tray, with the gel around the teeth.
4. Wipe away excess gel around the teeth.
5. After treatment, remove tray. Rinse tray and mouth with lukewarm water.
6. Brush your teeth and then the tray to remove any additional gel.

Note: Do not eat, drink, or smoke during treatment. Do not smoke immediately after treatment –wait for at least two hours. Foods and drinks containing strong colors should be avoided for at least 48 hours or consumed in moderation. Use gel at room temperature.

Storage and Shelf life: Store at temperatures between (35 degrees-45 degrees) F away from direct sunlight. Shelf life is 2 years. Keep any unused (capped) syringes refrigerated.

STAGE III
Whitening for life program

You will receive (one) tube of 22% POLA night whitening system each time you come in for your recommened hygiene recare appointment. It will be given to you by your hygienist. You must stay on your recare schedule, 3, 4, or 6 month, to receive this tube of whitening.

I have read the above statements and have received a copy (if requested), and recognize their importance in helping me with making my decisions. My signature indicates that I have read and understand this consent document.

I recognize that failures can occur for various reasons and complications can occur in any procedure. I hereby grant authority to the doctor in charge to administer such procedures that may be deemed necessary or advisable in the diagnosis and/or treatment. I also certify that the information I submitted in the health questionnaire is true and complete. In order to receive treatment, I contract that in the event of any difference or disagreement between the attending doctor and me, I will give that doctor the opportunity to resolve the problem.

The risks and benefits associated with the above-referenced dental treatment have been thoroughly explained to me. I understand there is no certainty that I will achieve the desired benefits and/or results, and no guarantee or assurance has been made to me regarding the outcome of such dental treatment. In authorizing the abovereferenced dental treatment to be performed, I understand that unforeseen conditions may occur during such treatment, which may necessitate a total change, extension or modification of the original treatment outlined above, or necessitate a different type of treatment than such authorized treatment set forth above. I therefore authorize and request that such treatment may be necessary and desirable in the exercise of my doctor’s professional judgment.

I understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the extraction(s), I agree to report them to the office as soon as possible. In case of an acute emergency, and in the event you cannot reach this office, or we have not returned your call in a reasonable amount of time, please proceed to the nearest emergency room for medical attention.

Furthermore, I have been fully informed as to the nature of my dental treatment including other such care and treatment, along with the potential benefits, risks or side effects of such dental treatment, and the likelihood of achieving the desired results. I have been told that the success of the dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status. I have discussed all of the above with the doctor, and have had all of my questions answered to my satisfaction. I consent to treatment.

Signature of Patient, Parent, or Guardian: _____

ENJOY YOUR BEATUIFUL WHITE SMILE!!!