

**SPECIAL INSTRUCTIONS**

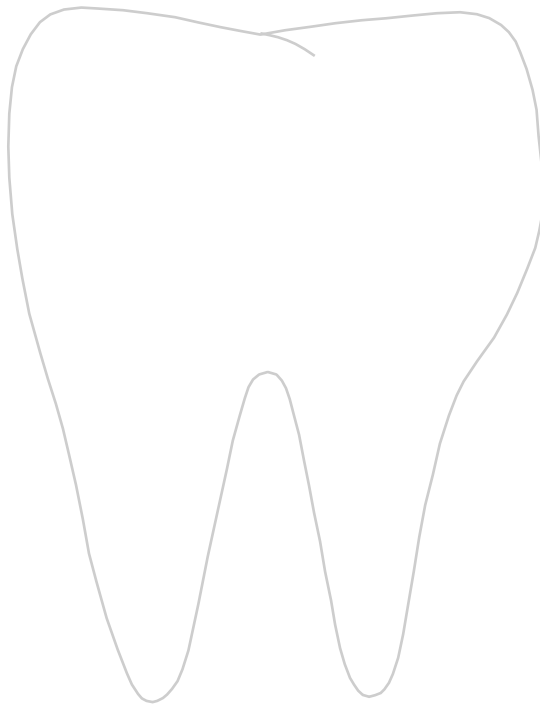
**Recommended** wearing time: \_\_\_\_\_ hours    **Replenish**                      solution every \_\_\_\_\_ hours

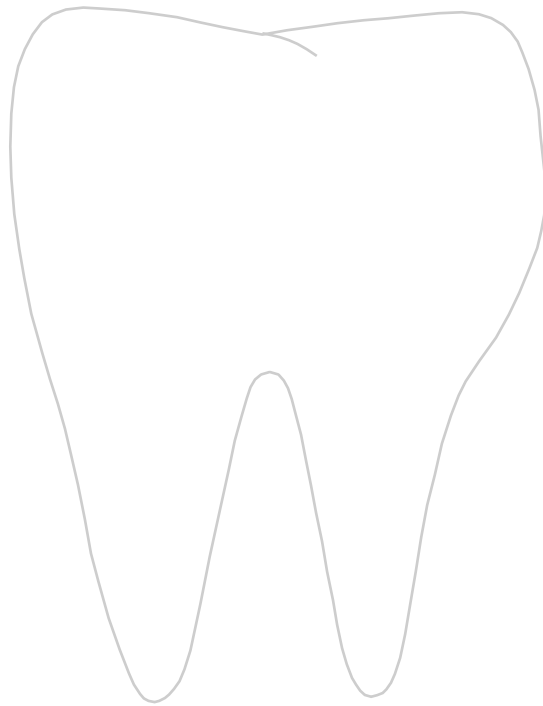
I have read the above and any of my questions and concerns have been answered and explained to me. I agree to return for examination during treatment as recommended by my dentist. I also agree to return for periodic oral examinations after treatment is completed. I have received a copy of this information and instruction sheet. I understand the directions and risks, and I consent to treatment.

I also consent to photographs being taken. I understand they will be used for documentation, treatment study, and for educational purposes.

I further understand the first bleaching gel syringe will be provided to me free of charge. If I desire more bleaching gel for future use, I would need to purchase the new supply.

**Patient:** \_\_\_\_\_ **Doctor:** \_\_\_\_\_ **Date:** \_\_\_\_\_





---

*Excellence in Dentistry*

6907 W. Boeing Drive, Midwest City, OK 73110. Ph: (405) 455-2552. Fax: (405) 455-2553  
7300 S. Western Ave, Oklahoma City, OK 73139. Ph: (405) 631-4439. Fax (405) 632-7905