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
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