Teeth Whitening Intake/Consent Form (NP)

General Information

New Section

Name

Date of Birth

Address

City/Town

Province

Postal Code

Phone Number

Email

Emergency Contact Name

Phone Number

Dental History

Have you done teeth whitening before? *

- ○ Yes
- ○ No

If yes, please state when:

Do you have any crowns, bridges, veneers, or fillings? *

- ○ Yes
- ○ No

If yes, please state where:

Do you have sensitive teeth? *

- ○ Yes
- ○ No

Please rate the sensitivity of your teeth to hot/cold *

- ○ High
- ○ Low
- ○ Average
- ○ None

When was your last dental visit?

Medical History

Do you currently or have you had any of the following?

- ○ Bleeding Gums
- ○ Dental Trauma
- ○ Genetic Disorder
- ○ Sores in Mouth
- ○ Tooth Discoloration
- ○ Untreated Dental Issues

Are you, or could you be pregnant? *

- ○ Yes
- ○ No

Are you currently taking any medications? *

- ○ Yes
- ○ No

If yes, Please explain:

Lifestyle

Do you use/consume any of the following? Please check all that apply:

- ☐ Coffee
- ☐ Tea
- ☐ Red Wine
- ☐ Dark Sodas
- ☐ Tobacco Products
- ☐ Other

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledg. I agree to inform the dental hygienist of any changes in the above information. I agree that I do not have any condition(s) that would make the required treatment unsuitable. I will inform the dental hygienist of any discomfort I may experience to allow them to adjust accordingly. I agree to waive all liability toward my dental hygienist for any injury or damages incurred due to my misrepresentation of my health.

Please *

- ○ I understand, and consent to the above
- ○ I do not understand, and do not consent to the above

Pease type your name

Date

Print name

Today's date

_____
Signature