COSMETIC TEETH WHITENING CONSULTATION FORM

Date: ____/____/____

A. CLIENT INFORMATION

Name: _____ Sex: M / F Date of Birth: ____/____/____

Address: _____ Town / City: _____ Post Code: _____

Telephone: _____ E-mail: _____

How did you hear about us?
Reason for teeth whitening?
Are you aged 18 or older? Yes: ____ No: ____, age: ____

Please answer the following two sections as completely as possible. Any questions which you are unsure of will be covered in the consultation.

B. DENTAL HISTORY

When was your last visit to a dentist/hygienist?
Please rate the sensitivity of your teeth to hot/cold? High / Average / Low / None
Do you have any fillings / crowns / veneers / bridges / implants? (Circle)
Do your gums bleed when brushing or flossing? Yes: ____ No: ____
Do you currently have any sores in your mouth? Yes: ____ No: ____
Are your teeth discolored due to trauma, medication or genetic disorder(s)?
Do you drink any of the following? Tea / Coffee / Red wine / Dark soft drinks
Do you use any tobacco products? Yes: ____ No: ____

C. MEDICAL HISTORY

Are you, or suspect that you might be, pregnant or breastfeeding? Yes: _____ No: _____
Are you allergic to Peroxide, Carbamide or Glycerine? Other? Yes: ____ No: _____
List any medical conditions or medications currently taking:
Signature: