

JOHN A. MONTTOYA DDS
BoulderDentalDesigns.Com
Diagonal Park Dental Offices
3400 Penrose Place #104
Boulder, Colorado 80301
303-443-1895

We look forward to having you join our great family of friends and patients.
The benefits of a healthy, beautiful smile are immeasurable. Our goal is to
allow you to obtain the healthy teeth and attractive smile you want and deserve.
Please complete this form so that we may provide the best possible care for you.

Today's date _____

ABOUT YOU:

Mr. Mrs. Ms. Dr _____
Preferred name _____

Home address _____
City _____ Zip _____ Birthdate _____
E mail address _____ Drivers License # _____
SS# _____ Occupation _____
Employer _____
Employer address _____ City/Zip _____
Spouse/Partner _____ Employer _____
Special interests or hobbies _____
Whom may we thank for referring you to us? _____

TELEPHONE INFORMATION:

Home phone _____
Work phone _____ Pager _____ Cellular phone _____
When is the best time to call you? _____ and where? _____
In case of an emergency is there someone we may call?
Name _____ Phone _____

MEDICAL INFORMATION:

Name of personal physician _____ Phone number _____
Last visit with physician _____
Current health: ___ Excellent ___ Good ___ Fair ___ Poor
Do you smoke? ___ YES ___ NO How much per day? _____
Are you now or have you recently been under a physician's care? ___ YES ___ NO
Reason: _____
Have you ever been a patient in a hospital or had any serious illness? ___ YES ___ NO
Explain: _____

Are you currently taking prescription medication? ___YES ___NO

Name of medication _____

Purpose _____

Check any of the following that you have had or suspected:

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Artificial Valves |
| <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Diabetes/Tuberculosis (TB) |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Epilepsy/Seizures/Fainting | <input type="checkbox"/> Fever Blisters/Herpes | <input type="checkbox"/> Heart Attack/Stroke |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Hemophilia/Abnormal bleeding |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> HIV+/AIDS |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Rheumatic/Scarlet Fever | <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Venereal Disease |

Have you been treated for any other illness not listed above? ___YES ___NO

If yes please explain _____

Do you need to be pre-medicated with antibiotics before dental treatment? ___YES ___NO

Are you allergic to or do you suffer ill effects from any of the following?

- | | | | |
|---|----------------------------------|--|----------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Dental Anesthesia | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Household Bleach | <input type="checkbox"/> Latex | <input type="checkbox"/> Erythromycin | |

Other: Explain _____

Women only: Are you pregnant? ___YES ___NO. If yes, how many months? _____

Are you breast feeding? ___YES ___NO

DENTAL HISTORY:

Why have you come to the dentist today? _____

Many patients consult us for a second opinion. Have you seen another dentist for your dental needs? ___YES ___NO

If yes please explain _____

How do you describe the condition of your teeth and gums? ___GOOD ___FAIR ___POOR

Are you currently in pain or discomfort with your teeth or gums? ___YES ___NO

If yes please explain _____

The date of your last dental visit _____ Previous dentist's name _____

If you could wave a magic wand and change anything about the appearance of your smile what would you like to do? _____

If you could easily and safely whiten your teeth would you be interested? ___YES ___NO

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

Do your gums bleed when you brush your teeth? ___YES ___NO Floss your teeth? ___YES ___NO

Have you ever experienced pain in your jaw? ___YES ___NO Do you grind your teeth? ___YES ___NO

Does the idea of dental work make you anxious? _____

Do you have trouble sleeping? _____ Do you snore? _____

Insured's name _____ Social Security # _____

Name of insurance _____ Insured's birthdate _____

Signature_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

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 acknowledgement of receipt of our Notice Of Privacy Practices, but
acknowledgement could not be obtained because:

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

New Patient Personal Interview

Name: _____

Our office is very different than the average, ordinary dental office. We place a high emphasis on helping you determine your present and future dental needs and creating a **Personalized Dental Plan** that is specifically tailored to your specific desires and needs. What follows are some questions that will help us discover what those desires and needs are. These may be about issues you have never thought about, but thoughtful answers will help us to understand your personal situation so we can create a plan suited perfectly for you.

- How long has it been since you have been to the dentist and what was that for?

- What are your areas of concern right now or what is your major reason for seeing us? _____

- Tell us your opinion about what you think the present state of health of your mouth is. _____
- Tell us about your good dental experiences. _____
- What did you like about your last dental office? _____
- Tell us about any bad dental experiences. _____
- What caused you to leave your last dentist? _____
- What would you like to change about your smile? _____
- What would it take for you to trust us to be your dentist? _____
- Do you have family or friends who already come to our office? _____
- What do you already know about our office and what are your expectations?

- Has fear ever been an issue for you in a dental office? _____
- Has time ever been a factor in getting your dental work done? _____
- Has the cost of dental treatment been a concern for you? What can we do to help you with this? _____

- We have the unique ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you? (circle)
As a general dentist As a cosmetic dentist As a functional dentist

- At what point do you want us to initiate treatment? (circle)
When my tooth hurts or breaks When something is worsening When something isn't ideal

- What quality of dentistry do you want us to recommend? (circle)
"just patch it" Average Ideal/The best

Is there anything else you would like us to know? _____

Boulder Dental Designs Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment.

Optional Payment Terms:

1. **Full Pay DOS Cash Discount:** We offer a 5% accounting courtesy for all treatment that is paid in full (cash or check) at the time of service. Total services must exceed \$500 to qualify for the cash discount.
2. **Credit Card Payment Option:** We allow (with a signed agreement form), a Credit Card Payment option. Our office accepts: Visa, Mastercard and Discover card. Our office personnel will charge these payments to your credit card on the dates of service. Payment with a credit card on the day of service does not qualify for the cash discount.
3. **Term Loan:** By arrangement we have partnered with two outside financing companies, the Dental Fee Plan and Care Credit. We offer our patients, upon approval, an interest-free term loan (up to 6 months) with no down payment, no annual fee, and no prepayment penalty. Extended payment options are also available. Please ask for an application.

To maintain the practice operations and to prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. Payments are expected at the time services are rendered.

Broken appointments: Appointment times have been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 48 hours notice, within our business days, to avoid a \$70.00 cancellation fee (emergencies are an exception).

Terms and Conditions:

As a condition of treatment by this office, I understand financial arrangements must be made ahead in advance. The practice depends upon reimbursement from the patient for the costs 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 prior financial arrangements, must be paid for in cash at the time the services are performed. I understand that dental services furnished to me are charged directly to me and I am personally responsible for payment of all dental services.

If I carry insurance, I understand that this office will prepare my insurance forms to assist in making collections from the insurance companies and the payments will be sent directly to me. This office does not render services on the assumption that the charges will be paid by the insurance companies. Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.**

Many people receive notification from their insurance company that dental fees are “above usual and customary.” An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, and then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. **Any doctor in private practice will have fees that insurance companies define as “higher than usual and customary.”**

I understand that the fees estimates listed for this dental case can only be extended for a period of six months from the date of the patient’s examination.

In consideration for the professional services rendered for me, or at my request, by the doctor/staff, I agree to pay, therefore, the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered. 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. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver from any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney’s fees.

I grant permission to you, or your assigns 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 agree to their content.

Sign: _____

Date: _____

Insurance Information:

Primary Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Carrier (Delta Dental Only)

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to me of the group insurance benefits. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Sign: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES

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

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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 April 14, 2003, 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 disclosures permitted by your authorization while it was in effect. Unless you give us 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, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

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 institution or law enforcement official 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, 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 practicably 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. You may also request access by sending us a letter to the address at the end of this Notice.)

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 April 14, 2003. 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.

Restrictions: 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 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 Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

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.

HIPAA Information Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides safeguards to protect your privacy. These safeguards include restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal of providing you with quality service and care. Additional information is available by calling the U.S. Department of Health and Human Services or at: www.hhs.gov.

For this reason our practice has adopted the following policies:

- (1) Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to you are handled appropriately. This specifically includes the sharing of the information with other healthcare providers, laboratories, as is necessary and appropriate for your care. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.
- (2) It is the policy of the office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.
- (3) The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the confidentiality rules of HIPAA.
- (4) The patient understands and agrees to inspections of the office and the review of documents which may include PHI by government agencies or insurance companies in the normal performance of their duties.
- (5) The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.
- (6) Your confidential information will not be used for purpose of advertising or marketing of products, goods or services. Such prohibition does not include treatment/product samples or goods of nominal value.
- (7) The practice agrees to provide the patient with access to their records in accordance with state law.
- (8) The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
- (9) You have the right to request restrictions in the use of your protected health information and to request changes in certain policies used within the office concerning your PHI. However, the practice is under no obligation to alter internal policies to conform with your request.
- (10) There is no patient right to litigation under HIPAA.

Dental Materials Fact Sheet

The Facts About Fillings

What About the Safety of Filling Materials?

Patient health and the safety of dental treatments are the primary goals of dental professionals and the Dental Board of Colorado. The purpose of this fact sheet is to provide you with the information concerning the risks and benefits of all the dental materials used in the restoration (filling) of teeth.

Your dentist is providing 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 the 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 a list of chemicals known 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 the safety in pregnant women, children, and diabetics. However, scientific evidence and research literature in peer-reviewed scientific journals suggest otherwise healthy women, children, and diabetics are not at 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 a list of chemicals known 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

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 a white, plastic, or tooth-colored fillings. It is used for fillings, inlays, onlays, veneers, partial and complete crowns, or to repair portions of broken teeth.

Advantages

- Strong and durable
- Tooth colored
- Single visit for fillings
- Resists breakage
- 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

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

depending on product used

-Resistance to further decay is moderate and easy to find

-May leak over time when bonded beneath the layer of enamel

-Frequency of repair or replacement is low to moderate

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 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

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 fixed bridges and most partial denture framework.

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

- It is not tooth colored; alloy is a dark silver metal color
- Conducts heat and cold; may irritate sensitive teeth
- Can be abrasive to opposing teeth
- High cost; requires at least two office visits and laboratory services
- Slightly higher wear to opposing teeth

PORCELAIN FUSED TO METAL

This type of porcelain is a glass-like material that is “enameled” on top of metal shells. It is tooth-colored and is used for crowns and fixed bridges.

Advantages

- Good resistance to further decay if the restoration fits well
- Very durable, due to metal substructure
- The material does not cause tooth sensitivity
- Resists leakage because it can be shaped for a very accurate fit

Disadvantages

- More tooth must be removed (than for porcelain) for the metal substructure
- Higher cost because it requires at least two office visits and laboratory services

GOLD ALLOY

Gold alloy is a gold-colored mixture of gold, copper, and other metals and is used mainly for crowns and fixed bridges and some partial denture frameworks

Advantages

Disadvantages

-Good resistance to further decay if the restoration fits well

-Is not tooth colored; alloy is yellow

-Excellent durability; does not fracture under stress

-Conducts heat and cold; may irritate sensitive teeth

-Does not corrode in the mouth

-High cost; requires at least two office visits and laboratory services

-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