BRITE SMILE℠ **Health History Form** Date: ___/___/___

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

Address: _____ City: _____

State: _____ Zip: _____ Home Telephone: _____- _____ Business Telephone: _____-_____

Email: _____

In Emergency, Contact: _____ Telephone: _____-_____

Family Physician: _____ Telephone: _____-_____

General Dentist: _____ Telephone:_____-_____

Employer: _____ Occupation: _____

YOUR DENTAL HISTORY - ***Please indicate 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 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 check the corresponding box if the answer is yes to any of the following: √√

(For Office Use Only)

❑ Are you sensitive to light?	❑ Do you sunburn easily?	❑ Are you pregnant?	**PD**_____ **T/SA**_____ **SNC**_____ **NSHC**_____/_____	**Cust. Number:** _____ **Source Code:** _____

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 ❑ Hayfever ❑ 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 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

IMPORTANT INFORMATION AND TERMS AND CONDITIONS APPLICABLE TO YOUR

BRITE SMILE℠

WHITENING PROCEDURE

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 (I.e.; 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 applied with the BriteSmile Sonicare Toothbrush twice daily, followed by rinsing with the BriteSmile Mouthrinse. The BriteSmile Whitening gum can be utilized between meals or when brushing is not an option as part of the total maintenance program.

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 BriteSmile, Inc., and for BriteSmile, Inc. 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 BriteSmile, Inc. the information provided on this form and information related to the results of your BriteSmile procedure to enable BriteSmile, Inc. 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 BriteSmile, Inc. may be subject to redisclosure by BriteSmile, Inc. 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: _____

AUTHORIZATION AND RELEASE

The information that I have provided on this form is accurate and complete to the best of my knowledge, information and belief. I certify that I have thoroughly read and understand the above information. I have had the opportunity to investigate the BriteSmile Whitening procedure and I have had all of my questions answered to my satisfaction. Furthermore, the above questions have been accurately answered. With this understanding, I authorize the BriteSmile affiliated dentist to perform the BriteSmile Whitening procedure on me. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

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.

BRITE SMILE

Health History Form

Date: ___/___/___

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

Address: _____ City: _____

State: _____ Zip: _____ Home Telephone: _____- _____ Business Telephone: _____-_____

Email: _____

In Emergency, Contact: _____ Telephone: _____-_____

Family Physician: _____ Telephone: _____-_____

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YOUR MEDICAL HISTORY

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