

**Whitening Screening**

Do you see a dentist/hygienist regularly?	YES	NO
Are you on a continuous hygiene program?	YES	NO
Do you grind you teeth?	YES	NO
Are you aware of any recession areas in your mouth?	YES	NO
Are you sensitive to hot or cold?	YES	NO
Do you have any outstanding/incomplete dental work?	YES	NO
Do you have filling or crowns on your front teeth?	YES	NO
Do your teeth have a gray/blue discoloration?	YES	NO
Do you have an autoimmune disease?	YES	NO
Are you pregnant or lactating?	YES	NO
Do you have a photo light sensitivity? (UV radiation, etc.)	YES	NO
Are you taking photo-reactive drugs?	YES	NO
Are you under the age of 16?	YES	NO

Please Note: Anatomy, calcifications, age, teeth conditions, hygiene, etc all determine the results each patient will attain. Whitening results vary for each individual.