



Joanne Copps, DDS, DC

4001 Governor Drive
San Diego, CA 92122
Tel: (858)366-4370
Fax: (858)366-4372

WELCOME!

Form with fields: TODAY'S DATE, Last Name, First, I PREFER TO BE CALLED, Email Address, Drivers License #, Birth Date, Social Sec #, Single, Married, Divorced, Widowed, Separated, Home Address, City, Zip, Home Phone #, Cell #, Work Phone #, Where and When are the best time to reach you?, Who may we Thank for referring you?, May we Text you?, Preferred Contact Method, Other Family members seen by us, Employer, How long there?, Occupation, Employer's Address, Zip.

EMERGENCY CONTACT (Relative or Friend not living with you)
Name, Relation, Phone #, Address, City, ST, Zip.

PERSON RESPONSIBLE FOR ACCOUNT or PARENTS / SPOUSE INFO
Name, Relation, Social Security, Employer, Driver's License, Home #, Cell #, Work #, Ext, Home Address, City, Zip.

PRIMARY INSURANCE INFORMATION
Dental Coverage, Orthodontic Coverage, Medical Coverage, Insurance Co. Name, Phone #, Group #, Insurance Address, Insured's Name, Insured's SS#, Insured's Birth Date, Insured's Employer, Insured's Address.

SECONDARY INSURANCE INFORMATION
Medical Coverage, Dental Coverage, Orthodontic Coverage, Insurance Co. Name, Phone #, Group #, Insurance Address, Insured's Name, Insured's SS#, Insured's Birth Date, Insured's Employer, Insured's Address.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.
Signature: X, Date.

I certify that I am covered by Insurance Co. and I assign directly to Dr. all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.
Signature: X, Date.

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

# MEDICAL HISTORY

Why have you come to the dentist today: \_\_\_\_\_

Are you currently in Pain?  Yes  No

Do you Require Antibiotics before dental treatment?  Yes  No

Your Current dental health is  Good  Fair  Poor

Do you floss daily  Yes  No

Type of bristles on your tooth brush?  Hard  Medium  Soft

Do you use an electric toothbrush?  Yes  No

How long do you use a toothbrush before replacing it? \_\_\_\_\_

Do you use anything in addition to your brush and floss?  Yes  No

If yes, what? \_\_\_\_\_

Would you like fresher breath  Yes  No Whiter Teeth?  Yes  No

Do you have pain/discomfort in your jaw/joint (TMJ/TMD)?  Yes  No

Do your gums ever bleed?  Yes  No

Do your gums ever Itch?  Yes  No

Have you ever had periodontal surgery?  Yes  No

Do you have mobility in your teeth?  Yes  No

Are your teeth sensitive to hot and cold?  Yes  No

Do you still have wisdom teeth?  Yes  No

If yes, Why? \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

Are you happy with the way your smile looks?  Yes  No

If not, what would you change? \_\_\_\_\_

### ARE YOU UNDER A PHYSICIAN'S CARE CURRENTLY? Yes No

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

### FOR WOMEN:

Are you Pregnant?  Yes  No  Unsure

Taking Oral Contraceptives?  Yes  No

Nursing?  Yes  No

Have you ever been hospitalized or had a major operation?  Yes  No

Have you ever had a serious head or neck injury?  Yes  No

Do you take, or have you taken Phen-Fen or Redux?  Yes  No

Do you take, or have you taken, Fosomax, Boniva, Actonel?  Yes  No

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No

Are you taking any medications, pills, or drugs?  Yes  No

Continue here: \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

List here: \_\_\_\_\_

### ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

None

Aspirin  Acrylic  Codeine  Latex  Local Anesthetics

Metal  Penicillin  Sulfa Drugs  Other: \_\_\_\_\_

### Do you have, or have you ever had any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Cold Sore/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cortisone Medication	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Other: _____	
Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments/Doctor's Notes: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office and staff of any changes in medical status.

Signature: **X** \_\_\_\_\_ Relationship to Patient:  Self  Parent  Guardian

If the patient is a minor, please print your name: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_ BP: \_\_\_\_\_



4001 Governor Drive  
San Diego, CA 92122  
Tel: (858) 366-4370  
Fax: (858) 366-4372

Joanne Copps, DDS, DC

Patient Name (Printed): \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT FOR TREATMENT**

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.

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

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

Lastly, 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 a 1½% late charge (18% APR) may be added to my account. Any balance over **120 days past due** will be sent to a collections agency.

Signature: **X** \_\_\_\_\_ Relationship to Patient: Self / Parent / Guardian

If the patient is a minor, please print your name: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received a copy of this office's Notice of Privacy Practices. In addition, we may use your confidential information to discuss financials, treatments, and to remind you of appointments by sending postcards, e-mails, texts and /or leaving messages at home and /or at work. You may make request or update how you like us to communicate with you at any time.

Signature of Patient (Parent or Guardian): **X** \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET**

I have received a copy of the Dental Materials Fact Sheet.

Signature of Patient (Parent or Guardian): **X** \_\_\_\_\_

**Appointment Policy:** I understand that I will call and give at least **2 Business Days** for any changes or cancellation to my appointment to avoid a charge of **\$65 per hour** for the reserved time. **All Cancellation Fees must be paid prior to scheduling another appointment.**

Signature of Patient (Parent or Guardian): **X** \_\_\_\_\_



*Joanne Copps, DDS, DC*

---

## 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 15, 2003, and will remain in effect until we replace it.

We reserve the right to change our policy 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 make the changes. Before we make a significant change in our privacy policy, 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 health care 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 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 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 With 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 any opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination.



*Joanne Copps, DDS, DC*

## Notice of Privacy Practices

---

**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.

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

**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.

### 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 in response to a request you make 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 may also submit a written complaint to 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 Officer: Joanne Copps, DDS, DC

Telephone: (858) 366-4370

Fax: (858)366-4372

E-Mail: Contact@GovernorDental

Address: 4001 Governor Drive  
San Diego, CA 92123



Joanne Copps, DDS, DC

4001 Governor Drive
San Diego, CA 92122
Tel: (858)366-4370
Fax: (858)366-4372

Patient Records Request Forms

If you have had X-rays (including a full series) completed in the last year, please fill out this form and send it directly to our office.

You do not need to contact your previous dentist.

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

Patient's Information:

Pt's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Hereby request and authorize \_\_\_\_\_ to disclose and provide copies of any and all clinical treatment records (medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models, and other related material) and information concerning my care which is in possession of this person or entity to Governor Dental - Joanne Copps, DDS, DC.

Signature: X \_\_\_\_\_ Relationship to the patient: Self / Parent / Guardian (Please circle one)

If the patient is a minor, please print your name: \_\_\_\_\_

Please e-mail them to Contact@GovernorDental.com or mail them to the address above.

Please e-mail Digital X-rays individually in a JPEG form so we can import them into our dental software.

Previous Dentist (Office) Information: \_\_\_\_\_

Tel: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Dental Materials – Advantages & Disadvantages

### PORCELAIN FUSED TO METAL

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

#### Advantages

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

#### Disadvantages

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

### GOLD ALLOY

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

#### Advantages

- ♥ Good resistance to further decay if the restoration fits well
- ♥ Excellent durability; does not fracture under stress
- ♥ Does not corrode in the mouth
- ♥ Minimal amount of tooth needs to be removed
- ♥ Wears well; does not cause excessive wear to opposing teeth
- ♥ Resists leakage because it can be shaped for a very accurate fit

#### Disadvantages

- Is not tooth colored; alloy is yellow
- Conducts heat and cold; may irritate sensitive teeth
- High cost; requires at least two office visits and laboratory services

### DENTAL BOARD OF CALIFORNIA

2005 Evergreen Street, Suite 1550, Sacramento, CA 95815

[www.dbc.ca.gov](http://www.dbc.ca.gov)

Published by

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

5/04

*The Facts About Fillings*

## The Facts About Fillings



### DENTAL BOARD OF CALIFORNIA

2005 Evergreen Street, Suite 1550, Sacramento, CA 95815

[www.dbc.ca.gov](http://www.dbc.ca.gov)



# Dental Materials Fact Sheet

## What About the Safety of Filling Materials?

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

The Dental Board of California is required by law\* to make this dental materials fact sheet available to every licensed dentist in the state of California. Your dentist, in turn, must provide this fact sheet to every new patient and all patients of record only once before beginning any dental filling procedure.

As the patient or parent/guardian, you are strongly encouraged to discuss with your dentist the facts presented concerning the filling materials being considered for your particular treatment.

\* *Business and Professions Code 1648.10-1648.20*

## Allergic Reactions to Dental Materials

Components in dental fillings may have side effects or cause allergic reactions, just like other materials we may come in contact with in our daily lives. The risks of such reactions are very low for all types of filling materials. Such reactions can be caused by specific components of the filling materials such as mercury, nickel, chromium, and/or beryllium alloys. Usually, an allergy will reveal itself as a skin rash and is easily reversed when the individual is not in contact with the material.

There are no documented cases of allergic reactions to composite resin, glass ionomer, resin ionomer, or porcelain. However, there have been rare allergic responses reported with dental amalgam, porcelain fused to metal, gold alloys, and nickel or cobalt-chrome alloys.

If you suffer from allergies, discuss these potential problems with your dentist before a filling material is chosen.

## PORCELAIN (CERAMIC)

Porcelain is a glass-like material formed into fillings or crowns using models of the prepared teeth. The material is tooth-colored and is used in inlays, veneers, crowns and fixed bridges.

### Advantages

- ♥ Very little tooth needs to be removed for use as a veneer; more tooth needs to be removed for a crown because its strength is related to its bulk (size)
- ♥ Good resistance to further decay if the restoration fits well
- ♥ Is resistant to surface wear but can cause some wear on opposing teeth
- ♥ Resists leakage because it can be shaped for a very accurate fit
- ♥ The material does not cause tooth sensitivity

### Disadvantages

- Material is brittle and can break under biting forces
- May not be recommended for molar teeth
- Higher cost because it requires at least two office visits and laboratory services

## NICKEL OR COBALT-CHROME ALLOYS

Nickel or cobalt-chrome alloys are mixtures of nickel and chromium. They are a dark silver metal color and are used for crowns and fixed bridges and most partial denture frameworks.

### Advantages

- ♥ Good resistance to further decay if the restoration fits well
- ♥ Excellent durability; does not fracture under stress
- ♥ Does not corrode in the mouth
- ♥ Minimal amount of tooth needs to be removed
- ♥ Resists leakage because it can be shaped for a very accurate fit

### Disadvantages

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



## Dental Materials – Advantages & Disadvantages

### 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

**T**he 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

