

Bleaching Analysis Form

Edited 2-00

Patient Name: _____

Dentist: _____

Chart Number: _____

Date: _____

INTERVIEW:

restorations

Medical History:

- YES NO Allergic to plastics or peroxides?
YES NO Taking tetracycline antibiotics now?
YES NO Taking hormones that cause bleeding?
YES NO Taking drugs that dry the mouth?
YES NO Tobacco user?
YES NO Pregnant or nursing mother?
YES NO Severe menstrual cycle?

Tooth visibility of smile:

Maxillary Vertical: **Tooth #s**
incisal third _____
middle third _____
gingival third _____

Mandibular vertical: **Tooth #s**
none _____
incisal third _____
middle third _____
gingival third _____

Dental History:

- Onset of discoloration? _____
YES NO Previous treatment for discoloration?
YES NO History of Trauma?
YES NO History of Tetracycline ingestion?
YES NO History of sensitive teeth?

some:

all

Type of toothpaste used? _____

Radiographs:

- YES NO periapical concerns? _____
YES NO pulp size differences? _____
YES NO internal resorption? _____

TMD status

- YES NO Previous treatment? _____
YES NO Current treatment? _____
Current status? _____
YES NO Appliance used? When worn?
YES NO Bruxism?
YES NO Other facial pain?

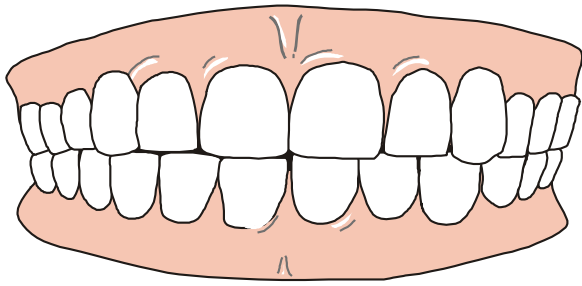
Restorations in the esthetic zone:

- YES NO Discolored restorations needing replacement:
crowns:
composites:
other:
YES NO Matching restorations that may need to be redone:
crowns:
composites:
other:

EXAMINATION

Diagnosis of discoloration:

- Inherit Trauma White fluorosis
Aging Nonvital Brown
fluorosis
Staining Tetracycline
Discolored



Outline teeth and restorations visible during the largest smile on the diagram to demonstrate to the patient which restorations may need to be replaced after bleaching.

Tooth morphology/characteristics:

		Tooth #s
YES	NO	surface white spots: _____
YES	NO	subsurface white spots: _____
YES	NO	brown areas: _____
YES	NO	developmental defects _____
YES	NO	single dark tooth: _____
YES	NO	translucent teeth: _____
YES	NO	exposed dentin: _____
YES	NO	caries: _____
YES	NO	cracks: _____
YES	NO	toothbrush abrasion: _____
YES	NO	abfractions: _____
YES	NO	wear facets from bruxism : _____
YES	NO	other smile deficiencies: _____
YES	NO	external stains: _____
YES	NO	anterior occlusal contacts: _____
YES	NO	sensitive to air or touch: _____

Soft Tissue morphology/characteristics:

YES	NO	soft tissue lesions: _____
YES	NO	periodontal conditions _____
YES	NO	attached gingivae: thick, frail, other _____
YES	NO	soft tissue defects: _____

Other prosthesis being worn:

YES	NO	removable ortho _____
YES	NO	fixed ortho _____
YES	NO	RPD (Partial) _____
YES	NO	FPD (Bridge) _____
YES	NO	RB-FPD (Maryland Bridge) _____

Patient expectations:

YES	NO	read consent form? _____
YES	NO	understands other treatment options? _____
YES	NO	reasonable success goals? _____
YES	NO	understands fee arrangement? _____
YES	NO	understands one-arch treatment? _____
YES	NO	understands directions? _____
YES	NO	smoking/tobacco discussed? _____
YES	NO	understands responsibility for treatment? _____
YES	NO	agrees to stop tx & call office if problems? _____
YES	NO	understands possible relapse / touch-up in future (1-3 yrs)? _____
YES	NO	patient interested in other treatment? (bonding, veneers, crowns, ortho) _____

Photographs taken: (take "before" and "after" photos at same magnifications) YES NO

	Magnification Used
normal smile	_____
cheeks retracted:	_____
teeth only:	_____
incisal edge end-to-end	_____
shade tab over lateral	_____

Shade taken: YES NO

initial shade on value-oriented guide	_____
special colorants	
incisal third variation	_____
middle third variation	_____
gingival third variation	_____
mis-matched teeth:	_____

COMMENTS and RECOMMENDATIONS:

Contraindications for At-Home Whitening

1. Unrealistic expectations
2. Unwilling to comply with at-home treatment
3. Excessive existing restorations not requiring replacement
3. Extensive white spots very visible
4. TMJ dysfunction or bruxism