DR. FAIZAN ABDUL HUSSAIN LAKHDIR

CONSENT FORM FOR BLEACHING / WHITENING (Surgeon's Copy)

Serial No	**Date**	**CNIC / MR No.**
Hospital / Clinic		
Patient Name	**Age**	**Gender**
Address	**Contact No**	
Medical Risk Details		

Important Limitations

I understand that bleaching works mainly on **natural tooth structure**. It does not whiten existing fillings, crowns, veneers, bridges, dentures, or other artificial restorations. These restorations may need replacement after bleaching if shade mismatch occurs.

I understand that deep stains, fluorosis, tetracycline stains, old discoloration, root canal-treated teeth, or uneven shades may not fully improve and may require additional treatment such as polishing, veneers, crowns, composite restorations, or repeat bleaching.

Consent Statement

I have been informed that teeth bleaching / whitening is a cosmetic dental procedure used to lighten the shade of natural teeth. The procedure, expected benefits, limitations, alternatives, cost, and possible complications have been explained to me in simple words.

I understand that the final shade result varies from person to person and depends on the original tooth colour, type of staining, age of teeth, enamel condition, oral habits, diet, smoking, and patient compliance.

Patient Responsibility

I understand that I must follow the dentist's instructions carefully, including the correct use of bleaching gel, trays, appointment schedule, oral hygiene advice, and diet restrictions

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I have been advised to avoid or reduce staining substances such as tea, coffee, tobacco, pan, gutka, coloured drinks, and highly pigmented foods during and after treatment, as advised by the dentist.

I understand that if I do not follow instructions, overuse bleaching material, miss appointments, or continue staining habits, the result may be poor, uneven, temporary, or unpredictable.

Possible Risks and Complications:

I understand that possible risks may include:

- Temporary or prolonged tooth sensitivity
- Gum irritation, burning sensation, ulceration, or soreness
- Uneven whitening or white spots becoming more visible
- Shade relapse or darkening again over time
- Unsatisfactory shade improvement
- Increased sensitivity in cracked teeth, exposed roots, cavities, leaking fillings, or gum recession
- Need for additional dental treatment before or after bleaching
- Failure or poor result if instructions are not followed properly

Patient Declaration

I confirm that the procedure, benefits, risks, limitations, alternatives, cost, and patient responsibilities have been explained to me. I have had the opportunity to ask questions, and my questions have been answered.

I understand that no guarantee has been given regarding the final shade, duration of whitening, comfort, or long-term result. I consent to teeth bleaching / whitening treatment as planned.

Patient / Guardian Name	**Patient / Guardian Signature**
Doctor Name and Signature	**Witness Name and Signature**

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Doctor Name and Signature	**Witness Name and Signature**