

TEETH WHITENING Consultation Form

PERSONAL INFORMATION

Name _____ Date _____

Date of birth _____ Age _____ Female Male NB

Address _____

City _____ State _____ ZIP Code _____

E-mail _____ Phone _____

Emergency Contact: _____ Phone _____

Would you like to be added to our email list for news and exclusive offers? YES NO

DENTAL HISTORY

Have you had professional teeth whitening before? No Yes

If yes, when was your last teeth whitening treatment? _____

Do you have any crowns, bridgers, veneers, or fillings? No Yes

If yes, please state where _____

MEDICAL HISTORY

Are you currently under the care of a physician? No Yes

If yes, please specify the condition: _____

List any medications you are currently taking: _____

Are you allergic to any medications or substances? No Yes

If yes, please list them: _____

Do you have a history of any of the following? (Please check all that apply)

- Gum Disease Receding Gums Any other problems:_____
- Tooth Sensitivity Allergies to Peroxide (used in some whitening agents)

Do you use tobacco products? No Yes

Do you regularly consume coffee, tea, wine, or other staining beverages? No Yes

How would you rate your daily oral hygiene routine? Excellent Good Fair Poor

What are your expectations for teeth whitening? _____

Are you aware of the risks and potential side effects associated with teeth whitening?

No Yes

How did you hear about our teeth whitening services? _____

I hereby provide consent to [Dental Practice Name] to perform a teeth whitening procedure. I understand that the results of teeth whitening vary for each individual and are not guaranteed. I have accurately completed this form to the best of my knowledge and have had the opportunity to ask any questions regarding the teeth whitening process. I understand the recommended guidelines for post-whitening care to ensure the best possible results.

Patient Printed Name _____

Patient Signature _____ Date _____

FOR OFFICE USE ONLY

Reviewed by: _____ Date _____

Comments: _____

Appointment Scheduled: Date _____ Time _____ Staff Initials _____

TEETH WHITENING Client Consent Form

PROCEDURE DESCRIPTION Teeth whitening (bleaching) is a process of lightening the color of teeth using a chemical agent that breaks down stains. The degree of whitening will vary from patient to patient, depending on the structure of the teeth, the number of applications, and/or the duration of time that the system is used. **POTENTIAL RISKS AND COMPLICATIONS**

- 1. **Tooth Sensitivity:** Some patients may experience tooth sensitivity during the treatment. The sensitivity is usually transient and subsides after the completion of the treatment.
- 2. **Gum Irritation:** Whitening can cause temporary irritation of gums or soft tissues in the mouth, particularly if higher concentrations of the whitening agent are used.
- 3. **Variations in Color Uniformity:** Pre-existing dental work such as crowns or veneers will not bleach and therefore may need to be replaced to match the new tooth shade.
- 4. **Incomplete Whitening:** Teeth with multiple colorations, bands, or spots due to tetracycline use or fluorosis may not achieve a uniform color change.
- 5. **Relapse:** After a period (usually 1-3 years), the teeth may darken again. Maintenance treatments can be necessary to retain the color achieved.
- 6. **Throat Irritation or Nausea:** Accidental ingestion of the whitening gel may lead to throat irritation or nausea.

CONSENT AND LIABILITY RELEASE I have requested and consent to receive a teeth whitening treatment. I understand the procedure and accept the potential risks and complications of the teeth whitening treatment as described above. I understand that the practice of dentistry is not an exact science and that no guarantees can be made or assumed about the results of the procedure. I acknowledge that I am responsible for following the post-care instructions provided by my dentist, and that the success of my treatment depends on my compliance with those instructions. I agree to assume the risks associated with the teeth whitening treatment, including but not limited to the risks described above and any other risks not discussed during our consultation. I do not hold [Your Dental Practice Name], its dentists, hygienists, or any other staff members liable for any complications that may occur during or following the teeth whitening procedure.

By signing this form, I am freely giving my consent to allow and authorize [Dentist's Name] and/or associated dental staff to perform the teeth whitening treatment.

Patient Signature: _____ Date _____

Dentist/Whitening Specialist: _____ Date _____

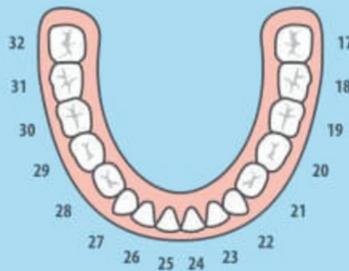
TOOTH CHART

- 1. 3rd Molar (wisdom tooth)
- 2. 2nd Molar (12-yr molar)
- 3. 1st Molar (6-yr molar)
- 4. 2nd Bicuspid (2nd premolar)
- 5. 1st Bicuspid (1st premolar)
- 6. Cuspid (canine/eye tooth)
- 7. Lateral incisor
- 8. Central incisor



- 9. Central incisor
- 10. Lateral incisor
- 11. Cuspid (canine/eye tooth)
- 12. 1st Bicuspid (1st premolar)
- 13. 2nd Bicuspid (2nd premolar)
- 14. 1st Molar (6-yr molar)
- 15. 2nd Molar (12-yr molar)
- 16. 3rd Molar (wisdom tooth)

- 25. Central incisor
- 26. Lateral incisor
- 27. Cuspid (canine/eye tooth)
- 28. 1st Bicuspid (1st premolar)
- 29. 2nd Bicuspid (2nd premolar)
- 30. 1st Molar (6-yr molar)
- 31. 2nd Molar (12-yr molar)
- 32. 3rd Molar (wisdom tooth)



- 17. 3rd Molar (wisdom tooth)
- 18. 2nd Molar (12-yr molar)
- 19. 1st Molar (6-yr molar)
- 20. 2nd Bicuspid (2nd premolar)
- 21. 1st Bicuspid (1st premolar)
- 22. Cuspid (canine/eye tooth)
- 23. Lateral incisor
- 24. Central incisor