# Practice Name

# Pre-Whitening Assessment Form

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinical Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART A: To be completed by patient.**

**On a scale of 1 – 10, please indicate on the line how important the following are when considering professional whitening;**

***Cost***  1 \_\_\_\_\_\_\_\_\_\_\_\_ 10

***Effectiveness*** 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10

***Convenience***1 \_\_\_\_\_\_\_\_\_\_\_\_\_ 10

***Comfort*** 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10

**Are you a candidate for whitening?**

YES NO Do you like the colour of your teeth?

YES NO Allergic to plastics or peroxides?

YES NO Taking tetracycline antibiotics now?

YES NO Are any front teeth darker than the rest?

YES NO Do the front teeth contain fillings or crowns?

YES NO Do you have receding gums in the front?

YES NO Do you feel your gums are healthy?

YES NO Are your front teeth even in appearance?

**PART B: To be filled out by the clinician**



**Draw a line to indicate the portion of the dentition that is visible**

**when patient is smiling as well as indicating restorations in esthetic**

**zone which may require replacement after whitening**

**Shade taken:**

Initial shade (natural lighting)

centrals (mx)\_\_\_\_\_\_\_ (md)\_\_\_\_\_\_\_\_\_

cuspids (mx) \_\_\_\_\_\_\_(md)\_\_\_\_\_\_\_\_\_

gingival third (mx)\_\_\_\_\_\_\_\_(md)\_\_\_\_\_

Please circle one indicating colour of whites of eyes:

white yellow very white red

YES NO Taking drugs that dry the mouth?

YES NO Tobacco user?

YES NO History of sensitive teeth?

YES NO Pregnant or nursing mother?

YES NO Taking any medications that cause photosensitivity or undergoing photochemotherapy?

If yes, please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Evaluation of Sensitivity:**

YES NO History of sensitive teeth?

site specific

generalized

Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO Perio Evaluation updated – Date:

YES NO Odontogram updated – Date:

YES NO Recent radiographs – Date:

YES NO Outstanding Caries

Patient has been informed we cannot determine the rate at which teeth will whiten or predict the end result. Patient has also been informed of possible replacement of fillings, crowns or prostheses as applicable as the natural dentition will lighten surrounding all restored or treated teeth. Patient has been advised that increased sensitivity may occur in areas of untreated decay.

**Patient Signature:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**