Endodontic Internal 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.

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, the patient must return for all additional appointments at the time specified by the doctor. 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 sole 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.

    These complications may require additional root canal surgery, extraction or follow-up of the tooth.

5. 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 and Dr. Bui is an endodontist therefore he does not perform such dental procedures. Followup with your general dentist is recommended.

7. I have been informed of the possible risks and complications involved and have had the opportunity to discuss any concerns that I have with Dr. Bui.

I hereby certify that I have read and understand the above information and give my consent for Dr. Baokhoi Bui to perform root canal treatments for _____(print patient's name).

_____	_____	_____
Signature of adult patient/parent/guardian	Date	Signature of Witness
_____		_____
Print Name of Signer		Signature of Dentist