# TOOTH WHITENING CENTER

Name: _____

Birthdate:: _____

Address: _____

City: _____ Postal Code: _____

Name of your Dentist: _____

Telelphone: _____ E-mail: _____

Are you pregnant? Yes ☐ No ☐

Do you have a gag reflex? Yes ☐ No ☐

Are you allergic to latex or vinyl? Yes ☐ No ☐

If yes, which product?: _____

Are you allergic to anything else? Yes ☐ No ☐

If yes, to what?: _____

When was your last tooth cleaning? _____

Do you have any sensitive teeth or sensitive gums? Yes ☐ No ☐

Do you have a Tooth Crystal? Yes ☐ No ☐

*Attention: If you have a Tooth Crystal and do not want to remove it for your treatment you do understand the Tooth Whitening Gel will not whiten under the Tooth Crystal:* Yes ☐ No ☐

Do you have fillings in your front teeth? Yes ☐ No ☐

Do you have any dental bridges, crowns or any other porcelain work? Yes ☐ No ☐

*Attention: If you have the above dental work you understand these will not change color during the treatment:* Yes ☐ No ☐

Have you tried other Tooth Whitening products? Yes ☐ No ☐

If yes, which products: ☐ Toothpaste ☐ Home-Kit ☐ by a Dentist ☐ Other

How many coffee or teas do you drink per day? _____

Do you smoke? Yes ☐ No ☐

If yes, how many per day? _____

Do you drink red wine? Yes ☐ No ☐

These questions are for your own safety and assist us in providing you with the best treatment possible. To the best of your knowledge you have answered the questions honestly and correctly and if circumstances between visits you will inform us before treatment.

Date: _____ Signature: _____

Tooth Shade before: _____ Tooth Shade after: _____

Tooth Whitening Technician: _____