

**Thank you** for choosing our dental healthcare team! We will strive to provide you with the best possible dental care.

To help us meet all your dental healthcare needs, please fill out this form completely in ink.

If you have any questions or need assistance, please ask us and we will be happy to help.

**Please bring your dental insurance card with you to your appointment.**

## Patient Information (CONFIDENTIAL)

Date \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS # \_\_\_\_\_

Home address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ Home # \_\_\_\_\_ Mobile # \_\_\_\_\_

Check appropriate box:  Minor  Single  Married  Divorced  Widowed  Separated

If student, School/College name \_\_\_\_\_  Full-time  Part-time

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone # \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Responsible Party

Name of person responsible for this account \_\_\_\_\_ Birthdate \_\_\_\_\_

Relationship to patient:  Self  Spouse  Parent/Guardian SSN # \_\_\_\_\_

Home address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ Home # \_\_\_\_\_ Mobile # \_\_\_\_\_

Employer name \_\_\_\_\_ Work # \_\_\_\_\_

Work address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary insurance \_\_\_\_\_ ID # \_\_\_\_\_ Phone # \_\_\_\_\_

Secondary insurance \_\_\_\_\_ ID # \_\_\_\_\_ Phone # \_\_\_\_\_

## Patient Dental History

Name of previous dentist and location \_\_\_\_\_ Date of last exam \_\_\_\_\_

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw			14. Do you wear dentures or partials? If yes, date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>
Clicking _____	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face) _____	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing _____	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in chewing _____	<input type="checkbox"/>	<input type="checkbox"/>			

## Patient Medical History

Physician \_\_\_\_\_ Office # \_\_\_\_\_ Date of last exam \_\_\_\_\_

<p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what medication(s) are you taking? _____</p> <p>4. Have you ever taken Fen-Phen/Redux? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medication containing bisphosphonates? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you have or have you had any of the following?</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="width: 50%;">Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Cardiac pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Swollen ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Fainting / Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Frequently tired <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Epilepsy / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Joint replacement or implant <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Kidney diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>AIDS or HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Thyroid problem <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Stomach troubles / ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen ankles <input type="checkbox"/> Yes <input type="checkbox"/> No	Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting / Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequently tired <input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Joint replacement or implant <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney diseases <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS or HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach troubles / ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>11. Are you allergic to or have you had any reactions to the following?</p> <p>Local anesthetics (e.g. Novocain) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or any other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbiturates <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any metals (e.g. nickel, mercury, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex rubber <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other (please list) _____</p> <p>12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Women only:</p> <p>a) Are you pregnant or think you man be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chest pains <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Easily winded <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hay fever / Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radiation therapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Recent weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor): \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's signature: \_\_\_\_\_ Date: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

**Jayson F. Tsuchiya, D.D.S., Inc.**  
**990 W. Fremont Ave, Suite H**  
**Sunnyvale, CA 94087**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (“HIPPA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPPA” provides penalties for covered entities that misuse personal health information.

As required by “HIPPA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interested to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of **April 14, 2003** and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services. Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Jayson F. Tsuchiya, D.D.S., Inc.  
990 W. Fremont Ave, Suite H  
Sunnyvale, CA 94087  
Tel: 408-739-0911  
Fax: 408-739-2610

For more information about HIPPA or to file a complaint:

The US Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll Free: 1-877-696-6775

*The Facts  
About Fillings*



**DENTAL BOARD OF CALIFORNIA**  
1432 Howe Avenue • Sacramento, California 95825  
[www.dbc.ca.gov](http://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



## Dental Materials – Advantages & Disadvantages

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### **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**

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