# Whitening Questionnaire

**Name** _____ **Date** _____

**Please answer the questions below so that we may best assess your whitening needs and expectations.**

1. What condition(s) are you trying to correct by whitening? _____

_____

2. When was your last dental cleaning? _____

3. Have you ever been diagnosed with gum disease? YES NO

4. When was the last time you whitened your teeth? _____

5. If you have whitened before, what are the methods of whitening have you used? Please list any product names that you can remember. _____

6. Do you have any habits that you think might affect your tooth color such as a daily coffee or tea habit, the use of dip/snuff, or cigarette smoking? If yes, please list those habits. _____

7. Do you have a history of any of the following conditions which are known to affect tooth color: tetracycline staining, fillings or crowns on your front teeth, existing white spots on your teeth as a result of orthodontic treatment (braces), a previous root canal treatment on a front tooth, or previous injury to a front tooth. If yes, please list the tooth and its condition. _____

_____

8. Do you experience high anxiety during dental procedures? YES NO

9. Do you have a strong gag reflex? YES NO

10. Can you tolerate wearing dental appliances for at least 2 hours at a time? YES NO

11. Are your teeth sensitive to hot and cold? YES NO

If yes, which teeth are sensitive? _____

**The following questions will be completed with the help of our staff using a tooth shade guide with shades labeled from lightest to darkest.**

What is the current color of your teeth? _____

Which shade do you feel is achievable for your teeth after using a whitening product as directed or having a whitening procedure? _____