CHIRAG R VAID, DDS

Welcome to our practice!

On behalf of our team, we welcome you to our office. We appreciate that you have selected us to care for your dental needs and we look forward to your initial visit.

We want you to know that we are committed to provide you with the highest quality of oral health care in the most gentle, efficient and enthusiastic manner possible. We pride ourselves on making dentistry a pleasant experience for you, while providing you with the best dental treatment.

Our emphasis is on early preventive care, but we also provide restorative care, including full mouth rehabilitation and emergency services. Our primary goal, whenever possible, is the retention of your healthy, natural teeth. With this in mind, let me tell you what you can expect on your first visit to our office.

During your first visit, a comprehensive examination will be completed. This exam will include necessary x-rays allowing us to diagnose the condition of your mouth, teeth and gums. In most instances, your dental condition will be determined at this visit, and if needed, a suitable treatment plan will be discussed with you.

We appreciate the value of your time, and except for emergency situations, you can expect us to be on time for you. We will appreciate the same courtesy. We expect at least 48-hour advance notice for appointment cancellation to allow us to schedule your reserved time to another patient in need.

If you have dental insurance, please bring your insurance card and your dental benefit booklet if one has been distributed. If a card is not available please have all insurance information, such as provider name, address, subscriber ID number, etc.

Should you have any questions about our practice, services or policies please do not hesitate to contact our office or visit our website at www.crvdds.com. Enclosed you will find our patient registration materials. Please fill them out and bring them in with you for Dr. Vaid to review with you during your initial examination appointment. We encourage open communication. We will answer any questions you may have about your dental health, dental care, outcomes and costs. Please email the forms attached to us at frontdeskvaid@gmail.com before your first appointment. We value your trust and confidence in selecting our office and look forward to meeting you.

Sincerely,

Sandra Wemmer, RDA
Office Manager

2201 Capitol Avenue, Suite 100 Sacramento, CA 95816
cvaid@crvdds.com | crvdds.com
916 444.2957

CHIRAG R. VAID, DDS
GENERAL DENTIST
WWW.CHIRAGRVAIDDDS.COM
C.VAID.DDS@GMAIL.COM
2201 CAPITOL AVENUE, SUITE 100
SACRAMENTO, CA 95816
916.444.2957

On behalf of our staff and ourselves, we welcome you to our family of fine patients. It is our hope that your dental visit will be prompt and pleasant so that in the future you will want to refer your friends and family. If at any time you have any questions, we appreciate the opportunity to answer them.

ACQUAINTANCE FORM

TODAY'S DATE:

Name_____ Marital Status_____
First MI Last

What do you prefer to be called?_____ **Birthdate**_____

Address_____
Street City Zip

Preferred Phone_____ **Social Security No.**_____ **Drivers Lic. No.**_____

Alternate Phone_____ Employer_____ Occupation_____

Email Address_____

Spouse's Name_____ Spouse's Occupation_____

Name & Phone of Relative or Close Friend_____

Emergency Contact_____ Relation_____ Phone_____

Who May We Thank for Referring You to Our Office_____

DENTAL INSURANCE INFORMATION

Primary Dental Ins. Co._____Employer_____ Group No._____

Insured's Name_____ SS#/I.D.#_____D.O.B._____

Covered Dependents & D.O.B._____

Secondary Insurance (if any)

Dental Ins. Co._____Employer_____ Group No._____

Insured's Name_____ SS#/I.D.#_____D.O.B._____

Covered Dependents & D.O.B._____

FINANCIAL POLICY

In order to keep our fees as low as possible, we ask that payment be made at the time of service. **Insurance is a method of partial payment and does not influence our treatment planning.** As a courtesy, we will submit claims on your behalf. If after 30 days, the insurance has not paid, we will bill you for the total amount. Each dental plan varies and not all services are covered, therefore you are ultimately responsible for the total amount of all dental treatment. For your convenience, we will provide you with an estimate prior to scheduling any treatment. We accept cash, checks, all major credit cards and CareCredit.

CANCELLATION POLICY

If you are unable to keep the appointment you scheduled, we require a 48–hour notice for cancellations or a $75.00 charge may be incurred. We realize that emergencies do occur and we will be flexible under those rare circumstances.

Acknowledgement of receipt of notice of **Privacy Practices** and **Dental Materials Fact Sheet**.

X_____
Patient Signature (Parent or Guardian) Date

X_____
Patient Signature (Parent or Guardian) Date

PATIENT NAME: _____

MEDICAL HISTORY:

Current medical doctor_____ Phone_____

Are you now under the care of a physician? If yes, please explain. _____ ☐ Yes ☐ No

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

Have you ever received a blood transfusion? When? _____ ☐ Yes ☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

Are you pregnant? If so when are you due? _____ ☐ Yes ☐ No

Are you taking or have you ever taken medications for Osteoporosis (i.e. Bisphosphonates)? ☐ Yes ☐ No

_____

Have you ever been diagnosed with sleep disorders or sleep apnea? ☐ Yes ☐ No

Do you have an allergy or sensitivity to latex? ☐ Yes ☐ No

Have you ever had an allergic reaction? If yes please list your allergies _____ ☐ Yes ☐ No

Have you ever been instructed to take antibiotic pre-medication before dental treatment? Why? _____ ☐ Yes ☐ No

Are you taking any medications, pills, drugs or over the counter medications? ☐ Yes ☐ No

Please list each mediation and reason for taking it.

_____ _____

_____ _____

_____ _____

Do you have or have you ever had any of the following conditions? Please **CIRCLE Y** or **N** for each condition listed:

Allergies/Hay Fever	Y N	Diabetes, Type____	Y N	Heart Surgery, Date____	Y N	Recreational Drug Use	Y N
Alzheimer's/Dementia	Y N	Dizziness/Fainting	Y N	Hepatitis, Type_____	Y N	Respiratory Problems	Y N
Anemia	Y N	Dry Mouth	Y N	Herpes/ Fever Blisters	Y N	Rheumatic Fever	Y N
Arthritis	Y N	Eating Disorders	Y N	High/Low Blood Pressure	Y N	Rheumatism	Y N
Arrhythmia	Y N	Emphysema/COPD	Y N	HIV/AIDS	Y N	Shortness of Breath	Y N
Artificial Heart Valve/Stent	Y N	Epilepsy/Seizure	Y N	Immunosuppression	Y N	Sinus Problems	Y N
Artificial Joints	Y N	Excessive Bleeding	Y N	Kidney Problems/UTI	Y N	Stomach Problems	Y N
Asthma	Y N	Gastric Reflux/GERD	Y N	Liver Disease/Jaundice	Y N	Stroke, Date_____	Y N
Autoimmune Disease	Y N	Glaucoma	Y N	Mental Disorders	Y N	Thyroid/Parathyroid Disease	Y N
Blood Disorders	Y N	Gout	Y N	Nervous Disorders	Y N	Tobacco Use	Y N
Cancer, Date_____	Y N	Head Injuries	Y N	Osteoporosis	Y N	Tuberculosis/Lung Disease	Y N
Canker Sores	Y N	Heart Attack, Date____	Y N	Pacemaker	Y N	Tumors/Growths	Y N
Chemical/Alcohol Dependency	Y N	Heart Disease	Y N	Psychiatric Care	Y N	Ulcers/Colitis	Y N
Congenital Heart Lesion	Y N	Heart Murmur	Y N	Radiation/Chemotherapy	Y N	Venereal Disease	Y N

Have you ever had any other serious illness or condition not circled above?_____ ☐ Yes ☐ No

Do you wish to talk to the doctor privately about any problem?_____ ☐ Yes ☐ No

Notes:_____

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I have any change in my health, I will inform the doctor at the next appointment without fail.

X_____Date _____

Patient Signature (Parent or Guardian)

X_____Date _____ B.P._____

Reviewed by Doctor

Date:_____ Notes:_____Patient:_____Doctor:_____

Date:_____ Notes:_____Patient:_____Doctor:_____

Date:_____ Notes:_____Patient:_____Doctor:_____

Date:_____ Notes:_____Patient:_____Doctor:_____

Chirag R. Vaid, D.D.S.
2201 Capitol Avenue
Sacramento, CA 95816
Ph# (916)444-2957

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

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

_____
Please Print Name

_____ _____
Signature Date

For Office Use Only

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

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

_____

_____

_____

Patient Responsibilities

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: Cash, Check, Visa, MasterCard.
** Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. Our practice may or may not be a contracted provider with your dental benefit plan.
- If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.
- If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Patient Authorizations

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.	_____ (initial)
I have read the above and agree to the financial and scheduling terms.	_____ (initial)
I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. (Assignment of benefits Release)	_____ (initial)

Patient Communication

Voice Messages: I understand brief messages from the dental practice may be left on my home answering machine or with anyone who answers the telephone at my home unless I have provided the practice with alternate instructions for communication	_____ (initial)
Email: We use secure methods to electronically communicate with our patients in regards to sensitive health information. **Unencrypted email is not a secure form of communication.** There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive unsecured email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. I consent and accept the risk in receiving information via unencrypted email. I understand I can withdraw my consent at any time, and will do so in writing.	_____ (initial)
Cellphone: I consent to the dental practice using my cellphone number to call and text appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time and will do so in writing.	_____ (initial)
Patient Acknowledgements I hereby acknowledge that a copy of this practice's **Notice of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.	_____ (initial)
I hereby acknowledge that a copy of this practice's **Dental Materials Fact Sheet** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.	_____ (initial)

Assignment of Benefits Form

Chirag R Vaid DDS Dental Corporation
2201 Capitol Avenue, Suite 100
Sacramento, CA 95816

I hereby assign to Chirag R Vaid DDS Dental Corporation, all my right, title, and interest in and to any and all dental benefits otherwise payable to me for oral health treatment rendered by the assignee as described in the attached claim form.

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.

To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Patient Name: _____ Dated: _____

Patient's signature: _____

If not signed by the patient, please indicate relationship:

☐ Patient or guardian or minor patient (to the extent minor could not have consented to the care)

☐ Guardian or conservator of patient

☐ Beneficiary or personal representative of deceased patient

☐ Spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

TO BE FILLED OUT BY OFFICE:

Policy Name: _____ Policy Number: _____

Policy Name: _____ Policy Number: _____

Policy Name: _____ Policy Number: _____

Notes:

California Authorization for the Release of Dental Records

I hereby authorize _____, D.D.S. to release the information

in the record of _____to **Chirag R. Vaid, D.D.S.**

By
Mail: 2201 Capitol Avenue, Sacramento, CA. 95816 or
Email: frontdeskvaid@gmail.com

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below.

_____

_____.

[Optional: I understand and agree to pay a reasonable charge to cover the cost of the transfer, as allowed in Health and Safety Code §§123100 et seq. and Evidence Code §1158].

This authorization is effective now and will remain in effect until_____.
(date)

I understand that I may receive a copy of this authorization.

Signed:_____ Date:_____

If not signed by the patient please indicate relationship:
[ ] parent or guardian of minor patient
[ ] guardian or conservator of an incompetent patient
[ ] beneficiary or personal representative of deceased patient

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Note: To be valid, an authorization must be clearly separate from the other language on a page and executed by a signature which serves no purpose other than to execute the authorization. It can be either hand written by the person who signs it or in typeface no smaller than 8-point (this is 8-point).

COPY TO BE PLACED IN PATIENT'S CHART

Chirag R. Vaid, D.D.S.
2201 Capitol Avenue, Suite 100
Sacramento, CA 95816
(916) 444-2957

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1/1/2017, and will remain in effect until we replace it.

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

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

USES AND DISCLOSURES OF HEALTH INFORMATION

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

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

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

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

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

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

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

Marketing Health-Related Services: We will not use your health information for marketing communications with-

out your written authorization.

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

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

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

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

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page. $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before May 16, 2016. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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

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

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

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form and may request so at any time.

QUESTIONS AND COMPLAINTS

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

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

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

Contact:
Chirag R. Vaid, DDS
2201 Capitol Avenue
Sacramento, CA 95816
(916) 444-2957

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
1432 Howe Avenue • Sacramento, California 95825
www.dbc.ca.gov

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The Facts About Fillings

The Facts About Fillings

DENTAL BOARD OF CALIFORNIA
1432 Howe Avenue • Sacramento, California 95825
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