

PROFESSIONAL WHITENING HEALTH HISTORY FORM

Date: _____

Name: _____ Sex: M F Birth Date: ___/___/___

Address: _____ City: _____

State: _____ Zip: _____ Home #: _____ Work #: _____

Social Security #: _____ Email: _____

In Emergency, Contact: _____ Telephone: _____

Family Physician: _____ Telephone: _____

General Dentist: _____ Telephone: _____

Employer: _____ Occupation: _____

YOUR DENTAL HISTORY

Please indicate by checkmark if any of the following items apply to you:

- Do you have limited mouth opening (TMJ/TMD)?
- Do you have sensitivity to sweet/sour liquids or foods?
- Have you ever had a root canal?
- Do you have any missing teeth (besides wisdom teeth)?
- Do you have fixed orthodontic appliances now?
- Do you have any cracked teeth?
- Do you have any fillings in your front teeth?
- Do you have teeth with extensive wear?
- Do you have receded gums?
- Do your gums bleed when brushing or flossing?
- Do you have any sores in your mouth?
- Are your teeth discolored due to trauma, endodontics or as a result of antibiotics?
- Do you use any tobacco products?
- Do you drink: (circle): Tea, Coffee, Dark Soft Drinks, Red Wine?
- Have you had orthodontic work (braces)?
- Braces removed in the last 4-week period?

Please indicate the date of your last dental exam/visit: ___/___/___, or circle the approximate time period since your last dental visit: 0-3 months 4-6 months 12 months or longer

Rate (circle) your dental anxiety level: High Average Low None

Rate (circle) your thermal sensitivity of your teeth to hot or cold:
High Average Low None

Have you used any teeth whitening products in the past? (Circle) Yes/No If yes, what product and what was the result?_____

Please list any current dental needs that you are aware of:_____

YOUR MEDICAL HISTORY

Please check the corresponding box if the answer is yes to any of the following:

- Are you sensitive to light?
- Do you sunburn easily?
- Are you pregnant?

Please check the corresponding box if you are allergic or had reactions to the following:

- Iodine
- Sulfa Drugs
- Aspirin/Advil/Tylenol
- Local Anesthetics
- Sedatives
- Penicillin or any other Antibiotics
- Latex Rubber
- Any metals (Nickel, Mercury, etc.)
- Other _____

Please check if being treated for or have been treated for any of the following:

- Kidney Disease
- Diabetes
- Stroke
- High Blood Pressure
- Blood Clots
- Heart Trouble/Attack
- Artificial Heart Valves
- Heart Murmur
- Congenital Heart Disease
- Mitral Valve Prolapse
- Lung Disorders
- Asthma
- Hay Fever
- Allergies
- Tuberculosis
- Respiratory Problems
- Cardiovascular Disease
- Hepatitis
- Liver Disease
- Leukemia
- Tumors/Growths
- Blood Disorders
- Swollen Ankles
- Stomach Ulcers
- Stomach Problems
- Fainting/Seizures
- Recent Weight Loss
- Drug/Alcohol Dependency
- Currently/Have Taken Fen/Phen, Redux &/or Pondium
- History of Bulimia or Anorexia
- Joint Replacement
- Frequently Tired
- Glaucoma
- AIDS/HIV
- Fever Blisters
- Canker sores
- Radiation Therapy
- Rheumatic Fever
- Thyroid Problem
- Venereal Disease
- Herpes
- Other _____

Please circle the following answers that apply:

Are you taking any medications? Yes No If yes, list them_____

Rate your present health status: Excellent Good Fair Poor

List your major operations:

1. _____ 2. _____ 3. _____

Anything else we should know about your health?_____

I attest that the above Dental/Medical Health History information I have provided is true and correct:

Patient/Parent or Legal Guardian Signature Date

Dentist Signature Date

(For Office Use Only)

PD _____ Customer Number: _____

T/SA _____ Source Code: _____

SNC _____

NSHC _____/ _____