CONGRATULATION ON YOUR DECISION TO ***ZOOM*!**

Zoom! is a professional tooth whitening system that uses Ultra Violet light and hydrogen peroxide to whiten enamel.
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 with you physician before going through the ***Zoom!*** procedure. To check photo reactive properties of any medications not listed below, please consult the most recent edition of the Physician's Drug Reference (PDR).
(If you are taking any of the medications listed below, we can only proceed with a *written release* from your physician.)

Generic Name	*Trade Name*	*Please circle*	
Chlorthiazide	Aldoclor, Diupres, Diuril	Yes	No
Hydrochlorothizxide	Aldacteride, Aldoril, Capozide, Dyazide, Hydodiuril, Lopressor, Orotic, Moduretic	Yes	No
Chlorthalidone	Combipres, Tenoretic, Hygroton	Yes	No
Naprosyn	Naproxen	Yes	No
Oxanprozin	Daypro	Yes	No
Nabimetone	Relafen	Yes	No
Piroxican	Feifene	Yes	No
Doxycycline	Vibramycin, Doryx	Yes	No
Ciprofloxacin	Cipro	Yes	No
Ofloxcin	Floxin	Yes	No
Psoralens	Methoxsalen, Trisoralen	Yes	No
Democlocyline	Declomycin	Yes	No
Norfloxacin	Chibroxin, Noroxin	Yes	No
Sparfloxacin	Zagan	Yes	No
Sulindac	Clinoril, Sulindac	Yes	No
Tetracycline	Achromycin	Yes	No
St. John's Wart		Yes	No
Isotretinoin	Accutane	Yes	No
Tretinoin	Retin A	Yes	No

Are you presently a patient of ***Aesthetic Smiles***? …………………… Yes No

If No, an exam, cleaning and radiographs are required prior to ***Zoom!***

Have you had a dental exam and radiographs in the last 6 months? …………………… Yes No

If Yes, When? ______________________

Date of last cleaning ______________________

*****Old discolored fillings may need to be replaced after Zoom!***

Are you 18 years or older?…………………… Yes No

Have you been diagnosed with active cavities that need treatment in the last 6 months? …………………… Yes No

Have you been diagnosed with periodontal infection? …………………… Yes No

Have you ever had orthodontic treatment? …………………… Yes No

If Yes, When? ______________________

** Exceptions can be made if used NSF treatment (or other) diligently during Ortho

Do you have diabetes? …………………… Yes No

Have you been diagnosed with high blood pressure? …………………… Yes No

Are you ***claustrophobic***? …………………… Yes No

If Yes, please discuss with the Doctor or Hygienist

Do you ***smoke***?…………………… Yes No

Do you ***gag easily***?…………………… Yes No

WOMEN: Are you pregnant or lactating? …………………… Yes No

Patient Acknowledgement

- ***NOTE: Results will vary from patient to patient.***

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 acknowledge that I do not currently take any of the above-prescribed medication.

I also certify that the above information is complete and accurate.

Patient's Name ______________________ Birth Date______________

Patient's Signature ______________________ Date ______________

Practitioner Signature ______________________ Date ______________

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INFORMED CONSENT FOR ZOOM!® TOOTH WHITENING 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 make my decision about signing this 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 my teeth using a combination of a hydrogen peroxide gel and a specially designed ultraviolet lamp. The *Zoom!* treatment involves using the gel and 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., my lips, gums, cheeks and tongue) will be covered to ensure they are not exposed to either the gel or light. Lip balm (SPF rating: 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 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 the *Zoom!* treatment at all. However, should I decide to undergo the treatment, I understand there are alternative treatments for whitening my teeth for which my dentist can provide me additional information. These treatments include: Whitening Toothpastes/Gels Other In-office Whitening Treatments Take-Home Whitening Kits.

COST

I understand that the cost of my *Zoom!* treatment is determined by my dentist. I understand that my dentist will inform me if there are any 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 treatments 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 fluorosis 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 provisional or temporaries 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 PUVA (Psoralen + UVA radiation) or other photo chemotherapeutic 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 insusceptible individuals. Normally, tooth sensitivity or pain following a *Zoom!* treatment subsides after a few days, but it may 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 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 or 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 a 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 indicated 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 allowing gel to penetrate the tooth are 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 fillings re-done before undergoing the *Zoom!* treatment.

Cervical Abrasion/Erosion – These are conditions which affect the roots of the teeth when the gums recede and they are characterized by grooves, notches 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 indicates 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. This is natural and should be very 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!* treatment 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, tea, colas, **ALL** tobacco products, mustard or ketchup, red wine, soy sauce, berry pie, 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 its stain potential 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!* treatment, the list of complications in this form is incomplete.

The basic procedures of *Zoom!* treatment and the advantages and disadvantages, risks and known possible complications 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.

SIGNATURES

By signing this document in the space provided I indicate that I have read and understand the entire document and that I give my permission for *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