

CONGRATULATION ON YOUR DECISION TO ZOOM!

Zoom! is a professional tooth whitening system that uses Ultra Violet light and hydrogen peroxide to whiten enamel. The following medications are commonly considered to be photo reactive and may cause an adverse condition if used in conjunction with the **Zoom!** System. If you are currently taking any of these medications, please consult with your physician before going through the **Zoom!** procedure. To check photo reactive properties of any medications not listed below, please consult the most recent edition of the Physician's Drug Reference (PDR).

(If you are taking any of the medications listed below, we can only proceed with a written release from your physician.)

<u>Generic Name</u>	<u>Trade Name</u>	<u>Please circle</u>	
Chlorthiazide	Aldoclor, Diupres, Diuril	Yes	No
Hydrochlorothiazide	Aldacteride, Aldoril, Capozide, Dyazide, Hydodiuril, Lopressor, Orotic, Moduretic	Yes	No
Chlorthalidone	Combipres, Tenoretic, Hygroton	Yes	No
Naprosyn	Naproxen	Yes	No
Oxaprozin	Daypro	Yes	No
Nabimetone	Relafen	Yes	No
Piroxican	Feifene	Yes	No
Doxycycline	Vibramycin, Doryx	Yes	No
Ciprofloxacin	Cipro	Yes	No
Ofloxacin	Floxin	Yes	No
Psoralens	Methoxsalen, Trisoralen	Yes	No
Democloxyline	Declomycin	Yes	No
Norfloxacin	Chibroxin, Noroxin	Yes	No
Sparfloxacin	Zagan	Yes	No
Sulindac	Clinoril, Sulindac.....	Yes	No
Tetracycline	Achromycin.....	Yes	No
St. John's Wart	Yes	No
Isotretinoin	Accutane.....	Yes	No
Tretinoin	Retin A.....	Yes	No

Who is your dentist? _____

Have you had a dental exam and radiographs in the last 6 months? Yes No
 If Yes, When? _____
 Date of last cleaning _____

****Old discolored fillings may need to be replaced after Zoom!**

Are you 18 years or older? Yes No
 Have you been diagnosed with active cavities that need treatment in the last 6 months? Yes No
 Have you been diagnosed with periodontal infection? Yes No
 Have you ever had orthodontic treatment? Yes No
 What? _____

What would you like to change about your smile? _____

Do you have diabetes? Yes No
 Have you been diagnosed with high blood pressure? Yes No
 Are you **claustrophobic**? Yes No
 If Yes, please discuss with the Doctor or Hygienist

Do you **smoke**? Yes No
 Do you **gag easily**? Yes No

WOMEN: Are you pregnant or lactating? Yes No

Patient Acknowledgement

➤ **NOTE: Results will vary from patient to patient.**

I have read the list above and understand that the medications listed, if taken, can have an adverse reaction when used with the **Zoom!** System. I acknowledge that I do not currently take any of the above-prescribed medication.

I also certify that the above information is complete and accurate.

Patient's Name _____ Birth Date _____

Patient's Signature _____ Date _____

Practitioner Signature _____ Date _____

DONALD J. NEELY, DMD, MS, PC
drneely.com
7 Allen Street - Suite 300
HANOVER NH 03755
603-643-1200

INFORMED CONSENT FOR ZOOM!® TOOTH WHITENING TREATMENT

INTRODUCTION

This information has been given to me so that I can make an informed decision about having my teeth whitened. I may take as much time as I wish to make my decision about signing this informed consent form. I have the right to ask questions about any procedure before agreeing to undergo the procedure. My dentist has informed me that my teeth are discolored and could be treated by in-office whitening (also known as "bleaching") of my teeth.

DESCRIPTION OF THE PROCEDURE

Zoom! in-office tooth whitening is a procedure designed to lighten the color of my teeth using a combination of a hydrogen peroxide gel and a specially designed ultraviolet lamp. The *Zoom!* treatment involves using the gel and lamp in conjunction with each other to produce maximum whitening results in the shortest possible time. During the procedure, the whitening gel will be applied to my teeth and my teeth will be exposed to the light from the *Zoom!* lamp for three (3), 20-minute sessions. During the entire treatment, a plastic retractor will be placed in my mouth to help keep it open and the soft tissues of my mouth (i.e., my lips, gums, cheeks and tongue) will be covered to ensure they are not exposed to either the gel or light. Lip balm (SPF rating: 30+) may also be applied as needed and I will be provided an ultraviolet light filter for my eyes. After the treatment is completed, the retractor and all gel and tissue coverings will be removed from my mouth. Before and after the treatment, the shade of my upper-front teeth will be assessed and recorded.

ALTERNATIVE TREATMENTS

I understand I may decide not to have the *Zoom!* treatment at all. However, should I decide to undergo the treatment, I understand there are alternative treatments for whitening my teeth for which my dentist can provide me additional information. These treatments include: Whitening Toothpastes/Gels Other In-office Whitening Treatments Take-Home Whitening Kits.

COST

I understand that the cost of my *Zoom!* treatment is determined by my dentist. I understand that my dentist will inform me if there are any other costs associated with my *Zoom!* treatment.

RISKS OF TREATMENT

I also understand that *Zoom!* treatment results may vary or regress due to a variety of circumstances. I understand that almost all natural teeth can benefit from *Zoom!* whitening treatments and significant whitening can be achieved in most cases. I understand that *Zoom!* whitening treatments are not intended to lighten artificial teeth, caps, crowns, veneers or porcelain, composite or other restorative materials and that people with darkly stained yellow or yellow-brown teeth frequently achieve better results than people with gray or bluish-gray teeth. I understand that teeth with multiple colorations, bands, splotches or spots due to tetracycline use or fluorosis do not whiten as well, may need multiple treatments or may not whiten at all. I understand that teeth with many fillings, cavities, chips or cracks may not lighten and are usually best treated with other non-bleaching alternatives. I understand that provisional or temporaries made from acrylics may become discolored after exposure to *Zoom!* treatment.

I understand that *Zoom!* treatment is not recommended for pregnant or lactating women, light sensitive individuals, patients receiving PUVA (Psoralen + UVA radiation) or other photo chemotherapeutic drugs or treatment, as well as patients with melanoma, diabetes or heart conditions. I understand that the *Zoom!* Lamp emits ultraviolet radiation (UVA and UVB) and that patients taking any drugs that increase photosensitivity should consult with their physician before undergoing *Zoom!* treatment.

I understand that the results of my *Zoom!* Treatment cannot be guaranteed.

I understand that in-office whitening treatments are considered generally safe by most dental professionals. I understand that although my dentist has been trained in the proper use of the *Zoom!* whitening system, the treatment is not without risk. I understand that some of the potential complications of this treatment include, but are not limited to:

Tooth Sensitivity/Pain – During the first 24 hours after *Zoom!* treatment, many patients can experience some tooth sensitivity or pain. This is normal and is usually mild, but it can be worse in susceptible individuals. Normally, tooth sensitivity or pain following a *Zoom!* treatment subsides after a few days, but it may persist for longer periods of time in susceptible individuals. People with existing sensitivity, recession, exposed dentin, exposed root surfaces and occlusal wear facets (severely worn teeth), damaged or missing enamel, cracked teeth, abfractions (micro-cracks), open cavities, leaking fillings, or other dental conditions that cause sensitivity or allow penetration of the gel into the tooth may find that those conditions increase or prolong tooth sensitivity or pain after *Zoom!* treatment.

Gum/Lip/Cheek Inflammation – Whitening may cause inflammation of your gums, lips or cheek margins. This is due to inadvertent exposure of a small area of those tissues to the whitening gel or the ultraviolet light. The inflammation is usually temporary which will subside in a few days but may persist longer and may result in significant pain or discomfort, depending on the degree to which the soft tissues were exposed to the gel or ultraviolet light.

Dry/Chapped Lips – The *Zoom!* treatment involves three, 20-minute sessions during which the mouth is kept open continuously for the entire treatment by a plastic retractor. This could result in dryness or chapping of the lips or cheek margins, which can be treated by application of lip balm, petroleum jelly or Vitamin E cream.

Cavities or Leaking Fillings – Most dental whitening is indicated for the outside of the teeth, except for patients who have already undergone a root canal procedure. If any open cavities or fillings that are leaking and allowing gel to penetrate the tooth are present, significant pain and damage to the tooth could result. I understand that if my teeth have these conditions, I should have my cavities filled or my fillings re-done before undergoing the *Zoom!* treatment.

Cervical Abrasion/Erosion – These are conditions which affect the roots of the teeth when the gums recede and they are characterized by grooves, notches and/or depressions, that appear darker than the rest of the teeth, where the teeth meet the gums. These areas appear darker because they lack the enamel that covers the rest of the teeth. Even if these areas are not currently sensitive, they can allow the whitening gel to penetrate the teeth, causing sensitivity, pain and possible damage to the nerve. I understand that if my teeth have these conditions, I should not undergo the *Zoom!* treatment.

Root Resorption – This is a condition where the root of the tooth starts to dissolve either from the inside or outside. Although the cause of this is still uncertain, I understand that there is evidence that indicates the incidence of root resorption is higher in patients who have undergone root canals followed by whitening procedures.

Relapse – After the *Zoom!* treatment, it is natural for teeth that underwent the *Zoom!* treatment to regress somewhat in their shading after treatment. This is natural and should be very gradual, but it can be accelerated by exposing the teeth to various staining agents. Treatment usually involves wearing a take-home tray or repeating the *Zoom!* treatment. I understand that the results of the *Zoom!* treatment are not intended to be permanent and secondary, repeat or take-home treatments may be needed for me to maintain the tooth shade I desire for my teeth.

I understand that after treatment, I will be required to refrain from consuming any substances that could discolor my teeth for the first **48 hours** after treatment. These substances include: coffee, tea, colas, **ALL** tobacco products, mustard or ketchup, red wine, soy sauce, berry pie, red sauces. I understand that there are other substances that could discolor my teeth, which I should avoid during the first 48 hours after treatment. If I have any questions regarding any such substance, I understand that I can discuss its stain potential with my dentist.

The safety, efficacy, potential complications and risks of *Zoom!* treatment can be explained to me by my dentist and I understand that more information on this will be provided to me upon my request. Since it is impossible to state every complication that may occur as a result of *Zoom!* treatment, the list of complications in this form is incomplete.

The basic procedures of *Zoom!* treatment and the advantages and disadvantages, risks and known possible complications of alternative treatments have been explained to me by my dentist and my dentist has answered all my questions to my satisfaction.

In signing this informed consent I am stating I have read this informed consent (or it has been read to me) and I fully understand it and the possible risks, complications and benefits that can result from the *Zoom!* treatment and that I agree to undergo the treatment as described by my dentist.

SIGNATURES

By signing this document in the space provided I indicate that I have read and understand the entire document and that I give my permission for *Zoom!* treatment to be performed on me.

_____ Patient's Signature	_____ Date
_____ Patient's Name (Printed)	_____ Date
_____ Dentist's Signature	_____ Date
_____ DONALD J. NEELY, DMD, MSD	_____ Date

Donald J. Neely, DMD, MS, PC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.25 for each page, \$25 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Kelly Loupis _____

Telephone: (603) 643-1200 _____ Fax: (603) 643-9269 _____

E-mail: kelly@drneely.com _____

Address: 7 Allen Street, Suite 300, Hanover, NH 03755 _____

©2002, 2009 American Dental Association. All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April 30, 2009).

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

(You may refuse to sign this Acknowledgement)

I, _____, have received a copy of Dr. Neely's Notice of Privacy Practices.

Signature

Date

[] Refused