DECLARATION
of informed consent of the patient about implementing of in-office teeth bleaching

I, the undersigned……..……..……..…,
EGN……..
ID N:…….. issued on…….by ……..
Address: City:……..Street:……
Tel……

hereby DECLARE that

I am acquainted by Dr. ……
with the condition of my masticatory apparatus, the registered teeth color and the type of their coloration. The possibilities for teeth whitening have been explained to me, as well as the necessary diagnostic and cosmetic procedures, as follows:

→ Color before start of bleaching procedure (registered by VITA shade)

→ Bleaching steps:
- professional cleaning of external coloration (clinical prophylaxis);
- setting of lip retractor and isolation of soft tissues, face and eyes;
- application of bleaching gel;
- bleaching acceleration (irradiation with BLUEDENT 12 BL unit);
- fluorization and polishing.

It is obligatory to wear the enclosed Protection goggles (supplied by the company manufacturer of the bleaching unit - BG LIGHT LTD) during the whole bleaching procedure.

→ Color after the end of bleaching procedure (registered by VITA shade)

I agree that during my teeth bleaching will be used LED Bleaching unit BLUEDENT 12 BL. I am acquainted with the description of the procedures that will be carried out with it.

1. Expected benefits:
a) expected improvement in implementing the treatment plan – change in teeth color satisfying the patient's expectations.

2. Possible risks
a) foreseen risks and inconveniences – teeth color that doesn't change or changes less, according to alternative bleaching methods.

b) possible adverse effects – adverse effects influencing general condition of patient are not expected. Patient may feel increased teeth sensitivity, gingival irritation - usually resolves up to 24 hours.

c) contraindications - The device should not be used with pregnant and breast-feeding mothers, patients with: oncological problems, severe paradental pathology, recessions, dental paresthesia and under 17 years of age. The device may only be used after medical

consultation on or by persons with implanted cardiac pacemaker; persons suffering from photobiological reactions; taking photosensitive medications; individuals with cataract surgery, people with retinal illnesses, allergy sufferers; persons with multiple sensitive skin or dermatitis, etc.
If the bleaching protocol is not followed, pain, hypersensitivity, enamel defects and even burning of the non-calcified, soft tissue may occur.

I understand that after treatment, I will be required to refrain from consuming any chromogenic substances (i.e. tomato sauce, coffee, all tobacco products) for 48 hours.

In signing this informed consent I am stating I have read this informed consent and I fully understand it and the possible risks, complications and benefits that can result from the implementation of in-office teeth bleaching.

After Dr. …… made me acquainted in details with the information, I give my consent for implementing the following treatment:
- professional cleaning of external coloration (clinical prophylaxis);
- setting of lip retractor and isolation of soft tissues, face and eyes;
- application of bleaching gel;
- bleaching acceleration (irradiation with BLUEDENT 12 BL unit);
- fluorization and polishing.

Date:……..

Declarer (patient):……
(signature)