

Date: _____

Contact Information

Name:	Sex:	Birth Date:
Address:	City:	
State:	Zip:	Email:
Home Telephone: ()		Telephone: ()
In Emergency, Contact:	Telephone: ()	
Family Physician:	Telephone: ()	
General Dentist:	Telephone: ()	
Employer:	Occupation:	

Your Dental History

Please if any of the following items apply to you.

<input type="checkbox"/> Do you have limited mouth opening (TMJ/TMD)?	<input type="checkbox"/> Do you have sensitivity to sweet/sour liquids or foods?	<input type="checkbox"/> Have you ever had a root canal?	<input type="checkbox"/> Do you have any missing teeth (besides wisdom teeth)?	<input type="checkbox"/> Do you have fixed orthodontic appliances now?
<input type="checkbox"/> Do you have any cracked teeth?	<input type="checkbox"/> Do you have any fillings in your front teeth?	<input type="checkbox"/> Do you have teeth with extensive wear?	<input type="checkbox"/> Do you have receded gums?	<input type="checkbox"/> Do your gums bleed when brushing or flossing?
<input type="checkbox"/> Do you have any sores in your mouth?	<input type="checkbox"/> Are your teeth discolored due to trauma, endodontics or as a result of antibiotics?	<input type="checkbox"/> Do you use any tobacco products?	<input type="checkbox"/> Do you drink: (circle): Tea, Coffee, Dark Soft Drinks, Red Wine	<input type="checkbox"/> Have you had orthodontic work (braces)? <input type="checkbox"/> 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 7-12 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 the corresponding box if the answer is yes to any of the following:

(For office use only)

<input type="checkbox"/> Are you sensitive to light?	<input type="checkbox"/> Do you sunburn easily?	<input type="checkbox"/> Are you pregnant?	PD _____ T/SA _____ SNC _____ NSHC _____ / _____	Customer Number: _____ Source Code: _____
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Please the corresponding box if you are allergic, or had reactions to the following:

<input type="checkbox"/> Iodine	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Aspirin / Advil / Tylenol	<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Sedatives
<input type="checkbox"/> Penicillin or any other Antibiotics	<input type="checkbox"/> Latex Rubber	<input type="checkbox"/> Any metals (Nickel, Mercury, etc.)	<input type="checkbox"/> Other _____	

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

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

Please circle the following answers that apply:

Are you taking any medication/s? 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

1. Background

We provide this information to give you insight into professional teeth whitening with the BriteSmile[®] Teeth Whitening System. Your cooperation and understanding of this material is necessary as we strive to achieve the best results for you. The safety of professional teeth whitening in general is very high, and the BriteSmile system is no exception. Like all professional health care, though, there are limitations and risks (which will be discussed below), and absolute success is variable and cannot be guaranteed.

2. This Appointment is Limited To Teeth Whitening

Today's visit consists of an exam, which pertains only to elective cosmetic tooth whitening. As a result, you understand that you presently may have a dental condition or health condition that goes undetected during your BriteSmile visit, but which may be detectable during a comprehensive dental examination. If any dental issues are noted the Dentist will inform you. We insist you continue to see a General Dentist for Dental Health issues (e.g., X-rays, cleanings, fillings, comprehensive exam, periodontal assessment, oral cancer screening, charting of the teeth). If you do not have a Dentist the attending Dentist can refer you to one.

3. Candidates For BriteSmile Professional Teeth Whitening

Eligibility for treatment is determined through information gathered during the consultation and screening. While many individuals will qualify for treatment, not all people are deemed candidates for the procedure. If this situation occurs, the doctor will discuss his/her findings with you, perhaps along with certain other possible treatments or options as appropriate.

4. Expectations Upon Completion Of the BriteSmile Professional Whitening

Significant whitening can be achieved in many cases, but there is no definite way to predict how light your teeth will get. Candidates with yellow or yellow-brown teeth tend to whiten better or quicker than people with gray or gray-brown teeth. Teeth discolored by antibiotics, decalcification (white spots), root canal therapy, or trauma do not always respond as quickly or predictably, and may require additional treatment. On the other hand, if your teeth are already a light shade of white, for example a shade of A1-B1 or offscale on the Vita-Shade guide, your additional whitening results could be minimal. The level of whiteness varies with each individual; therefore, you may or may not achieve a higher degree of whiteness. During the consultation, you may be shown before/after pictures of previous clients so that you may have an overall perspective on the kind of results we typically can achieve. The dentist may also provide an assessment as to the level of whiteness you may achieve. If you have questions regarding this issue, please discuss them with the dentist prior to signing this form and proceeding with the BriteSmile procedure.

5. Maintenance

It may appear that there is a slight change in the shade of your teeth within the first 24-48 hours. This is due to the reformation of a saliva coating. Also, through the normal staining process of day-to-day eating and drinking, you may experience a slight regression of shade. This will depend on the frequency of your use of tobacco products, coffee, tea, red wine, and other staining foods/drinks. This can generally be managed by a maintenance program at home. We recommend the use of BriteSmile Toothpaste, followed by rinsing with the BriteSmile Mouth Rinse.

6. Alternative Treatment Options

While we feel that BriteSmile is by far the fastest, most effective means (both in terms of results and costs) for most people to whiten their teeth, please take note that there are other options available to you for whitening teeth. Among these options are:

- a) porcelain crowns
- b) porcelain veneers
- c) composite bonding veneers
- d) gel/tray systems (for use at home)
- e) other in-office procedures (using different light sources and chemicals)

If you have questions regarding the other treatment alternatives, please ask the dentist or consult manager.

7. Potential Risks/Problems

All forms of health treatment, including teeth whitening, have some risks and limitations. Complications that can occur in professional teeth whitening are generally infrequent, and are usually minor in nature. Please read the following information. If you have any questions about these potential risks/problems, please ask us before signing this consent form.

- a) Tooth Sensitivity** – During the whitening process some patients may experience tooth sensitivity. This sensitivity is usually mild if your teeth are not normally sensitive. If your teeth are normally sensitive, please inform us before treatment so that we can make certain adjustments designed to reduce the risk of sensitivity. We cannot eliminate this risk. In some cases, we may suggest taking a mild analgesic before beginning the procedure. Please let us know if you experience any discomfort during the procedure. If your teeth become, or stay sensitive following the procedure, a mild analgesic (such as Tylenol or Advil) will usually be effective in helping you feel comfortable. This sensitivity generally goes away in 12-24 hours. If it persists for more than 24 hours please contact our BriteSmile Dentist.
- b) Gum and Soft Tissue Irritation** – Temporary inflammation of the gums and other soft tissues of the mouth can occur during the procedure. This is generally the result of the whitening gel coming in contact with these tissues. Protective materials are placed in the mouth to prevent this, but despite our efforts, it can still sometimes occur. Stretching and/or irritation of the lips can also occur because of the use of the cheek retractor. If it does, the stretching and/or irritation is generally short in duration (less than two hours), and is very mild (most patients never feel it). If it is felt, rinsing with warm salt water can relieve it. If discomfort persists for more than 24 hours please contact our BriteSmile Dentist.
- c) Fillings and Other Dental Restorations** – Tooth colored fillings (composites), composite veneers/bondings, porcelain crowns, and/or porcelain veneers will not whiten at all or evenly with your natural teeth during this procedure. We may however be able to remove certain stains (tobacco) from the surface of these restorations. All dental restorations that show when you smile may need to be replaced at your expense. Please be sure to discuss this with the dentist prior to beginning treatment.
- d) Decalcified, Traumatized, Antibiotic Discoloration** - Teeth discolored by antibiotics, decalcification (white spots) root canal therapy, or trauma do not always respond predictably, and may require additional treatment other than whitening.

8. Your Treatment Responsibilities

- a) Follow All Directions** – Please take time to read all written instructions and listen carefully to all oral directions. You are welcome and encouraged to ask us any questions you may have.
- b) Communication** – If you do not understand something communicated to you during the consultation, the exam, in any printed material given to you, and/or before or after the procedure, please feel free to ask us.

9. Confidentiality and Use and Disclosure of Information

You understand that information obtained in this form will be treated as privileged and confidential and will not be released or revealed to any third party (other than for treatment, payment, or health care operations purposes) without your authorization, as described below.

Your signature below indicates your authorization for the dentist and the dentist’s staff to release to Discus Dental, LLC, and for Discus Dental, LLC, to use, reproduce, and publish photographic or computer illustrations of your teeth/mouth for educational or marketing purposes, and you waive all claims against any party based on the usage of the images, including, but not limited to, claims that the use of the image defames you or constitutes an infringement of your rights to privacy, or any other right you may enjoy.

Your signature below also indicates your authorization for the dentist and the dentist’s staff to disclose to any employee of Discus Dental, LLC the information provided on this form and information related to the results of your BriteSmile procedure to enable Discus Dental, LLC to: (i) send marketing and promotional materials to you in the future concerning the dentist’s services, the BriteSmile procedure, BriteSmile products, and other related matters; (ii) conduct quality control surveys; and (iii) compile a research data base and conduct research regarding the safety, efficacy, quality, outcomes and cost effectiveness of BriteSmile’s tooth whitening light and gel process, or any component thereof. The information disclosed to Discus Dental, LLC may be subject to redisclosure by Discus Dental, LLC and may not be considered protected health information that is subject to federal privacy protections.

It is not mandatory that you sign this paragraph 9, and you agree that if you choose to sign this paragraph 9, you have done so knowingly and voluntarily. Your authorization, as it relates to marketing and quality control, will remain in effect until the date or event you specify below. If no date or event is specified below, your authorization will remain in effect until you revoke your authorization. The expiration date or event of your authorization, as it relates to research, is “none,” and the research authorization will remain in effect indefinitely. You may revoke this paragraph 9 authorization, in whole or in part, at any time by providing a written notice of revocation to the dentist.

Signature: _____

Date: _____

Expiration Date/Event for Marketing and Quality Control Authorization: _____

Patient Release Form - Authorization And Release

By signing below, I hereby acknowledge that I have read and understand the information provided above, and that I have had the opportunity to investigate the BriteSmile Whitening procedure and to have all of my questions answered to my satisfaction. I hereby certify that all the information and answers that I have provided on this form is accurate and complete to the best of my knowledge, information and belief. **I acknowledge and understand that no results are guaranteed and that no one has made any guarantees to me regarding the BriteSmile Whitening procedure or any results associated therewith. I understand and agree that once the BriteSmile Whitening procedure has been performed, I shall be responsible for all fees and payments associated therewith. I further understand and agree that such fees and payments shall be final and that no refund, including any charge back for payments made by credit card, shall be available or may be requested. With this understanding, I hereby authorize the BriteSmile affiliated dentist to perform the BriteSmile Whitening procedure on me.**

Signature of Client/Parent or Legal Guardian _____

Date ____/____/____

How Did You Hear About BriteSmile ?

TV Radio Newspaper Mail Magazine Website Friend Other _____

Additional Information: _____

Signature of Dentist _____ Date ____/____/____

Provide a signed copy of this informed consent form to the patient.