TCD SPECIALTY GROUP

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PATIENT INFORMATION

Clear All Fields | Print

PATIENT

Name: _____ (First) _____ (Last) ____ (M.I.)

Address: _____

City: _____ ST: CA Zip Code: _____

Length at Current Address (Years): _____

Phone (Home): _____

Phone (Mobile): _____

E-mail: _____

Preferred Contact Method: ❑ Phone ❑ Email ❑ Text

Social Security# (For insurance use): _____

DL#: _____ Date of Birth (DOB): _____

Responsible Party - If Same as Patient: [ ] skip this section

Name: _____ (First) _____ (Last) ____ (M.I.)

Address: _____

City: _____ ST: _____ Zip Code: _____

Length at Current Address (Years): _____

Phone (Home): _____

Phone (Mobile): _____

E-mail: _____

Preferred Contact Method: ❑ Phone ❑ Email ❑ Text

Relationship to Patient: _____

Social Security# (For insurance use): _____

DL#: _____ Date of Birth (DOB): _____

EMPLOYMENT

Occupation: _____

Employer Name: _____

Years with Employer: _____

Business Address: _____

City: _____ ST: _____ Zip Code: _____

Business Phone: _____ Ext. #: _____

Verified By (Office Use Only): _____ Date: _____

REFERENCE

Name: _____ (First) _____ (Last) ____ (M.I.)

Address: _____

City: _____ ST: _____ Zip Code: _____

Phone: _____

Spouse Name: _____

Spouse Work Phone: _____

EMERGENCY CONTACT

Name: _____ (First) _____ (Last) ____ (M.I.)

Address: _____

City: _____ ST: _____ Zip Code: _____

Phone: _____

Relationship to Patient: _____

GETTING TO KNOW YOU

1. Are there other members of your household who are not patients at our office? ❑ Yes ❑ No If yes, list their names and relationship (e.g., son, daughter, husband):
   - Name/Relationship 1: _____
   - Name/Relationship 2: _____
2. How did you hear about our office? (Check all that apply)
   ❑ Flyer ❑ Insurance Plan ❑ Sign ❑ Billboard
   ❑ Website ❑ Family or Friend: _____
   ❑ Other: _____
3. When was your last dental exam? _____
4. What is the reason for your dental visit today?

_____

_____

INSURANCE INFORMATION

****Primary Insurance****

Insurance Name: _____

Address: _____

City: _____ ST: _____ Zip Code: _____

Phone: _____

Employer: _____

Union/Local: _____ Group #: _____

Insured's Name: _____

SS #: _____ DOB (Date of Birth): _____

****Secondary Insurance****

Insurance Name: _____

Address: _____

City: _____ ST: _____ Zip Code: _____

Phone: _____

Employer: _____

Union/Local: _____ Group #: _____

Insured's Name: _____

SS #: _____ DOB (Date of Birth): _____

****Managed Care Plan (HMO)****

Plan Name: _____

Group #: _____ Plan #: _____

Employer: _____

Insured's Name: _____

SS #: _____ DOB (Date of Birth): _____

ACKNOWLEDGEMENT AND AUTHORIZATION

1. I certify that the above information is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for charges not covered or paid for by my insurance, for any reason.
2. By signing below, I authorize verification and exchange of information, including obtaining reports from credit reporting agencies if necessary.
3. I authorize payment directly to the dentist for group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I also authorize the release of any information required to process dental claims.
4. I acknowledge that Total Care Dental & Orthodontics provides business support services to independent dentists. I understand that this dental practice is owned and operated by an independent dentist. Each dentist is individually responsible for the dental care provided, and neither other dentists nor the support organization are responsible for my dental treatment.

Insert Today's Date

Signature: _____ **Date:** _____

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GENERAL HEALTH INFORMATION

Patient Name: _____ Date of Birth (DOB): _____ Date: _____

Your oral health is closely connected to your overall health. Conditions you may have or medications you are taking can significantly affect the dental care you receive. Please take a moment to answer the following questions, as this information helps us provide you with safe and effective treatment. Thank you!

Are you currently under a physician's care? ❑ Yes ❑ No If yes, please explain: _____
Have you ever been hospitalized or had a major surgery? ❑ Yes ❑ No If yes, please explain: _____
Have you ever experienced a serious head or neck injury? ❑ Yes ❑ No If yes, please explain: _____
Are you currently taking any medications, pills, or drugs? ❑ Yes ❑ No If yes, please list them: _____
Do you currently or have you ever taken Phen-Fen or Redux? ❑ Yes ❑ No If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑ Yes ❑ No If yes, please explain: _____
Are you on a special diet? ❑ Yes ❑ No If yes, please explain: _____
Do you use tobacco products? ❑ Yes ❑ No If yes, what type and how often: _____
Do you use controlled substances? ❑ Yes ❑ No If yes, please specify: _____

Women: Are you
Pregnant or trying to become pregnant? ❑ Yes ❑ No Taking oral contraceptives? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Are you allergic to any of the following?
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Sulfa Drugs ❑ Metal ❑ Latex ❑ Local Anesthetics
❑ Other please explain: _____

Do you have, or have you had, any of the following? **Select "No" for All** **Clear All Selections**

AIDS/HIV+ ❑ Yes ❑ No	Cortisone Medicine ❑ Yes ❑ No	Hemophilia ❑ Yes ❑ No	Renal Dialysis ❑ Yes ❑ No
Alzheimer's Disease ❑ Yes ❑ No	Diabetes ❑ Yes ❑ No	Hepatitis A ❑ Yes ❑ No	Rheumatic Fever ❑ Yes ❑ No
Anaphylaxis ❑ Yes ❑ No	Drug Addiction ❑ Yes ❑ No	Hepatitis B or C ❑ Yes ❑ No	Rheumatism ❑ Yes ❑ No
Anemia ❑ Yes ❑ No	Easily Wounded ❑ Yes ❑ No	Herpes ❑ Yes ❑ No	Scarlet Fever ❑ Yes ❑ No
Angina ❑ Yes ❑ No	Emphysema ❑ Yes ❑ No	High Blood Pressure ❑ Yes ❑ No	Shingles ❑ Yes ❑ No
Arthritis/Gout ❑ Yes ❑ No	Epilepsy or Seizures ❑ Yes ❑ No	Hives or Rash ❑ Yes ❑ No	Sickle Cell Disease ❑ Yes ❑ No
Artificial Heart Valve ❑ Yes ❑ No	Excessive Bleeding ❑ Yes ❑ No	Hypoglycemia ❑ Yes ❑ No	Sinus Trouble ❑ Yes ❑ No
Artificial Joint ❑ Yes ❑ No	Excessive Thirst ❑ Yes ❑ No	Irregular Heartbeat ❑ Yes ❑ No	Spina Bifida ❑ Yes ❑ No
Asthma ❑ Yes ❑ No	Fainting Spells/Dizziness ❑ Yes ❑ No	Kidney Problems ❑ Yes ❑ No	Stomach/Intestinal Disease ❑ Yes ❑ No
Blood Disease ❑ Yes ❑ No	Frequent Cough ❑ Yes ❑ No	Leukemia ❑ Yes ❑ No	Stroke ❑ Yes ❑ No
Blood Transfusion ❑ Yes ❑ No	Frequent Diarrhea ❑ Yes ❑ No	Liver Disease ❑ Yes ❑ No	Swelling of Limbs ❑ Yes ❑ No
Breathing Problem ❑ Yes ❑ No	Frequent Headaches ❑ Yes ❑ No	Low Blood Pressure ❑ Yes ❑ No	Thyroid Disease ❑ Yes ❑ No
Bruise Easily ❑ Yes ❑ No	Genital Herpes ❑ Yes ❑ No	Lung Disease ❑ Yes ❑ No	Tonsillitis ❑ Yes ❑ No
Cancer ❑ Yes ❑ No	Glaucoma ❑ Yes ❑ No	Mitral Valve Prolapse ❑ Yes ❑ No	Tuberculosis ❑ Yes ❑ No
Chemotherapy ❑ Yes ❑ No	Hay Fever ❑ Yes ❑ No	Pain in Jaw Joints ❑ Yes ❑ No	Tumors or Growths ❑ Yes ❑ No
Chest Pains ❑ Yes ❑ No	Heart Attack/Failure ❑ Yes ❑ No	Parathyroid Disease ❑ Yes ❑ No	Ulcers ❑ Yes ❑ No
Cold Sores/Fever Blisters ❑ Yes ❑ No	Heart Murmur ❑ Yes ❑ No	Psychiatric Care ❑ Yes ❑ No	Venereal Disease ❑ Yes ❑ No
Congenital Heart Disorder ❑ Yes ❑ No	Heart Pace Maker ❑ Yes ❑ No	Radiation Treatments ❑ Yes ❑ No	Yellow Jaundice ❑ Yes ❑ No
Convulsions ❑ Yes ❑ No	Heart Trouble/Disease ❑ Yes ❑ No	Recent Weight Loss ❑ Yes ❑ No	

Have you ever had any serious illness not listed above? ❑ Yes ❑ No _____

Comments: _____

I certify that the information provided is complete and accurate to the best of my knowledge. I will inform my dentist of any changes in my health or medications and consent to x-rays and an oral examination.

Patient signature or parent if patient is a minor: _____ Date: _____

Doctor Signature: _____ Date: _____

UPDATE TO MEDICAL HISTORY

Date	Comments	Patient Signature	Doctor Signature

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PATIENT INFORMATION CONSENT

Financial Responsibility: I request that all benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the service provider. I understand that I am responsible for all charges for services whether or not paid by insurance. I authorize the service provider to disclose all information necessary to verify my insurance eligibility and secure the payment of benefits.

Initials _____

Information Verification: The information provided herein is true and complete to the best of my knowledge. I authorize Total Care Dental & Orthodontics (TCD), or anyone acting on its behalf, to obtain, review and/or share with its designated agents, or any assignee of my account, my credit report for the purpose of evaluating my credit and verifying my identity, or for updating, renewing, servicing, modifying or collecting my account. This authorization is valid as long as any amounts are owed on my account to TCD or any assignee of my account. I acknowledge that TCD may report information about my account to consumer reporting agencies and other persons who may legally receive such information. Late payments, missed payments or other defaults on my account may be reflected in my credit report.

Initials _____

Prior Express Consent for Calls/Texts/Email: By providing the number of my land line, cell phone or other wireless device and my email address now or in the future, I expressly consent and agree that TCD and any of its affiliates, agents, service providers or assignees may call me using an automatic telephone dialing system or otherwise, leave me a voice, prerecorded, or artificial voice message, or send me a text, e-mail, or other electronic message for any purpose related to the servicing or collection of any account that I may establish with TCD, or for other informational purposes related to my account or treatment ("Communication"). I also agree that TCD and any of its affiliates, agents, service providers or assignees may include my personal information in a Communication. TCD will not charge for a Communication, but my service provider may. I agree that Total Care Dental may monitor and record any telephone calls to assure the quality of its service or for other reasons.

Initials _____

Video Taping: TCD is committed to providing high-quality healthcare to its patients in a safe environment. As such, the use of video cameras is limited to the purpose of security only. We do not record audio. All recordings are saved on a local hard drive and available for viewing by TCD employees only. Video recordings are not available for viewing by any third parties unless instructed by a court order. By signing this document, you are acknowledging and providing consent to be video recorded during your visit and treatment.

Initials _____

By signing below, I acknowledge that I have read, fully understand, and agree to be bound by this consent.

Patient's Name	Signature of Patient, Parent, Guardian or Legally Authorized Representative of Patient	Date
_____	_____	_____

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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

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, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services weprovide 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. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

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 or nationalsecurity activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

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

Video Taping: TCD is committed to providing high-quality healthcare to its patients in a safe environment. As such, the use of video cameras is limited to the purpose of security only. We do not record audio. All recordings are saved on a local hard drive and available for viewing by TCD employees only. Video recordings are not available for viewing by any third parties unless instructed by a court order. By signing this document, you are acknowledging and providing consent to be video recorded during your visit and treatment.

Initials _____

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

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 writtencomplaint to the US 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 with the U.S. Department of Health and Human Services.

A Privacy/Contact Officer has been designated for this office. Please ask our front desk personnel and they will direct you to the Privacy/Contact Officer.

_____ _____

Patient's Name Date

_____

Signature of Patient or Parent or Legal Guardian

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DENTAL SERVICES AGREEMENT

Patient Name: _____

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention and agreement of the parties that this arbitration agreement shall cover all claims or controversies relating to the matters described in Article 1 above, except claims within the jurisdiction of the Small Claims Court, whether in tort (intentional or negligent), contract, or otherwise, including but not limited to suits relating to the matters described in Article 1 and also involving claims for loss of consortium, wrongful death, discrimination, emotional distress or punitive damages. Arbitration pursuant to the terms of this Contract shall bind all parties whose claims as described in Article 1 may arise out of or in any way relate to treatment or services provided or not provided by Keivan Sarraf, DDS, Inc ("TCD") or any employee or agent or providers of TCD, including any spouse or heirs of Patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. The undersigned understands and agrees that if the undersigned signs this Contract on behalf of some other person for whom the undersigned has responsibility, then, in addition to the undersigned, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. The reference to TCD includes the corporation, and its employees, agents and providers. Filing any action in any court by TCD to collect any fee from Patient shall not waive the right to compel arbitration of any claim described in Article 1. However, following the assertion of any claim against TCD, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by the same arbitration.

Article 3: Procedures and Applicable Law: Patient shall initiate arbitration by serving a Demand for Arbitration on TCD and each defendant. The claim shall be mailed by U.S. mail, postage prepaid, to: Total Care Dental,5703 S. Vermont Ave, Los Angeles, CA 90037. A Demand for Arbitration must be communicated in writing to all parties, identify each defendant, describe the claim against each party, and the amount of damages sought, and the names, addresses and telephone numbers of the Patient andhis/her attorney. Patient and TCD agree that any arbitration hereunder shall be conducted by a single, neutral arbitrator selected bythe parties and shall be resolved using the rules of the American Arbitration Association. (Arbitration, however, shall not be conductedby the American Arbitration Association.) Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall begoverned pursuant to Civil Code §§ 3333.1 and 3333.2, Code of Civil Procedure §§ 340.5, 667.7, 1281-1295 and the FederalArbitration Act (9 U.S.C. §§ 1- 9), as in effect from time to time.

Article 4: Retroactive Effect: Patient intends this Contract to cover services rendered by TCD not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Severability: If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this Contract. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient's Name	Signature of Patient, Parent, Guardian or Legally Authorized Representative of Patient	Date

TCD'S AGREEMENT TO ARBITRATE

In consideration of the foregoing agreements under this Contract, TCD likewise agrees to be bound by the terms set forth in this Contract and to the rules specified in Article 3 above.

Prepared by TCD Employee (Print Name)	Signature of TCD Employee	Date

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DENTAL MATERIALS FACT SHEET

I acknowledge that I have received the Dental Material Fact Sheet, Dated May 2004.

Signature of Patient or Parent or Legal Guardian

Date

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INFORMACIÓN SOBRE MATERIALES DENTALES

He recibido la hoja informativa sobre Materiales Dentales, Con fecha de Mayo 2004.

Firma del Paciente o Representante Legal

Fecha

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 (4354%) 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 COBALTCHROME 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