Teeth Whitening Consent Form

Patient Information

Full Name

Date of Birth

Email

Phone Number

Medical History

Please list any allergies, medications, or relevant medical conditions

Consent & Acknowledgements

- [ ] I understand the risks and possible side effects of teeth whitening.
- [ ] I have disclosed all relevant medical information to my provider.
- [ ] I consent to proceed with teeth whitening treatment.

Patient Signature

_____

Date