

Date: \_\_\_\_\_ No. \_\_\_\_\_

Client's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Business Telephone: \_\_\_\_\_

### For Dentist Use Only

Is client an existing patient of record? No  Yes  If Yes, medical and dental up-date is needed.

Client had whitening process done previously? If so, what type? \_\_\_\_\_

Any problems? \_\_\_\_\_

If BriteSmile, medical and dental up-date is needed.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Reviewed Consent Form     | <input type="checkbox"/> Reviewed Medical History  | <input type="checkbox"/> Reviewed Dental History |
| <input type="checkbox"/> Assessment of Hard Tissue | <input type="checkbox"/> Assessment of Soft Tissue | <input type="checkbox"/> Reviewed Expectations   |

### Areas of Concern (please circle)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Antibiotic Stain? Yes  No  **Rx BriteSmile Process.**  **If no, please explain** \_\_\_\_\_ **Sent referral letter**

### Treatment Record

Client's picture taken and teeth brushed  Eye Wear  Cheek Retractor and Facial Napkin

Fiber Optic Positioner  Resin  Dam/Cotton Rolls \_\_\_\_\_ Masking Gel and Lip Protection  Gel Batch # \_\_\_\_\_

1st Gel Time \_\_\_\_\_ 2nd Gel Time \_\_\_\_\_ 3rd Gel Time \_\_\_\_\_ 4th Gel Time \_\_\_\_\_ Pre-whitening Shade \_\_\_\_\_

Post-whitening Shade \_\_\_\_\_ Number of shade changes \_\_\_\_\_ Fluoride Treatment: Yes  No  Photo taken? Yes  No

Client's sensitivity to treatment: None  Slight  Moderate  Severe  Post Op Instructions: Written  Verbal

Treatment Notes \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Lic# \_\_\_\_\_ Operator's Initials \_\_\_\_\_ Lic# \_\_\_\_\_