

EXAMINATION, DIAGNOSIS & PRESCRIPTION SHEET FOR WHITENING

Patient Details Title	Surname	First Names
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Address		
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Date of Birth	Male/Female	Tel No Home
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Tel Mobile	Tel No Work
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Hopes & Aspirations for Tooth Whitening

Medical History (Medication taken)

Diagnosis of Discolouration:

Type of discolouration:	<i>Basic</i>	Intermediate	Severe	
Current Shade:	Expected Shade:			
White Spots	Fluorosis			
Brown Spots	Tetracycline			
Dehydration Line	Dark Crack Lines			
Other				
Lasting Sensitivity	Yes	No	Treatment for Sensitivity	
			Yes	No

Radiographs & Photographs:

Radiographs Taken date:	Radiographs Checked date:		
Periapicals	Bite Wings	Full Mouth Series	OPG
Photographs taken date: Extra-oral	Photographs taken date: Intra-oral		
Viability Testing			

Intra-oral Examination:

Recession																	
Treatment Required																	
Existing Restoration																	
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	
Existing Restoration																	
Treatment Required																	
Recession																	

Significant Gingival Condition:	Yes	No
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Patient will need further restorative treatment as follows:

Dentist's Signature	Date:
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Whitening Prescription:

Please provide whitening for the above patient.

Type of Whitening Procedure	<i>Basic</i>		<i>Intermediate</i>		<i>Advanced</i>	
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Medical History Checked date			Medication review date:	
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Patient has existing:		Patient's attention has been drawn to the following issues:			
Fillings (Anterior Composite)		Gingival condition		Gum recession	
Crowns		White spots		Lichen Planus	
Implant Crowns		Brown spots		Existing sensitivity	
Veneers		Existing fillings		Dehydration line	
		Crowns		Fluorosis, Tetracycline line	
Home Whitening		Power Whitening			

Products provided for Whitening Procedure:

Product Name	
Product Name	
Concentration	
De-sensitising Products Prescribed:	

Disclaimer discussed:
Date:

Patient's Consent to Treatment:

Patient's Signature: _____ Date: _____

Parents' Consent Given for under 16 year olds: _____ Date: _____

Parents' Signature: _____ Date: _____

Completion of Treatment:

How many appointments		Review Appt Date:	
Final Appointment Date:			
Final Photographs Taken date:		Final Shade Achieved:	

Patient referred back to (dentist's name):
for treatment diagnosed prior to whitening.

Date of referral:

Signature of referrer: