Dental Hygiene Clinic

The Dental Hygiene Clinic welcomes adult patients as well as pediatric patients (5 years of age & older).

Since our clinic is an educational environment, the length of an appointment is extended compared to the private practice setting.

Fees can be paid with cash, check, or credit card.
We do not accept or file insurance.
Payment is due at the time of service.

Services & Fees

Adult Debridement (Cleaning) ages 13 & up: $20
Senior Citizen/Military/STC Student: $10
Child Debridement (Cleaning) ages 12 & under: $15
Sealant per Tooth: $5
Periodontal Debridement with Anesthetics (Deep Cleaning): $10 per quadrant
Non-Surgical Periodontal Re-evaluation: $10
Fluoride: $5
Full-mouth Series Radiographs: $15
Panorex: $15
Bitewing Radiographs $10
Whitening Trays with Kit $90
Whitening Touch-Up Kit $30

Southeastern TECHNICAL COLLEGE
Equal Opportunity Institution

Dental Hygiene Clinic
3001 E. First Street, Vidalia, GA 30474
Appointments are available on Tuesdays & Wednesdays by calling (912) 538-3280.

Dental Hygiene Clinic
Patient's Rights Policy, Consent, and Disclaimer Form

Southeastern Technical College (STC) assures all patients the following standard of care when seeking services at our facility: an assessment of your needs, an explanation of recommended treatment, treatment alternatives, the option to refuse treatment at anytime, the risk of not undergoing treatment, and the expected outcome of various treatments, advanced knowledge of the cost of treatment, considerate and respectful treatment, treatment that meets the standard of care in the profession, reasonable continuity and completion of care, access to complete and current information about your condition, appropriate and timely referrals for other needed services, informed consent, and confidentiality of all information pertinent to your care.

This is a teaching clinic and our primary responsibility rests with supplying appropriate learning experiences for the dental hygiene students. You can expect your treatment to take longer in the STC Dental Hygiene Clinic than it would in a private practice. A single appointment averages three hours, and multiple appointments may be required to complete your dental care. The students are learning and should not be rushed because education takes time. Your promptness is important. The dental hygiene students have set aside a certain amount of time to complete their clinical requirements. Their time, like yours, is very valuable. Failure to keep appointments without a 24-hour advance notice, too many cancellations, or being more than fifteen (15) minutes late to appointments, for whatever reason, may lead to your dismissal as a clinic patient. Fees will be charged for services provided. They are based on covering the expenses of supplies needed to provide services. You are responsible for payment of services at each visit.

It is your responsibility to select a personal dentist for annual exams, continuing care (preventive and restorative), dental clearance paperwork for medical procedures, and emergencies. Recalls are not guaranteed in our clinic. The clinic does not complete dental clearance paperwork for pending medical procedures. This is beyond the scope of practice in our clinic. The dentist does not issue prescriptions, restore teeth, or extract teeth in the dental hygiene clinic. Services provided in the STC Dental Hygiene Clinic are limited to preventive treatment performed by dental hygiene students. All records and radiographs are property of STC Dental Hygiene Clinic. Patients may request to pick up a copy of radiographs. A copy of radiographs must be picked up in person by the patient. Patients must submit a request for a copy of radiographs at least seven (7) business days in advance. We do not mail or email radiographs.

Records and radiographs may be used for teaching and other educational purposes by the Dental Hygiene students or faculty. STC and the Dental Hygiene Department reserve the right to refuse treatment if the patient does not consent to recommended treatment and procedures, including radiographs. Radiographs will be taken based on guidelines developed by the United States Department of Health and Human Services and adopted by the American Dental Association. These guidelines are subject to clinical judgment and may not apply to every patient. All individuals cannot be accepted as patients in the STC Dental Hygiene Clinic. People with complicated medical conditions, rigid time requirements, and extensive and advanced dental care needs may not be accepted.

You understand that treatment performed by students cannot be guaranteed. The treatment performed is ordinarily harmless to healthy teeth and dental restorations; however, damage to teeth and restorations may occur due to the present condition of the dentition. You agree not to hold liable the student(s), instructor(s), dentist(s), or STC. In order to protect the privacy of all patients as well as respect the clinical learning environment of our students, you agree not to use your cell phone in the clinic. By signing below, you are stating that you have read and understand the above information.

_____ _____

Date ***Signature of Patient/Legal Guardian***

INITIAL APPOINTMENT:

_____ P: _____ R: _____ T: _____

Blood Pressure ***Pulse*** ***Respirations*** ***Temperature***

_____ _____

Signature of Student Hygienist ***Instructor Signature***

ACKNOWLEDGEMENT OF HIPAA

I acknowledge that I have been informed concerning the Health Insurance Portability and Accountability Act of 1996. A copy will be made available to me if requested. The Dental Hygiene Clinic at Southeastern Technical College supports your right to the privacy of your health information.

Signature of Patient/Legal Guardian: _____ Date: _____

Print Name of Patient/Legal Guardian: _____

If legal guardian signs for patient, list the legal guardian's relationship to patient. _____

HIPAA Waiver (optional)

I agree to give STC dental hygiene clinic students and faculty permission to discuss my medical or dental records/condition with the individual(s) listed below.

_____

Signature of Patient/Legal Guardian: _____ Date: _____

HEALTH HISTORY FORM

E-mail: Today's Date

As required by law, our clinic adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This clinic does not use this information to discriminate.

Name: Last First Middle	**Home Phone:** Include Area Code ( )	**Business Phone:** Include Area Code ( )	**Cell Phone:** Include Area Code ( )
Address:	**City:**	**State:**	**Zip:**
Occupation:	**Height:**	**Weight:**	**Date of birth:**
Sex: M ☐ **F** ☐			
Emergency Contact:	**Relationship:**	**Home Phone:** Include Area Code ( )	**Cell Phone:** Include Area Code ( )

Do you have any of the following diseases or problems: (Check DK if you Don't Know)	**Yes No DK**
Active Tuberculosis	☐ ☐ ☐
Persistent cough greater than a 3-week duration	☐ ☐ ☐
Cough that produces blood	☐ ☐ ☐
Been exposed to anyone with Tuberculosis	☐ ☐ ☐
IF "YES" TO ANY OF THE FOUR (4) ITEMS ABOVE, PLEASE STOP AND RETURN THIS FORM TO THE RECEPTIONIST.	

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes No DK		**Yes No DK**
Do your gums bleed when you brush or floss?	☐ ☐ ☐	**Do you brux or grind your teeth?**	☐ ☐ ☐
Is your mouth dry?	☐ ☐ ☐	**Do you have sores or ulcers in your mouth?**	☐ ☐ ☐
Have you had any problems associated with previous dental treatment?	☐ ☐ ☐	**Do you wear dentures or partials?**	☐ ☐ ☐
Are you currently experiencing dental pain or discomfort?	☐ ☐ ☐	**Have you ever had a serious injury to your head or mouth?**	☐ ☐ ☐
Do you have dental implants? Where?	☐ ☐ ☐	**Date of Last Dental Exam:**	**Dentist Name & Address:**
Do you have any clicking, popping, or discomfort in the jaw?	☐ ☐ ☐	**Date of Last Dental X-rays:**	

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

Physician Name:	***Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?*** ……...Yes ☐ No ☐ DK ☐
Physician Phone: Include Area Code ( )	***Name of physician or dentist making recommendation for antibiotic premedication:***
Physician Address / City / State / Zip Code:	**Joint Replacement:** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes ☐ No ☐ DK ☐ Date: _____ Have you had any complications? _____
Date of last physical exam:	Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?..... Yes ☐ No ☐ DK ☐

What condition is being treated:	Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ..... Yes ☐ No ☐ DK ☐ Date Treatment Began: _____
List any serious illness, operations, or hospitalizations in the past five (5) years:	***WOMEN ONLY*** **ARE YOU:** Pregnant?..... Yes ☐ No ☐ Number of Weeks/Trimester: _____/_____ Taking birth control pills? …….. Yes ☐ No ☐ DK ☐ Taking hormonal replacement?.....Yes ☐ No ☐ DK ☐ Nursing? .....Yes ☐ No ☐ DK ☐

Medical Information: *Please mark (X) to indicate if you have or have not had any of the following diseases or problems.*

ALLERGIES: *Are you allergic to or have you had a reaction to the following (specify type of reaction to all **YES** responses):*

Allergies and Reaction	**Yes No DK**	***Allergies and Reaction***	**Yes No DK**
Local Anesthetics	☐ ☐ ☐	**Latex (Rubber)**	☐ ☐ ☐
Penicillin	☐ ☐ ☐	**Iodine**	☐ ☐ ☐
Other Antibiotics	☐ ☐ ☐	**Hay Fever/Seasonal**	☐ ☐ ☐
Barbiturates, Sedatives, or Sleeping Pills	☐ ☐ ☐	**Red Dye**	☐ ☐ ☐
Sulfa Drugs	☐ ☐ ☐	**Animals**	☐ ☐ ☐
Codeine	☐ ☐ ☐	**Food**	☐ ☐ ☐
Other Narcotics	☐ ☐ ☐	**Gluten**	☐ ☐ ☐
Metals	☐ ☐ ☐	**Other Allergies**	☐ ☐ ☐

Medical Information: *Please mark (X) to indicate if you have or have not had any of the following diseases or problems.*

Except for the conditions listed here, antibiotic prophylaxis is no longer recommended for any other form of CHD.	**Yes No DK**	***Except for the conditions listed here, antibiotic prophylaxis is no longer recommended for any other form of CHD.***	**Yes No DK**
Artificial (Prosthetic) Heart Valve	☐ ☐ ☐	Congenital Heart Disease (CHD)	☐ ☐ ☐
Previous Infective Endocarditis	☐ ☐ ☐	Unrepaired, Cyanotic CHD	☐ ☐ ☐
Damaged Valves in Transplanted Heart	☐ ☐ ☐	Repaired (Completely) in Last Six (6) Months	☐ ☐ ☐
Pacemaker	☐ ☐ ☐	Repaired CHD with Residual Defects	☐ ☐ ☐

Please mark (X) to indicate if you have or have not had any of the following diseases or problems.

	Yes No DK		**Yes No DK**
Cardiovascular Disease	☐ ☐ ☐	Diabetes Type I or II	☐ ☐ ☐
Angina	☐ ☐ ☐	Eating Disorder	☐ ☐ ☐
Arteriosclerosis	☐ ☐ ☐	Malnutrition	☐ ☐ ☐
Congestive Heart Failure	☐ ☐ ☐	Gastrointestinal Disease	☐ ☐ ☐
Heart Attack	☐ ☐ ☐	Reflux	☐ ☐ ☐
Heart Murmur	☐ ☐ ☐	Persistent Heartburn	☐ ☐ ☐
High Cholesterol	☐ ☐ ☐	Ulcers	☐ ☐ ☐
Blood Pressure Problems (High or Low)	☐ ☐ ☐	Thyroid Problems (Hypo or Hyper)	☐ ☐ ☐
Mitral Valve Prolapse	☐ ☐ ☐	Stroke	☐ ☐ ☐
Pacemaker	☐ ☐ ☐	Glaucoma	☐ ☐ ☐
Rheumatic Fever	☐ ☐ ☐	Hepatitis (A, B, C, D)	☐ ☐ ☐
Rheumatic Heart Disease	☐ ☐ ☐	Jaundice or Liver Disease	☐ ☐ ☐

Abnormal Bleeding	☐ ☐ ☐	Epilepsy/Seizures	☐ ☐ ☐
Anemia	☐ ☐ ☐	If yes, date of last seizure:	
Blood Transfusion	☐ ☐ ☐	Neurological Disorders	☐ ☐ ☐
If yes, date:		If yes, please specify:	
Hemophilia	☐ ☐ ☐	Mental Health Disorder	☐ ☐ ☐
AIDS or HIV Infection	☐ ☐ ☐	If yes, please specify:	
Autoimmune Disease	☐ ☐ ☐	Kidney Failure	☐ ☐ ☐
Arthritis	☐ ☐ ☐	If yes, dialysis?	
Rheumatoid Arthritis	☐ ☐ ☐	Organ Transplant	☐ ☐ ☐
Systemic Lupus Erythematosus	☐ ☐ ☐	Osteoporosis	☐ ☐ ☐
Inhalant Dependent Asthma	☐ ☐ ☐	Persistent Swollen Glands in Neck	☐ ☐ ☐
Emphysema	☐ ☐ ☐	Severe Headaches/Migraines	☐ ☐ ☐
Sinus Trouble	☐ ☐ ☐	Severe/Rapid Weight Loss	☐ ☐ ☐
Chest Pain Upon Exertion	☐ ☐ ☐	Sexually Transmitted Disease	☐ ☐ ☐
Radiation Treatment	☐ ☐ ☐	Excessive Urination	☐ ☐ ☐
Shunt or Port	☐ ☐ ☐		

Do you have any disease, condition, or problem not listed above that you think we should know about?

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that the STC Dental Hygiene Clinic will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold STC Dental Hygiene Clinic or any STC instructional staff member responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:	Date:

Patient ASA Classification I II III IV V

Date: _____ **Caries (Cavities) Risk Assessment Form (Ages >6)**

	Low Risk	*Moderate Risk*	*High Risk*
Contributing Conditions	**Check or Circle the Conditions That Apply**		
Fluoride Exposure (through drinking water, supplements, professional application, toothpaste)	☐ YES	☐ NO	
Sugary Foods or Drinks (including juice, carbonated or noncarbonated soft drinks, energy drinks, medicinal syrups)	☐ **Primarily at mealtimes**		☐ **Frequent or prolonged between meal exposures/day**
Caries Experience of Mother, Caregiver, and/or other siblings (for patients ages 6-14)	☐ **No carious lesions in last 24 months**	☐ **Carious lesions in last 7-23 months**	☐ **Carious lesions in last six (6) months**
Dental Home: established patient of record, receiving regular dental care in a dental office	☐ YES	☐ NO	
General Health Conditions	**Check or Circle the Conditions That Apply**		
Special Health Care Needs (developmental, physical, medical, or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	☐ NO	☐ YES (over age 14)	☐ YES (ages 6-14)
Chemo/Radiation Therapy	☐ NO		☐ YES
Eating Disorders	☐ NO	☐ YES	
Medications that Reduce Salivary Flow	☐ NO	☐ YES	
Drug/Alcohol Abuse	☐ NO	☐ YES	

***** STOP HERE! Student will complete the remainder of this form with you. *****

Contributing Conditions	**Check or Circle the Conditions That Apply**		
Cavitated or Non-Cavitated (incipient) **Carious Lesions or Restorations** (visually or radiographically evident)	☐ **No new carious lesions or restorations in last 24 months**	☐ **1 or 2 new carious lesions or restorations in last 36 months**	☐ **3 or more carious lesions or restorations in last 36 months**
Teeth Missing Due to Caries in Past 36 Months	☐ NO		☐ YES
Visible Plaque	☐ NO	☐ YES	
Unusual Tooth Morphology that compromises oral hygiene	☐ NO	☐ YES	
Interproximal Restorations – 1 or more	☐ NO	☐ YES	
Exposed Root Surfaces Present	☐ NO	☐ YES	
Restoration with Overhangs and/or **Open Margins; Open Contacts** with Food Impaction	☐ NO	☐ YES	
Dental/Orthodontic Appliances Present (fixed or removable)	☐ NO	☐ YES	
Severe Dry Mouth (Xerostomia)	☐ NO		☐ YES
Circle or check the boxes of the conditions that apply. Low Risk=only conditions in "Low Risk" column present; Moderate Risk = only conditions in "Low" and/or "Moderate Risk" columns present; High Risk = one or more conditions in the "High Risk" column present.			

Overall assessment of dental caries risk: ☐ Low ☐ Moderate ☐ High

The dentist's clinical judgment may justify a change in the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high for a follow up patient; or other risk factors not listed may be present. The assessment cannot address every aspect of a patient's health, and should not be used as a replacement for the dentist's inquiry and judgment. Additional or more focused assessment may be appropriate for patients with specific health concerns. As with other forms, this assessment may be only a starting point for evaluating the patient's health status.

Information Packet for Prospective Patients of the Dental Hygiene Clinic

Health Sciences Annex Building C, Room 907
(912) 538-3280 Phone
(912) 538-3278 Fax

Thank you for your interest in being a patient in the Dental Hygiene clinic at Southeastern Technical College (STC). Your participation makes it possible for our students to complete the clinical portion of their dental hygiene education. Without you, the students could not complete their education. All dental hygiene patients are treated with compassion and respect. STC does not discriminate on the basis of race, color, creed, national or ethnic origin, gender, religion, disability, age, political affiliation or belief, genetic information, disabled veteran, veteran of the Vietnam Era, spouse of military member, or citizenship status (except in those special circumstances permitted or mandated by law). Your care will be provided by dental hygiene students who are directly supervised by highly trained and licensed dental hygiene instructors. The Dental Hygiene program is accredited by the ADA Commission on Dental Accreditation. Our graduates are awarded an Associate of Applied Science degree in Dental Hygiene.

Clinic Hours

Vary from semester to semester.

Patient Responsibilities

- Your promptness is important. If you are more than 15 minutes late and you do not contact the clinic, you forfeit your appointment. If you do not give a 24-hour cancellation notice, you will be inactivated from our patient pool. Students are penalized when they do not have a patient in the clinic during every clinical session. Please be respectful of their educational endeavors.
- At each appointment, you are responsible for payment of services.
- It is your responsibility to select a personal dentist for annual exams, continuing care (preventive and restorative), completion of dental clearance paperwork for medical procedures, and emergencies. We do not guarantee recall appointments. Patients should not expect an appointment every six months.
- There are no childcare services at STC. Children cannot be left unattended in the reception area and cannot accompany a parent/guardian to his/her appointment.
- There is no seating in the waiting room and atrium. Please do not bring family members to your appointment.
- If you would like to request a copy of your x-rays, you must do so at least seven (7) business days in advance. You must pick up the copy in person. We do not email or mail radiographs.
- Since the Dental Hygiene Clinic is a quiet learning environment, cell phones may not be used in the clinic. Please do not bring these devices into the clinic.
- You are expected to treat students, instructors, and staff with respect, understanding, and professionalism.

STC Dental Hygiene Clinic's Responsibilities to You

Our goal is to provide for you, the patient, quality health care in a learning environment where your well-being is foremost. It is important for you to acknowledge that this is a teaching institution, and the treatment that you will receive is provided by supervised students. As such, you accept any possible inconvenience to you or your treatment as an inherent risk of participating as a patient.

You are entitled to the following standards of care:

1. You will be provided with a comprehensive assessment and an individualized treatment plan.
2. You will have an evaluation of oral hygiene using a quantitative measure.
3. You will be provided preventive and therapeutic dental hygiene services.
4. You will be provided oral health education strategies for disease prevention.
5. You will be provided prevention strategies for individualized risk factors related to oral disease.

Patient Bill of Rights

Patients in the STC Dental Hygiene Clinic have the right, consistent with the law, to:

1. Courteous, respectful, and confidential treatment.
2. Treatment that meets the standard of care in the profession including the use of appropriate infection control measures.
3. Inspect their patient record and any radiograph taken.
4. Advanced knowledge of fees for services.
5. Explanation of recommended treatment, alternative treatment options, and explanation of risks with no treatment.
6. Participation in the planning of treatment (informed consent).
7. Refuse recommended treatment (informed refusal).
8. Continuity of care or referral for continued care.
9. Provide feedback, comments, or complaints about treatment using the confidential Patient Satisfaction Survey.

Appointment Policies

This is a teaching clinic and our primary responsibility rests with supplying appropriate learning experiences for our Dental Hygiene students. You can expect your treatment to take longer in our clinic than it would in private practice. Annual recall appointments cannot be guaranteed. Availability of appointments and services may vary from semester to semester. Individuals with complicated medical and dental conditions or rigid time requirements may not be suitable patients for our educational setting.

Services Disclaimer

The STC Dental Hygiene Clinic does not provide a dental exam or diagnosis of restorative needs. Services such as fillings, crowns, root canals, extractions, partials, dentures, prescriptions, and completion of dental clearance paperwork for medical procedures, are not provided in our clinic. A dentist in the private sector must provide these services.

If a patient has medical or dental conditions that warrant further consultation with the patient's physician/dentist, treatment in our clinic will be delayed until written approval is obtained from the patient's physician/dentist.

Patients with dental emergency symptoms, such as pain or active infection, CANNOT be treated in our clinic.

Multiple appointments and extended appointment times lasting up to three (3) hours are sometimes required. Treatment may not be completed in one appointment.

Infection Control

The STC Dental Hygiene Clinic adheres to the current OSHA guidelines for infection control based on input from CDC Guidelines for Infection Control for Dental Health Care Settings. All patients treated in our clinic will be treated with standard precautions.

Individuals with Bloodborne Infectious Diseases

The STC Dental Hygiene Clinic is obligated to maintain standards of healthcare ethics and professionalism that are consistent with the public's expectations of the health profession. All dental personnel are obligated to respect the rights and confidentiality of patients with infectious diseases. We will not refuse treatment or discriminate against a patient who has an infectious disease or is at risk for contracting an infectious disease.

Services Provided

Health Questionnaire (including blood pressure screening)
Radiographs (dental x-rays)
Extraoral and Intraoral Exam (including oral cancer screening)
Dental and Periodontal Assessment (teeth charted and measurement of bone/gum health)
Oral Hygiene Assessment and Individualized Patient Education
Risk Assessments for Oral Disease
Oral Debridement (dental cleaning)
Non-surgical Periodontal Therapy (deep cleaning)
Fluoride Treatment
Dental Sealants
Nutrition Counseling
Tobacco Cessation Counseling and Referral
Night Guards
Athletic Mouth Guards
Teeth Whitening Trays
Teeth Whitening
Supplemental Therapy within the Scope of Dental Hygiene Practice in the State of Georgia

After-Hours Dental Emergency Protocol

If you are a patient in our clinic and you encounter a dental emergency, you should contact your personal dentist. This is one of the many reasons that you are encouraged to keep a joint and ongoing relationship with a general dentist. If the emergency should occur after normal business hours or your general dentist is not available, please go to an urgent care facility or the emergency room at the nearest hospital. The address of the local emergency room is:

Memorial Health Meadows Hospital
1015 First Street East
Vidalia, GA 30474
Phone # 911

Complaints: Complaints may be addressed by any Dental Hygiene Clinic instructor. If you do not get a resolution, you may contact the Dental Hygiene Program Director at (912) 538-3210.

Dental Hygiene Clinic
Schedule of Fees

Service fees can be paid with cash, check, credit card, or debit card. We accept Visa, Mastercard, Discover, and American Express. We do not accept insurance or file insurance. Payment is due at the time of services. Due to our policy, no refunds can be issued.

Cleaning for Adult (13 and older)	$ 20.00
Cleaning for STC Student, Military, Adult over 60	$ 10.00
Cleaning for Child (12 and under)	$ 15.00
Sealant per Tooth	$ 5.00
Periodontal Debridement (Deep Cleaning)	$ 40.00
Non-Surgical Periodontal Reevaluation (NSPR)	$ 10.00
Fluoride	$ 5.00
Full Mouth Series Radiographs	$ 15.00
Panorex	$ 15.00
Bitewing Radiographs	$ 10.00
Periapical Radiograph (per image)	$ 1.00
Second Request for X-rays (1st copy provided as a courtesy)	$ 15.00
Whitening Trays with Kit	$ 90.00
Athletic Mouth Guard	$ 20.00
Night Guard	$ 20.00
Whitening Touch-Up Kit	$ 30.00