

Bleaching Analysis Form

Edited 2-00

Patient Name: _____

Dentist: _____

Chart Number: _____

Date: _____

INTERVIEW:

Medical History:

- YES NO Allergic to plastics or peroxides?
YES NO Taking tetracycline antibiotics now?
YES NO Taking hormones that cause bleeding?
YES NO Taking drugs that dry the mouth?
YES NO Tobacco user?
YES NO Pregnant or nursing mother?
YES NO Severe menstrual cycle?

Dental History:

- Onset of discoloration? _____
YES NO Previous treatment for discoloration?
YES NO History of Trauma?
YES NO History of Tetracycline ingestion?
YES NO History of sensitive teeth?
 some: # _____
 all

Type of toothpaste used? _____

TMD status

- YES NO Previous treatment? _____

- YES NO Current treatment? _____

- Current status? _____
- YES NO Appliance used? When worn?
YES NO Bruxism?
YES NO Other facial pain?

EXAMINATION

Diagnosis of discoloration:

- Inherit Trauma White fluorosis
 Aging Nonvital Brown fluorosis
 Staining Tetracycline Discolored restorations

Tooth visibility of smile:

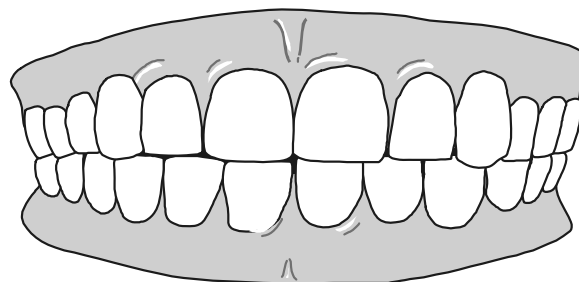
- | | |
|---|-----------------|
| Maxillary Vertical: | Tooth #s |
| <input type="checkbox"/> incisal third | _____ |
| <input type="checkbox"/> middle third | _____ |
| <input type="checkbox"/> gingival third | _____ |
| Mandibular vertical: | Tooth #s |
| <input type="checkbox"/> none | _____ |
| <input type="checkbox"/> incisal third | _____ |
| <input type="checkbox"/> middle third | _____ |
| <input type="checkbox"/> gingival third | _____ |

Radiographs:

- YES NO periapical concerns? _____
YES NO pulp size differences? _____
YES NO internal resorption? _____

Restorations in the esthetic zone:

- YES NO Discolored restorations needing replacement:
 crowns:
 composites:
 other:
- YES NO Matching restorations that may need to be redone:
 crowns:
 composites:
 other:



Outline teeth and restorations visible during the largest smile on the diagram to demonstrate to the patient which restorations may need to be replaced after bleaching.

Tooth morphology/characteristics:

		Tooth #s	
YES NO	surface white spots:	_____	
YES NO	subsurface white spots:	_____	
YES NO	brown areas:	_____	
YES NO	developmental defects	_____	
YES NO	single dark tooth:	_____	
YES NO	translucent teeth:	_____	
YES NO	exposed dentin:	_____	
YES NO	caries:	_____	
YES NO	cracks:	_____	
YES NO	toothbrush abrasion:	_____	
YES NO	abfractions:	_____	
YES NO	wear facets from bruxism :	_____	
YES NO	other smile deficiencies:	_____	
YES NO	external stains:	_____	
YES NO	anterior occlusal contacts:	_____	
YES NO	sensitive to air or touch:	_____	

Soft Tissue morphology/characteristics:

YES NO soft tissue lessons: _____
 YES NO periodontal conditions _____
 YES NO attached gingivae: thick, frail, other _____
 YES NO soft tissue defects: _____

Other prosthesis being worn:

YES NO removable ortho _____
 YES NO fixed ortho _____
 YES NO RPD (Partial) _____
 YES NO FPD (Bridge) _____
 YES NO RB-FPD (Maryland Bridge) _____

Patient expectations:

YES NO read consent form? _____
 YES NO understands other treatment options? _____
 YES NO reasonable success goals? _____
 YES NO understands fee arrangement? _____
 YES NO understands one-arch treatment? _____
 YES NO understands directions? _____
 YES NO smoking/tobacco discussed? _____
 YES NO understands responsibility for treatment? _____

YES NO agrees to stop tx & call office if problems? _____
 YES NO understands possible relapse / touch-up in future (1-3 yrs)? _____
 YES NO patient interested in other treatment? (bonding, veneers, crowns, ortho) _____

Photographs taken: (take "before" and "after" photos at same magnifications) YES NO

	Magnification Used	
<input type="checkbox"/>	normal smile	_____
<input type="checkbox"/>	cheeks retracted:	_____
<input type="checkbox"/>	teeth only:	_____
<input type="checkbox"/>	incisal edge end-to-end	_____
<input type="checkbox"/>	shade tab over lateral	_____

Shade taken: YES NO

initial shade on value-oriented guide _____
 special colorants
 incisal third variation _____
 middle third variation _____
 gingival third variation _____
 mis-matched teeth: _____

COMMENTS and RECOMMENDATIONS:

Contraindications for At-Home Whitening

1. Unrealistic expectations
2. Unwilling to comply with at-home treatment
3. Excessive existing restorations not requiring replacement

Guarded Prognosis for Whitening

1. History or presence of sensitive teeth
2. Extremely dark gingival third or tooth visible during smile
3. Extensive white spots very visible
4. TMJ dysfunction or bruxism