Tooth Whitening Prescription Form v1.0

Prescribing Dentist Details

Name: **Prescription Date:**

Signature:

Patient Details

Patient Name

D.O.B

Prescription Details:

Treatment requested:

Purpose / Justification

Tooth Whitening Record Form v1.0

Treatment Record

(To supplement not replace clinical records)

Trained Operator Name:

Date of Procedure: **Time:**

Supervising onsite dentist:

Location:

Cost of procedure:

System Used:

Observations or Complications noted:

Start Shade: **End Shade:**

Operator Comments:

Operator Signature: