

PATIENT REGISTRATION FORM

(This information is necessary for our records and your health. It will be considered CONFIDENTIAL.)

PURE GOLD PROFESSIONALS IN DENTISTRY
303 Brookside Avenue
Redlands, CA 92373
(909)793-8837

PATIENT INFORMATION:

LAST NAME: _____ **FIRST NAME:** _____ **M.I.** _____
Res. Phone () _____ Bus. Phone () _____ Cell Phone () _____
Social Security No. _____ Birthdate: ___ / ___ / ___ Age: _____ E-Mail: _____
Home Address _____ City _____ Zip _____ How long? _____
Occupation _____ Whom may we thank for referring you? _____
Nearest relative not living with you _____ Relationship _____ Phone _____
Address _____ City _____ Zip _____

FINANCIAL INFORMATION: (Can skip address if the same as patient information)

Person Responsible _____ Relationship _____ Birthdate _____
Address _____ City _____ Zip _____ Phone () _____
Occupation _____ Years with firm _____
Employer _____ Business Phone () _____
Social Security No. _____
Does this person have dental insurance? ___ YES ___ NO If so, is it through the employer? ___ YES ___ NO
Name of Dental Plan _____ Group No. _____ Local No. _____ Effective _____
Insurance limit per year? \$ _____ Amount of annual deductible? \$ _____ Amount of deductible paid this year? \$ _____

SPOUSE/PARENT INFORMATION: (Can skip address if the same as patient information)

Spouse or parent _____ Relationship _____ Birthdate _____
Address _____ City _____ Zip _____ Phone () _____
Occupation _____ Years with firm _____
Employer _____ Bus. Phone () _____ Social Security No. _____
Does this person have dental insurance? ___ YES ___ NO If so, is it through the employer? ___ YES ___ NO
Name of Plan _____ Group No. _____ Local No. _____ Effective date _____
Insurance limit per year? \$ _____ Amount of annual deductible? \$ _____ Amount of deductible paid this year? \$ _____

ADDITIONAL INFORMATION

If Patient is a student – Name of school attending _____ City _____
Name of Physician _____ Phone () _____ Address/City _____
Former Dentist _____ Phone () _____ Address/City _____

IN CASE OF EMERGENCY CALL: _____ **Relationship** _____ **Phone ()** _____

I, the undersigned, shall be responsible for the payment of charges incurred for all services rendered. I also agree to be responsible for the payment of all charges incurred in excess of existing insurance coverage.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ **DATE** _____

HEALTH QUESTIONNAIRE

PATIENT _____

Please answer each question. Mark (X) your response.

This is for our records only. **ALL ANSWERS ARE CONSIDERED CONFIDENTIAL**

MEDICAL HISTORY

- | | |
|--|--|
| <p>1. Are you in good health? YES NO
 <input type="checkbox"/> <input type="checkbox"/></p> <p>2. Date of last physical examination: _____</p> <p>3. Are you now under the care of a Physician?</p> <p>4. Have you ever had a serious illness or operation? <input type="checkbox"/> <input type="checkbox"/>
 If so, explain: _____</p> <p>5. Have you ever been hospitalized? <input type="checkbox"/> <input type="checkbox"/>
 If so, What was the problem? _____</p> <p>6. Are you sensitive or allergic to drugs/materials? <input type="checkbox"/> <input type="checkbox"/>
 If so, what? <input type="checkbox"/> Sulfa drugs <input type="checkbox"/> Codeine <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillins or other antibiotics <input type="checkbox"/> Latex <input type="checkbox"/> Other: _____</p> | <p>7. Are you taking any drugs or medication? YES NO
 <input type="checkbox"/> <input type="checkbox"/>
 If so, what are you taking?
 <input type="checkbox"/> Antibiotics <input type="checkbox"/> Anticoagulants
 <input type="checkbox"/> High Blood Pressure Medications <input type="checkbox"/> Aspirin (A.S.A.)
 <input type="checkbox"/> Recreational Drugs _____ or Methadone
 <input type="checkbox"/> Others Medications _____</p> |
|--|--|

Please mark (X) your response to indicate if you have or have not had any of the following disease or problems:

- | | | |
|--|--|--|
| <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> AIDS/HIV</p> <p><input type="checkbox"/> <input type="checkbox"/> Seasonal Allergies / Hay Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Joints Replacement</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Diseases</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding/Transfusion</p> | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting spells or seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Head Injuries</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Murmur/Mitral Valve Prolapse</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis, Jaundice or Liver disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Pressure <input type="checkbox"/> High <input type="checkbox"/> Low</p> <p><input type="checkbox"/> <input type="checkbox"/> Cholesterol</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Osteoporosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental or Nervous Disorders</p> | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Radiation treatment of any kind</p> <p><input type="checkbox"/> <input type="checkbox"/> Respiratory Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatism or Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus Trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Stomach Ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Tumors or Growths</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Diseases</p> |
|--|--|--|

- Do you have a cardiac pacemaker/defibrillator? YES NO
- Have you had a heart valve or bypass surgery? YES NO
- Have you ever used Fen/Phen for Weight Loss? YES NO
- Are you being treated for **Osteoporosis** with bisphosphonates such as alendronate (Fosamax®) or Risendronate (Actonel®), Aredia® or Zometa®? YES NO

Are you ... Pregnant ? Number of Weeks? _____
 Nursing
 Taking Oral Contraceptives or Hormone Replacement Therapy

DENTAL HISTORY

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Have you ever had a local anesthetic ("Novocaine", etc.)? <input type="checkbox"/> Have you ever had any unfavorable reaction from a local anesthetic? <input type="checkbox"/> Have you ever had any serious trouble associated with any previous dental treatment? <input type="checkbox"/> Does dental treatment make you nervous? <input type="checkbox"/> How long since last dental x-rays of your entire mouth? _____ <input type="checkbox"/> How long since last dental treatment? _____ Last Cleaning? _____ <input type="checkbox"/> Have you ever had excessive bleeding requiring treatment? <input type="checkbox"/> Have you ever had instructions in the care of your teeth and gums? | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> | <div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center;">BASELINE VITALS</p> <p style="text-align: center;">Blood Pressure</p> <p style="text-align: center;">____ Sys / ____ Dia</p> <p style="text-align: center;">Pulse _____</p> </div> |
|---|--|---|

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING, PLEASE INDICATE WITH A CHECK MARK.

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Teeth sensitive to cold, heat, sweets or pressure <input type="checkbox"/> Bleeding gums. How long? _____ <input type="checkbox"/> Food impaction <input type="checkbox"/> Clenching or grinding <input type="checkbox"/> Burning of tongue <input type="checkbox"/> Swelling or lumps in mouth <input type="checkbox"/> Pain around ear | <ul style="list-style-type: none"> <input type="checkbox"/> Bad breath <input type="checkbox"/> Unpleasant taste <input type="checkbox"/> Complications from extractions <input type="checkbox"/> Periodontal (gums) treatment <input type="checkbox"/> Orthodontic treatment <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Oral Habits, i.e., fingernail biting, cheek biting, etc. | <ul style="list-style-type: none"> <input type="checkbox"/> Cigarettes, pipe or cigar smoking <input type="checkbox"/> Dental Floss <input type="checkbox"/> Inter-dental stimulators <input type="checkbox"/> Water jet device <input type="checkbox"/> Disclosing tablets or solution <input type="checkbox"/> Fluoride supplements <input type="checkbox"/> Fluoride treatments |
|---|---|---|

CONSENT FOR TREATMENT: I hereby authorize the dentist to perform such dental operations or procedures and to administer such medications and/or drugs as may be deemed necessary or advisable in the diagnosis and treatment of this patient. Our staff includes dental auxiliaries who perform functions under the supervision of the dentist. I understand that the dentist will use his knowledge, skill and training to do his very best, but there is no guarantee of success of treatment. Treatment alternatives have been explained as well as the preferred method of treatment. I have been informed and I understand that occasionally there are complications with dental treatment, which have been explained for each procedure. I understand I can ask for a full recital of all possible risks attendant to treatment rendered. I understand my responsibility in maintaining good oral hygiene, following the dentist's instructions, and keeping scheduled appointments. I have read and filled out the above information and confirm its accuracy.

***Authorization must be signed by the patient, or by the nearest relative in the case of a minor, or when the patient is physically or mentally incompetent.

Signature: _____ Date: _____

DDS Checked Medical History

SIGNATURE _____, DDS

DATE _____

Terry L. Vines, Jr., D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of
Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Pure Gold Professionals in Dentistry

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$20 per chart which includes postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (expect in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Leesa Robertson
Telephone: 909-793-8837 Fax: 909-335-0497
E-Mail: Tvinesdds@earthlink.com

Address: 303 Brookside Ave.
Redlands, CA 92373

Welcome To Our Practice

Dental Office Financial Policy

We would like to thank-you for selecting our office for your dental care and would like this opportunity to advise you of our financial policy.

Our office uses a composite material for all fillings and finds that some plans do not allow this type on molar teeth. Therefore, there will be an additional charge for this service.

Payment is expected at the time services are rendered.

For our patients with dental insurance, we will be happy to process your dental claims and call your insurance company for ESTIMATED benefits. This will be no guarantee of what they will pay when they receive the claim.

ALL BENEFITS ARE SUBJECT TO ELIGIBILITY AND THE PROVISIONS AND LIMITATIONS OF THE POLICY.

Your estimated portion will be due at the time services are rendered.

Financial arrangements may be considered on patients requiring extensive dental treatment.

I am aware that if my insurance company does not pay on a claim for any reason, I am responsible for all charges that have been incurred.

We accept CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

FINANCING CAN BE DONE WITH APPROVAL OF CARE CREDIT FINANCING. APPLICATIONS ARE AVAILABLE HERE. (NOTE: CARE CREDIT IS NOT AFFILIATED WITH OUR OFFICE BUT THEIR SERVICES ARE OFFERED)

Signature _____ Date: _____

PURE GOLD

PROFESSIONALS IN DENTISTRY



Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I, _____ (patient), acknowledge I have received from
Pure Gold Professionals in Dentistry a copy of the Dental Materials Fact Sheet
Dated May 2004.

Patient (or Parent/Guardian)

Date

303 BROOKSIDE AVENUE • REDLANDS, CA 92373 • (909) 793-8837 • Fax (909) 335-0497
Web: www.puregolddental.com ★ E-Mail: bkwongdds@puregolddental.com



HISTORY OF THE PURE GOLD BUILDING

During the turn-of-the-century orange boom, Redlands was made a center of wealth on the West Coast. Mutual Orange Distributors, a co-operative of orange growers that was once a major contributor to the local economy, broke ground in 1927 for offices at the corner of Brookside Avenue and Grant Street. In 1956, the name was changed to Pure Gold. The company finally folded in 1989, long after it's Redlands packing house had closed its doors.

The Facts About Fillings



DENTAL BOARD OF CALIFORNIA

www.dbc.ca.gov



Dental Materials Fact Sheet

What About the Safety of Filling Materials?

Patient health and the safety of dental treatments are the primary goals of California's dental professionals and the Dental Board of California. The purpose of this fact sheet is to provide you with information concerning the risks and benefits of all the dental materials used in the restoration (filling) of teeth.

The Dental Board of California is required by law* to make this dental materials fact sheet available to every licensed dentist in the state of California. Your dentist, in turn, must provide this fact sheet to every new patient and all patients of record only once before beginning any dental filling procedure.

As the patient or parent/guardian, you are strongly encouraged to discuss with your dentist the facts presented concerning the filling materials being considered for your particular treatment.

** Business and Professions Code 1648.10-1648.20*

Allergic Reactions to Dental Materials

Components in dental fillings may have side effects or cause allergic reactions, just like other materials we may come in contact with in our daily lives. The risks of such reactions are very low for all types of filling materials. Such reactions can be caused by specific components of the filling materials such as mercury, nickel, chromium, and/or beryllium alloys. Usually, an allergy will reveal itself as a skin rash and is easily reversed when the individual is not in contact with the material.

There are no documented cases of allergic reactions to composite resin, glass ionomer, resin ionomer, or porcelain. However, there have been rare allergic responses reported with dental amalgam, porcelain fused to metal, gold alloys, and nickel or cobalt-chrome alloys.

If you suffer from allergies, discuss these potential problems with your dentist before a filling material is chosen.

Toxicity of Dental Materials

Dental Amalgam

Mercury in its elemental form is on the State of California's Proposition 65 list of chemicals known to the state to cause reproductive toxicity. Mercury may harm the developing brain of a child or fetus.

Dental amalgam is created by mixing elemental mercury (43-54%) and an alloy powder (46-57%) composed mainly of silver, tin, and copper. This has caused discussion about the risks of mercury in dental amalgam. Such mercury is emitted in minute amounts as vapor. Some concerns have been raised regarding possible toxicity. Scientific research continues on the safety of dental amalgam. According to the Centers for Disease Control and Prevention, there is scant evidence that the health of the vast majority of people with amalgam is compromised.

The Food and Drug Administration (FDA) and other public health organizations have investigated the safety of amalgam used in dental fillings. The conclusion: no valid scientific evidence has shown that amalgams cause harm to patients with dental restorations, except in rare cases of allergy. The World Health Organization reached a similar conclusion stating, "Amalgam restorations are safe and cost effective."

A diversity of opinions exists regarding the safety of dental amalgams. Questions have been raised about its safety in pregnant women, children, and diabetics. However, scientific evidence and research literature in peer-reviewed scientific journals suggest that otherwise healthy women, children, and diabetics are not at an increased risk from dental amalgams in their mouths. The FDA places no restrictions on the use of dental amalgam.

Composite Resin

Some Composite Resins include Crystalline Silica, which is on the State of California's Proposition 65 list of chemicals known to the state to cause cancer.

It is always a good idea to discuss any dental treatment thoroughly with your dentist.

DENTAL AMALGAM FILLINGS

Dental amalgam is a self-hardening mixture of silver-tin-copper alloy powder and liquid mercury and is sometimes referred to as silver fillings because of its color. It is often used as a filling material and replacement for broken teeth.

Advantages

- ♥ Durable; long lasting
- ♥ Wears well; holds up well to the forces of biting
- ♥ Relatively inexpensive
- ♥ Generally completed in one visit
- ♥ Self-sealing; minimal-to-no shrinkage and resists leakage
- ♥ Resistance to further decay is high, but can be difficult to find in early stages
- ♥ Frequency of repair and replacement is low

Disadvantages

- Refer to “What About the Safety of Filling Materials”
- Gray colored, not tooth colored
- May darken as it corrodes; may stain teeth over time
- Requires removal of some healthy tooth
- In larger amalgam fillings, the remaining tooth may weaken and fracture
- Because metal can conduct hot and cold temperatures, there may be a temporary sensitivity to hot and cold.
- Contact with other metals may cause occasional, minute electrical flow

The durability of any dental restoration is influenced not only by the material it is made from but also by the dentist’s technique when placing the restoration. Other factors include the supporting materials used in the procedure and the patient’s cooperation during the procedure. The length of time a restoration will last is dependent upon your dental hygiene, home care, and diet and chewing habits.

COMPOSITE RESIN FILLINGS

Composite fillings are a mixture of powdered glass and plastic resin, sometimes referred to as white, plastic, or tooth-colored fillings. It is used for fillings, inlays, veneers, partial and complete crowns, or to repair portions of broken teeth.

Advantages

- ♥ Strong and durable
- ♥ Tooth colored
- ♥ Single visit for fillings
- ♥ Resists breaking
- ♥ Maximum amount of tooth preserved
- ♥ Small risk of leakage if bonded only to enamel
- ♥ Does not corrode
- ♥ Generally holds up well to the forces of biting depending on product used
- ♥ Resistance to further decay is moderate and easy to find
- ♥ Frequency of repair or replacement is low to moderate

Disadvantages

- Refer to “*What About the Safety of Filling Materials*”
- Moderate occurrence of tooth sensitivity; sensitive to dentist’s method of application
- Costs more than dental amalgam
- Material shrinks when hardened and could lead to further decay and/or temperature sensitivity
- Requires more than one visit for inlays, veneers, and crowns
- May wear faster than dental enamel
- May leak over time when bonded beneath the layer of enamel



GLASS IONOMER CEMENT

Glass ionomer cement is a self-hardening mixture of glass and organic acid. It is tooth-colored and varies in translucency. Glass ionomer is usually used for small fillings, cementing metal and porcelain/metal crowns, liners, and temporary restorations.

Advantages

- ♥ Reasonably good esthetics
- ♥ May provide some help against decay because it releases fluoride
- ♥ Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
- ♥ Material has low incidence of producing tooth sensitivity
- ♥ Usually completed in one dental visit

Disadvantages

- Cost is very similar to composite resin (which costs more than amalgam)
- Limited use because it is not recommended for biting surfaces in permanent teeth
- As it ages, this material may become rough and could increase the accumulation of plaque and chance of periodontal disease
- Does not wear well; tends to crack over time and can be dislodged

RESIN-IONOMER CEMENT

Resin ionomer cement is a mixture of glass and resin polymer and organic acid that hardens with exposure to a blue light used in the dental office. It is tooth colored but more translucent than glass ionomer cement. It is most often used for small fillings, cementing metal and porcelain metal crowns and liners.

Advantages

- ♥ Very good esthetics
- ♥ May provide some help against decay because it releases fluoride
- ♥ Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
- ♥ Good for non-biting surfaces
- ♥ May be used for short-term primary teeth restorations
- ♥ May hold up better than glass ionomer but not as well as composite
- ♥ Good resistance to leakage
- ♥ Material has low incidence of producing tooth sensitivity
- ♥ Usually completed in one dental visit

Disadvantages

- Cost is very similar to composite resin (which costs more than amalgam)
- Limited use because it is not recommended to restore the biting surfaces of adults
- Wears faster than composite and amalgam

PORCELAIN (CERAMIC)

Porcelain is a glass-like material formed into fillings or crowns using models of the prepared teeth. The material is tooth-colored and is used in inlays, veneers, crowns and fixed bridges.

Advantages

- ♥ Very little tooth needs to be removed for use as a veneer; more tooth needs to be removed for a crown because its strength is related to its bulk (size)
- ♥ Good resistance to further decay if the restoration fits well
- ♥ Is resistant to surface wear but can cause some wear on opposing teeth
- ♥ Resists leakage because it can be shaped for a very accurate fit
- ♥ The material does not cause tooth sensitivity

Disadvantages

- Material is brittle and can break under biting forces
- May not be recommended for molar teeth
- Higher cost because it requires at least two office visits and laboratory services

NICKEL OR COBALT- CHROME ALLOYS

Nickel or cobalt-chrome alloys are mixtures of nickel and chromium. They are a dark silver metal color and are used for crowns and fixed bridges and most partial denture frameworks.

Advantages

- ♥ Good resistance to further decay if the restoration fits well
- ♥ Excellent durability; does not fracture under stress
- ♥ Does not corrode in the mouth
- ♥ Minimal amount of tooth needs to be removed
- ♥ Resists leakage because it can be shaped for a very accurate fit

Disadvantages

- Is not tooth colored; alloy is a dark silver metal color
- Conducts heat and cold; may irritate sensitive teeth
- Can be abrasive to opposing teeth
- High cost; requires at least two office visits and laboratory services
- Slightly higher wear to opposing teeth



PORCELAIN FUSED TO METAL

This type of porcelain is a glass-like material that is “enameled” on top of metal shells. It is tooth-colored and is used for crowns and fixed bridges

Advantages

- ♥ Good resistance to further decay if the restoration fits well
- ♥ Very durable, due to metal substructure
- ♥ The material does not cause tooth sensitivity
- ♥ Resists leakage because it can be shaped for a very accurate fit

Disadvantages

- More tooth must be removed (than for porcelain) for the metal substructure
- Higher cost because it requires at least two office visits and laboratory services

GOLD ALLOY

Gold alloy is a gold-colored mixture of gold, copper, and other metals and is used mainly for crowns and fixed bridges and some partial denture frameworks

Advantages

- ♥ Good resistance to further decay if the restoration fits well
- ♥ Excellent durability; does not fracture under stress
- ♥ Does not corrode in the mouth
- ♥ Minimal amount of tooth needs to be removed
- ♥ Wears well; does not cause excessive wear to opposing teeth
- ♥ Resists leakage because it can be shaped for a very accurate fit

Disadvantages

- Is not tooth colored; alloy is yellow
- Conducts heat and cold; may irritate sensitive teeth
- High cost; requires at least two office visits and laboratory services

DENTAL BOARD OF CALIFORNIA

www.dbc.ca.gov

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CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

5/04