Patient Information

Date _____

Last Name_____First Name_____MI_____

Address_____City_____State_____Zip_____

Home Phone_____ Cell_____

Work Phone_____E-Mail_____

D.O.B._____ Social Security Number _____

Preferred Contact Method Home ☐ Work ☐ Cell ☐ E-mail ☐

Whom may we thank for referring you? _____

Emergency Contact Information Name_____

Address_____

Phone #_____ Relationship_____

Primary Insurance Information
Subscriber Name_____

Insurance Co_____

Group #_____ID#_____

Employer_____

Date of Birth_____Relationship_____

Insured's Social Security #_____

Secondary Insurance Information
Subscriber Name _____

Insurance Co_____

Group #_____ID#_____

Employer_____

Date of Birth_____Relationship_____

Insured's Social Security #_____

Authorization for Signature on File Release of Information/Financial Responsibility/Authorization for Payment

I, _____ and or_____
Name of Patient (Parent/Guardian) Name of Insured
hereby authorize the office of Dr. Juergen Langenbach DMD, APDC, to affix my name to any and all insurance claims or documents as related to any and all health benefits due me and my dependants through my dental insurance company. I hereby authorize payment of dental benefits otherwise payable to me to the office of Dr. Juergen Langenbach DMD, APDC. I have reviewed the treatment and fees. I agree to be responsible for all the charges for dental services and materials not paid by my dental benefit plan. I authorize release of any information relating to the claim. This "Authorization" will be valid from this date or as long as the patient is active in the practice. A photo copy of this document may act as the original.

_____ _____
Signature of Insured Witnessed By

_____ _____
Signature of Patient (Parent or Guardian) Today's Date

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents'. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that late charges and finance charges at 18% APR may be added to my account on balances older than 60 days.

Patient's Signature_____

Date_____ Witness_____

Parent/Responsible Party's Signature_____

Juergen Langenbach, DMD, A Professional Dental Corporation
15725 Pomerado Road, Ste. 104, Poway, CA 92064
858-451-3110

FINANCIAL GUIDELINES

This is an agreement between Dr. Juergen Langenbach, DMD, A Professional Dental Corporation, as creditor, and the Patient/Guarantor named on this form.

Payments: **Payment in full is expected at the time of service.**

Finance Charge: A finance charge will be applied to any portion of your balance that becomes sixty (60) days past due. The **Finance Charge** will be computed at the rate of 1/5% per month or an **Annual Percentage Rate** of eighteen (18) %.

Returned Checks: There is a $40.00 charge for any checks returned by the bank.

RESERVED APPOINTMENT AGREEMENT

An appointment time has been reserved specially for you. This convenient system helps our office run smoothly for both our patients and our team. We schedule an appropriate amount of time for your treatment, and we take pride in staying on schedule, preventing any unnecessary waiting time. We want you to know that we value and honor your time!

When making an appointment, please be sure that your other obligations allow you enough time to arrive promptly for your dental visit. Your cooperation allows us to be on time for your appointment and our other patients.

If you find you are unable to keep your scheduled appointment, please call in advance so that we may reschedule you at a more convenient time. There will be no charge if we are notified at least 2 business days before the scheduled appointment. Office hours are Monday-Wednesday 7:00AM to 4:30PM and Thursday 7:00AM - 3:30PM.

1st Time: We will waive the fee as a courtesy (things happen!)
2nd Time: and thereafter: A minimum charge of $50.00 per visit for the missed appointment time (relative to the treatment time scheduled). If you are a family of 2 or 3 scheduled for the same time and find that one of them is not able to attend, please try to keep the other appointments to avoid multiple charges for each of the missed appointments.

DENTAL INSURANCE

In an effort to avoid potential misunderstandings, we are taking this opportunity to explain our relationship and responsibility to you, our patient, regarding your dental benefits. Your benefits are provided by you (in the case of an individual policy), or an employer. We have no control over the quality of policy you or an employer may have chosen. Therefore, our involvement must be limited to a business courtesy to aid you in maximizing your benefits as regulated by policy limitations, whatever they may be. We encourage you to familiarize yourself with your benefits; they are as varied as there are policies.

Currently, we are considered out-of-network. I understand that being out-of-network means my dentist is not bound by a contractual fee limitation. I understand that predeterminations **are not a guarantee of payment. I agree to pay my account balance for all charges regardless of how dental benefits are determined by my dental carrier.**

As a courtesy, we will bill your insurance carrier to help you realize as much of your annual maximum as we can but we have no affiliation with nor any control over how they process the claim or determine benefits. You will receive any reimbursements directly from your insurance company. It is important to note dual insurance is not a guarantee of 100% coverage. **If there is any follow-up needed, we are happy to make up to two phone calls and/or provide any additional support or information your insurance carrier may need. In the case of disputes, we readily write letters to advocate your ability to maximize your dental benefit but we cannot guarantee they will find in your favor.**

I have read and agree to the financial policy of Juergen Langenbach, DMD, A Professional Dental Corporation.

Patient's Name: _____ Date: _____
Responsible Party: _____ Responsible Party Signature _____

Patient Name	DENTAL HISTORY
Patient Account No.	Medical Alert

Welcome! Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care.
All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit? _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are you currently using topical fluoride? ☐ Yes ☐ No

What other dental aids do you use (Interplak, toothpick, etc.)? _____

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	☐ Yes	☐ No
Sweets?	☐ Yes	☐ No
Biting or chewing?	☐ Yes	☐ No
Have you noticed any mouth odors or bad taste?	☐ Yes	☐ No
Do you frequently get cold sores, blisters or any other oral lesions?	☐ Yes	☐ No
Do your gums bleed or hurt?	☐ Yes	☐ No
Have your parents experienced gum disease or tooth loss?	☐ Yes	☐ No
Have you noticed any loose teeth or change in your bite?	☐ Yes	☐ No
Does food tend to become caught in between your teeth?	☐ Yes	☐ No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	☐ Yes	☐ No
Bite your lips or cheeks regularly?	☐ Yes	☐ No
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)?	☐ Yes	☐ No
Mouth breathe while awake or asleep?	☐ Yes	☐ No
Have tired jaws, especially in the morning?	☐ Yes	☐ No
Snore or have any other sleeping disorders?	☐ Yes	☐ No
Smoke/chew tobacco or use other tobacco products?	☐ Yes	☐ No

Have you ever had:

Orthodontic treatment?	☐ Yes	☐ No
Oral surgery?	☐ Yes	☐ No
Periodontal treatment?	☐ Yes	☐ No
Your teeth ground or the bite adjusted?	☐ Yes	☐ No
A bite plate or mouth guard?	☐ Yes	☐ No
A serious injury to the mouth or head?	☐ Yes	☐ No

If yes, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw?	☐ Yes	☐ No
Pain (joint, ear, side of face)?	☐ Yes	☐ No
Difficulty in opening or closing the mouth?	☐ Yes	☐ No
Difficulty in chewing on either side of the mouth?	☐ Yes	☐ No
Headaches, neck aches or shoulder aches?	☐ Yes	☐ No
Sore muscles (neck, shoulders)?	☐ Yes	☐ No
Are you satisfied with your teeth's appearance?	☐ Yes	☐ No
Would you like to keep all of your teeth all of your life?	☐ Yes	☐ No
Do you feel nervous about having dental treatment?	☐ Yes	☐ No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience?	☐ Yes	☐ No

If yes, please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☐ No

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe _____

PLEASE COMPLETE OTHER SIDE

Patient Name	**MEDICAL HISTORY**
Patient Account No.	**Medical Alert**

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? ☐ Yes ☐ No
   Describe _____
2. Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No
3. Are you currently taking an medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ☐ Yes ☐ No
4. Have you ever taken prescription medications for weight loss (diet pills)? ☐ Yes ☐ No
   If yes, did you take any of the following? (Check if yes) ☐ Fen-Phen ☐ Pondimen ☐ Redux ☐ Other
   If yes to any of the above, did you have a medical exam for heart issues? ☐ Yes ☐ No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ☐ Yes ☐ No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? ☐ Yes ☐ No
   If yes, please specify _____
7. Have you been a patient in the hospital during the past five years? ☐ Yes ☐ No
8. Indicate which of the following you have had, or have at present. Check "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No	AIDS/HIV Positive	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Cold Sores/Fever Blisters	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Contact Lenses	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Artificial Heart Valve/ Pacemaker	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Chronic Cough	☐ Yes	☐ No	Liver Disease/Yellow Jaundice	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No	Hay Fever/Allergy/Hives	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Latex Sensitivity	☐ Yes	☐ No	Nervous/Anxious	☐ Yes	☐ No
Diet (Special/Restricted)	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Artificial Joints (Hip, Knee, etc.)	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No			
			Chemotherapy	☐ Yes	☐ No			
			Tumors	☐ Yes	☐ No			
			Hepatitus A, B, C	☐ A	☐ B	☐ C		

9. Have you lost or gained more than 10 pounds in the last year? ☐ Yes ☐ No
10. Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No
11. Women: Are you pregnant or think you could be pregnant? ☐ Yes ____ Months ☐ No Nursing? ☐ Yes ☐ No
12. Do you use birth control prescriptions? ☐ Yes ☐ No

I understand the above information in necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

Lynne D. Thomas, D.D.S., M.A.G.D.
Juergen Langenbach, D.M.D., M.A.G.D.
15725 Pomerado Road, Suite #104
Poway, CA 92064
powaydds@gmail.com
(858)451-3110

LIST OF MEDICATION(S) & DOSE(S)

NAME: _____

DATE: _____

Medication(s)	Dose(s)

NOTES:

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act — 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named _____.

2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ from (date) _____ - to (date)_____ OR
   b ☐ all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one):
   a. ☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   b. ☐ my complete health record *with the exception of the following information* (check as appropriate):
      ☐ Mental health records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol/drug abuse treatment
      ☐ Other (please specify): _____ .

4. In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____
Signature of Patient

Keep original, and give copies to your health care provider, agent and family members

Photograph Authorization

I _____hereby give my consent for Dr. Langenbach or Dr. Thomas to take photographs, slides and/or videotape of face, jaw, and teeth. I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, or advertisements to promote cosmetic dentistry.
I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, bridges, or dentures and these images will become part of my dental record.
I do not expect compensation, financial or otherwise, for the use of these images.

Please initial:

_____ I consent to the use of my photographs, slides, and/or videotape for articles, lectures, marketing, advertising, and laboratory use.
_____ I consent to the use of my photographs, slides, and/or videotape **ONLY** for laboratory use.
_____ I **DO NOT** consent to the use of my photographs, slides, and/or videotape.

I understand that the information disclosed under this authorization may be subject to redisclosure and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to Dr. Langenbach stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization. Unless revoked by me, this authorization expires 10 years from the date I sign below.

Patient's or Legal Guardian's/Representative's Signature Date

COPY OF THIS SIGNED DOCUMENT TO BE PLACED IN PATIENT'S CHART

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 Materials - Advantages & Disadvantages

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 glasslike 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

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

The Dental Board of California requires that we distribute to our patients a copy of The Dental Material Fact Sheets.

I, _____, acknowledge that I have received a copy of the Dental Materials Fact Sheet.

_____ _____

Signature Date