# HIPAA Privacy Rule of Patient Authorization Agreement

**P.D. Tran, DDS, Inc.**

## Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (Patient's name) understand that as part of my health care, P.D. Tran, DDS, Inc., originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review P.D. Tran, DDS, Inc. notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

# Privacy Rule of Patient Consent Agreement

## Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review P.D. Tran, DDS, Inc. Notice of Information practices prior to signing this consent;
- That P.D. Tran, DDS, Inc., reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that P.D. Tran, DDS, Inc., is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that P.D. Tran, DDS, Inc., has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness .....

Printed Name of Patient or Legal Representative Witness .....

Date: .....

I have received a copy of the Dental Materials Fact Sheet as required by law

_____ Signature

_____ Date

over

# HIPAA Privacy Rule Receipt of Notice of Privacy Practices
# Written Acknowledgement Form

**P.D. Tran, DDS, Inc.**

**Acknowledgement of receipt of Information Practices Notice (§164.520(a))**

I,_____ (Patient's Name) understand that as part of my health care, P.D. Tran, DDS, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that P.D. Tran, DDS, Inc. **Notice of Privacy Practices** provides a complete description *of* the uses and disclosures of my health information. I understand that:

- I have the right to review P.D. Tran, DDS, Inc. Notice of Privacy Practices prior to signing this acknowledgement;
- that P.D. Tran, DDS, Inc. reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness ..... .....

Printed Name of Individual or Legal Representative Witness.....

Date: .....

**FOR OFFICE USE ONLY**

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

- ❑ Individual refused to sign
- ❑ Communication barrier prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Others (please specify)

_____

_____

_____ _____

Ms. Diala El-Asha
Privacy Official

Date

# HEALTH QUESTIONAIRE

Patient Name_____

Sex_____ Age____ Height_____ Weight_____

Date_____ Pulse _____

Blood Pressure _____

**Directions**

Please circle the appropriate answer to the questions and fill in the blanks where indicated. Answer all questions and blanks completely.

Answers to the following questions are for our records and will be considered confidential.

1. Are you in good health..... Yes No
   A. Has there been any change in your general health ..... Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician ..... Yes No
   A. If so, what is the condition being treated _____
4. The name and address of my physician is: _____ _____
5. Have you had a serious illness or operation ..... Yes No
   A. If so, what was the illness or operation:_____ _____ _____
6. Have you been hospitalized or had serious illness within the last five (5) years ..... Yes No
   A. Do you have a persistent cough or cough up blood ..... Yes No
   B. Low blood pressure ..... Yes No
   C. Venereal Disease ..... Yes No
   D. AIDS or HIV+..... Yes No
   E. Other_____ _____
7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma ..... Yes No
   A. Do you bruise easily ..... Yes No
   B. Have you ever required a blood transfusion ..... Yes No
   If so, explain the circumstances_____ _____
8. Do you have any blood disorder such as anemia..... Yes No
9. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips..... Yes No
10. Are you taking any drug or medication..... Yes No
    If so, what_____ _____
11. Are you taking any of the following:
    A. Antibiotics or sulfa drugs..... Yes No
    B. Anticoagulants (blood thinners)..... Yes No
    C. Medicine for high blood pressure..... Yes No
    D. Cortisone (steroids)..... Yes No
    E. Tranquilizers..... Yes No
    F. Aspirin..... Yes No
    G. Insulin, Tolbutamide (Orinase) or similar drug..... Yes No
    H. Digitalis or drugs for heart trouble..... Yes No
    I. Nitroglycerin..... Yes No
    J. Fen-Phen (now, or in the past) or any related drugs such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramin), and Redux (dexfenfluramine)..... Yes No
    K. Oral Contraceptives..... Yes No
    If so, what are you using_____ _____
    L. Other_____ _____
12. Do you have a heart murmur/mitral valve prolapse..... Yes No
13. Do you have any implants and/or Prosthesis (i.e. knee joints, elbow pins, etc.)..... Yes No
    If so, explain_____
14. Do you drink alcoholic beverages..... Yes No
15. Do you smoke..... Yes No
    If so, how much_____
16. Do you have or have you had any of the following diseases or problems:
    A. Rheumatic fever or rheumatic heart disease..... Yes No
    B. Congenital heart lesions..... Yes No
    C. Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)... Yes No
       1) Do you have pain in the chest upon exertion..... Yes No
       2) Are you ever short of breath after mild exercise..... Yes No
       3) Do you get short of breath when you lie down or do you require extra pillows when you sleep..... Yes No
    D. Allergy..... Yes No
    E. Asthma or hay fever..... Yes No
    F. Hives or skin rash..... Yes No
    G. Fainting spells or seizures..... Yes No
    H. Diabetes..... Yes No
       1) Do you have to urinate (pass water) more than six (6) times a day..... Yes No
       2) Are you thirsty much of the time..... Yes No
       3) Does your mouth frequently become dry..... Yes No
    I. Hepatitis, jaundice, or liver disease..... Yes No
    J. Arthritis..... Yes No
    K. Inflammatory rheumatism (painful, swollen joints).. Yes No
    L. Stomach ulcers..... Yes No
    M. Kidney trouble..... Yes No
    N. Tuberculoses..... Yes No
17. Are you allergic or have you reacted adversely to:
    A. Local anesthetic..... Yes No
    B. Penicillin or other antibiotics..... Yes No
    C. Barbiturates, sedatives, or sleeping pills..... Yes No
    D. Sulfa Drugs..... Yes No
    E. Aspirin..... Yes No
    F. Iodine..... Yes No
    G. Latex..... Yes No
    H. Other:_____
18. Have you had any serious trouble associated with previous dental treatment..... Yes No
    If so, explain_____ _____
19. Are you pregnant or could you be..... Yes No
    If so, when are you due?_____

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

Patient/Guardian_____ Date_____

Doctor _____ Date_____

Updates:

Patient/Guardian_____ Doctor's Initials_____ Date_____

Patient/Guardian_____ Doctor's Initials_____ Date_____

Patient/Guardian_____ Doctor's Initials_____ Date_____

# We Would Like to Get to Know You Better!

Date _____

Full Name _____ Phone (Hm) (____)_____-_____ (Wk) (____)_____-_____

Email Address _____ (Cell) (____)_____-_____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Driver's License # _____ Social Security # _____-_____-_____ Spouse's Name _____

Occupation _____ Employer _____

Contact in Case of Emergency _____ Phone (____)_____-_____

When was your last dental appointment? _____ Person responsible for your dental investment _____

Whom may we thank for referring you? _____ Why did you leave your last dentist? _____

# We Want to Take Care of Your Concerns and Needs First...

What are your present dental problems? _____

Do you avoid brushing any part of your mouth? ( ) Yes ( ) No

Do your gums bleed when brushing? ( ) Yes ( ) No

Are your teeth sensitive to sweets, hot/ cold, or biting pressure? ( ) Yes ( ) No

I want to know about longer lasting solutions that may cost more. ( ) Yes ( ) No

Are you dissatisfied with your teeth and their appearance? ( ) Yes ( ) No

Does dental treatment make you nervous?
( ) No ( ) Slightly ( ) Moderately ( ) Very

I think my dental health is…
( ) Excellent ( ) Good ( ) Fair ( ) Poor

If I could change my smile I would make my teeth…
( ) Whiter ( ) Straighter ( ) Close Spaces ( ) Repair Chips

Other concerns/ needs of mine are _____

# For Insurance Purposes...

Name of Policy Holder _____ Policy Holder Social Security # _____-_____-_____

Policy Holder's Date of Birth _____ Employer _____ Name of Insurance Company _____

Insurance Company's Phone (____)_____-_____ Group # _____ Ins. Co. Address _____

**Are you covered by another plan?** If so, please complete the following…

Name of Policy Holder _____ Policy Holder Social Security # _____-_____-_____

Policy Holder's Date of Birth _____ Employer _____ Name of Insurance Company _____

Insurance Company's Phone (____)_____-_____ Group # _____ Ins. Co. Address _____

# Consent for Services and Financial Agreement

I hereby authorize P.D. TRAN, DDS, INC. and/or each associate(s) or assistants to provide me, or my dependents, with dental treatment, and release any medical or incidental information that may be necessary for either medical/ dental care or in processing applications for financial benefit. It is P.D. TRAN, DDS, Inc.'s procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. The office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days unless previously written financial arrangements are satisfied.

I understand that the fee estimates listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand that delinquent accounts may be assigned to a credit reporting collection service and a $50.00 minimum fee will be added to the unpaid balance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

As a courtesy, if I need to reschedule my appointment, I have to call 48 hours ahead of time.

I grant permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____ Relationship to Patient:_____

Patient or Personal Representative Signature

# Informed Consent

**I understand that by signing below and initialing any of the following items that I request and authorize the procedure to be done and have read and understand the possible risks and complications of the procedure(s).**

**Initials _____**

## 1) X-Rays & Examination

I understand that I will be receiving a dental examination from a state licensed dental practitioner. I understand that while X-rays are taken on my teeth that I will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive examination. I also understand that if I am pregnant radiation exposure posses a serious threat to the life and health of my unborn child. **Pregnant women are required to have medical release from their Medical Doctor prior to X-rays and Dental treatment.**

Initials _____

## 2) Changes in Treatment Plan

I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination. I understand that there may be unforeseen changes that may occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. I give my permission to the Dentist to make any and/ or all changes and additions as necessary.

Initials _____

## 3) Drugs & Medication

I understand that antibiotics, analgesics and other medications can cause allergic reactions. The reactions can cause redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock.

Initials _____

## 4) Removal of Teeth

Alternatives for tooth removal have been explained to me (root canal therapy, crowns, and periodontal surgery) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #2. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the following risks involved in having teeth removed; these are pain, spread of infection, dry socket, swelling, fractured jaw, loss of feeling in my teeth, lips, tongue, and surrounding tissue that can last for an indefinite period of time. I understand I may need further treatment by a specialist, the cost of which is my responsibility.

Initials _____

## 5) Crowns, Bridges, Inlays, & Onlays

I understand that I may be wearing temporary crowns or fillings, and that I must be careful to ensure that they are not removed until the permanent crowns or inlays/ onlays are delivered. I understand that sometimes it is not possible to match the color of my natural teeth with artificial teeth. I realize the last opportunity to make changes in my crown, bridge, or inlay/ onlay will be before permanent cementation. I must return to the dentist for permanent cementation within 20 days from tooth preparation. Extended delays between the time of tooth preparation and crown cementation may allow for tooth movement, accumulation of bacteria, and/ or infection of tooth structure and the surrounding tissues. This may cause the necessity to remake the crown, bridge, or inlay/ onlay, and even could lead to tooth loss. I understand there will be additional charges for remakes due to my delaying permanent cementation. I understand that significant sensitivity is a common after effect of a newly placed crown, bridge, or inlay/ onlay. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the crown, bridge, or inlay/ onlay being done.

Initials _____

## 6) Root Canals/ Endodontic Treatment

I understand that there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that sometimes root canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers can separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment.

Initials _____

## 7) Periodontal Loss

I understand that I have a condition that causes gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical periodontal therapy, gum surgery, replacements and/ or extractions. I understand that undertaking any dental procedures may have future adverse effect on my periodontal condition.

Initials _____

## 8) Fillings

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the filling being done.

Initials _____

## 9) Dentures

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. **(Initials _____)**

I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges.

Initials _____

**I understand that there has been no guarantee of assurance made by anyone in regards to my dental treatment that I have authorized. I also acknowledge that I am responsible for payment of all my dental fees regardless of any dental insurance coverage.**

Signature of Patient/ Guardian _____ Date _____

Signature of Doctor _____ Date _____

## Dental Materials Advantages & Disadvantages

### 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**
2005 Evergreen Street, Suite 1550, Sacramento, CA 95815
www.dbc.ca.gov

Published by
California Department of Consumer Affairs
5/04

*The Facts About Fillings*

# *The Facts About Fillings*

**DENTAL BOARD OF CALIFORNIA**
2005 Evergreen Street, Suite 1550, Sacramento, CA 95815
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.



## 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

## 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



## 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