DENTAL REGISTRATION AND HISTORY

CASTAIC DENTAL CENTER

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

City_____ State ___ Zip ____

Sex: ❑ M ❑ F Age ___ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Home phone _____

Best time and place to reach you _____

Patient SS# _____

Occupation_____

Employer/Parent's (if minor) _____

Employer Address _____

Employer Phone _____ Ext. _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation_____

Spouse's Employer_____

Employer Address _____

Employer Phone _____ Ext. _____

IN CASE OF EMERGENCY, CONTACT
(Specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

. . . . . .

Whom may we thank for referring you?_____

2 DENTAL INSURANCE

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
and assign directly to Charu Aggarwal, D.D.S. Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financlally responsible for all charges whether or not paid by Insurance, (Interest charges @ 1.5% per month / 18% APA on accounts over 90 days). I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all Insurance submissions.

_____
Patient Name

_____
Signature / Parent (if minor) Date

CONSENT FOR DENTAL TREATMENT

This is my consent for Dr. Charu Aggarwal and/or her Associates, to perform the dental treatment indicated on the examination chart and any other dental treatment deemed necessary or advisable as a corollary of the planned treatment. I agree to the use of a local anesthetic and analgesia depending on the judgement of the dentist involvement in my case. I understand the possible hazards in connection with these procedures, such as pain, swelling, infection, numbness or tingling of the lip, tongue, and trismus. I will be Informed of all probable complications of the treatment, anesthesia and other drugs.

_____
Patient Name

_____
Signature / Parent (if minor) Date

Person responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional Insurance? ❑ Yes ❑ No

If yes, Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group#_____

3 DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "Yes" or "No" to Indicate if you have had any of the following:

Bad Breath	❑ Yes	❑ No
Bleeding Gums	❑ Yes	❑ No
Blisters on lips or mouth	❑ Yes	❑ No
Burning sensation on tongue	❑ Yes	❑ No
Chew on one side of mouth	❑ Yes	❑ No
Cigarette, pipe, or cigar smoking	❑ Yes	❑ No
Clicking or popping jaw	❑ Yes	❑ No
Dry mouth	❑ Yes	❑ No
Fingernail biting	❑ Yes	❑ No
Food collection between the teeth	❑ Yes	❑ No
Foreign objects	❑ Yes	❑ No
Grinding teeth	❑ Yes	❑ No
Gums swollen or tender	❑ Yes	❑ No
Jaw pain or tiredness	❑ Yes	❑ No
Lip or cheek biting	❑ Yes	❑ No
Loose teeth or broken fillings	❑ Yes	❑ No
Mouth breathing	❑ Yes	❑ No
Mouth pain, brushing	❑ Yes	❑ No
Orthodontic treatment	❑ Yes	❑ No
Pain around ear	❑ Yes	❑ No
Periodontal treatment	❑ Yes	❑ No
Sensitivity to cold	❑ Yes	❑ No
Sensitivity to heat	❑ Yes	❑ No
Sensitivity to sweets	❑ Yes	❑ No
Sensitivity when biting	❑ Yes	q No
Sores or growths in your mouth	❑ Yes	❑ No

How often do you floss? _____

How often do you brush? _____

continued on the back

CASTAIC DENTAL CENTER

4 HEALTH HISTORY

Medical Doctor's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	❑ Yes	❑ No	Fainting or dizziness	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Radiation Treatment	❑ Yes	❑ No
Arthritis, Rheumatism	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Respiratory Disease	❑ Yes	❑ No
Artificial Heart Valves	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No	Heart Problems	❑ Yes	❑ No	Scarlet Fever	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No	Type _____			Sinus Trouble	❑ Yes	❑ No
Bisphosphonates	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Skin Rash	❑ Yes	❑ No
Bleeding abnormally, with extractions or surgery	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Special Diet	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No	HIV Positive	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	Swelling of Feet or Ankles	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No	Jaw Pain	❑ Yes	❑ No	Swollen Neck Glands	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Circulatory Problems	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No
Congenital Heart Lesions	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Cortisone Treatments	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No	Tumor or growth on head or neck	❑ Yes	❑ No
Cough, persistent or bloody	❑ Yes	❑ No	Nervous Problems	❑ Yes	❑ No	Ulcer	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Phen-fen	❑ Yes	❑ No	Weight Loss, unexplained	❑ Yes	❑ No
Do you wear contact lenses?	❑ Yes	❑ No	Women:					
Epilepsy	❑ Yes	❑ No	Are you pregnant?	❑ Yes	❑ No			
			Due Date _____					
			Are you nursing?	❑ Yes	❑ No			

_____
Doctor's Signature Date

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

- ❑ Aspirin
- ❑ Barbiturates (Sleeping pills)
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ Bleach products
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other _____

_____

• DO NOT WRITE BEYOND THIS POINT • FOR OFFICE USE ONLY •

5 UPDATES (To be filled in at future appointments)

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions		Patient's Signature	BP _	Reviewed By
_____	_____	None ❑	_____	Dr.	_____
_____	_____	None ❑	_____	Dr.	_____
_____	_____	None ❑	_____	Dr.	_____
_____	_____	None ❑	_____	Dr.	_____
_____	_____	None ❑	_____	Dr.	_____
_____	_____	None ❑	_____	Dr.	_____
_____	_____	None ❑	_____	Dr.	_____
_____	_____	None ❑	_____	Dr.	_____

INFORMED CONSENT

CASTAIC DENTAL CENTER
31886 N. Castaic Road, Castaic, CA 91384 • tel: 661-257-2300
www.CastaicDentalCenter.com

NAME _____

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings _____, Bridges _____, Crowns _____, Extractions _____, Impacted teeth removed _____, Root Canals_____ , Other _____ . (**Initials** _____)

2. DRUGS AND MEDICATION

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphalactic shock (severe allergic reaction). (**Initials** _____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (**Initials** _____)

4. **REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need furt11er treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (**Initials** _____)

5. CROWNS. BRIDGES AND VENEERS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that l must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. (**Initials** _____)

(a) It is possible a RCT may be needed in the future when a crown is placed and this is an additional fee and not included in the cost of the crown. (**Initials** _____)

(b) It is possible for porcelain to fracture off of the crown. If this occurs and the crown needs replacing there will be charges which will be the patient's responsibility. (**Initials** _____)

6. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit.
I understand that most dentures require relining approximately three to twelve months after initial placement.
The cost for this procedure is not included in the initial denture fee. (**Initials** _____)

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily effect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (**Initials** _____)

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that not undertaking any dental procedures may have a future adverse effect on my periodontal condition. (**Initials** _____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results.
I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.
I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me.
I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.

Signature:_____Date: _____

Doctor _____ Witness: _____

NOTICE OF PRIVACY PRACTICE

CASTAIC DENTAL CENTER
31886 N. Castaic Road, Castaic, CA 91384 • tel: 661-257-2300
www.CastaicDentalCenter.com

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy or 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 January I, 2011, 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 reaerve 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 we received before we made the changes. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you at your next visit.

You may request a copy or 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 health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care and service that you receive. Your health Information is contained in a dental record that is the physical property of Castaic Dental Center.

How We May Use or Disclose Your Health Information

Persons Involved In Care

We may use or disclose health information to notify, or assist in the notification or (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location or your general condition. 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, photos, or other similar forms of health information.

To You, Your Family and Friends

We must disclose your health information to you, as described in the Your Health Information 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 or, if you are not able to agree, if it is necessary in our professional judgment.

For Treatment

We may use or disclose your health information to a dentist, specialist, or other healthcare providers providing treatment to you for:

- the provision, coordination, or management of health care and related services by health care providers;
- consultation between health care providers relating to a patient/ customer;
- the referral of a patient for health care from one health to another; or appointment reminders and recall information.

Decedents

Health information may be disclosed to funeral directors enable them to carry out their lawful duties.

For Payment

We may use and disclose your health information to others for purposes of processing and receiving payment for treatment and services provided to you. This may include:

- billing and collection activities and related data processing:
- actions by a health plan or insurer to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage adjudication or subrogation of health benefit claims;
- medical necessity and appropriateness of care reviews, utilization review activities; and disclosure to consumer reporting agencies of information relating to collection of payments.

Appointments, Treatment and Quality Assurance

We may use your information to provide appointment reminders or recall Notices (such as voicemail messages, postcards or letters) or information about treatment alternatives or other health-related benefits, products and services that may be of interest to you. We may also contact you to conduct our own surveys about the quality of the products and services we provide.

For Health Care Operations

We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of staff to:

- evaluate the performance of our dentists;
- assess the quality of service, product and care in your case and similar cases;
- learn how to improve our facilities and services;
- conduct training programs or credentialing activities;
- determine how to continually improve the quality and effectiveness of the products, service and care we provide.

Organ/Tissue Donation

Your health information may be used or disclosed for cadaver organ or tissue donation purposes.

Reguired by law

We may use and disclose information about you as required by law, For example, we may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence;
- to assist law enforcement officials in their law enforcement duties;
- to assist public health officials avert a serious threat to the health or safety of you or any other person.

Research

We may use your health information for research purposes when an institutional review board of privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Government Functions

Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require us of disclosure of your health Information.

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 yon 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.

Marketing Health Products or Services

We will not use your health information for marketing communications without prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without your prior authorization.

Workers Compensation

Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Your Health Information Rights

Access

You have the right to review 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 may be asked to 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 or this Notice. We will charge you a reasonable cost 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 setting forth the specific information to which you desire access. If you request an alternative format, provided that it is practical for us to produce the information in such 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.

Alternative Communication

You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. 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.

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, where you have provided an authorization and certain other activities, for the last 6 years, but not for disclosures made prior to 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.

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 an emergency).

Electronic Notice

If you receive this Notice on our site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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. You may obtain a form to request an amendment to your health information by using the contact information listed at the end of this Notice.

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 or Health and Human Services.

Contact Information

If you have any questions or complaints please contact:
Castaic Dental Center
661-257-2300

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CASTAIC DENTAL CENTER
31886 N. Castaic Road, Castaic, CA 91384 • tel: 661-257-2300
www.CastaicDentalCenter.com

Date_____

You have the right to refuse to sign this Acknowledgement

I, _____, have received a copy of this office's ***NOTICE OF PRIVACY PRACTICES*** as required by federal law.

_____

PRINT PATIENT'S NAME

_____

PATIENT'S SIGNATURE

FOR OFFICE USE ONLY

On the date above we made a "good faith effort" to obtain written acknowledgment of receipt of our ***NOTICE OF PRIVACY PRACTICES.*** We were unable to obtain acknowledgment for the following reasons

☐ Patient refused to sign

☐ Other_____

(Possible reasons: Language difficulties, communication barriers, dental emergency)

_____ _____

PRINT EMPLOYEES NAME **SIGNATURE OF EMPLOYEE ATTEMPTING TO GAIN ACKNOWLEDGMENT**

Comparisons of Direct Restorative Dental Materials

COMPARATIVE FACTORS	TYPES OF DIRECT RESTORATIVE DENTAL MATERIALS			
	AMALGAM	COMPOSITE RESIN (DIRECT AND INDIRECT RESTORATIONS)	GLASS IONOMER CEMENT	RESIN-IONOMER CEMENT
General Description	Self-hardening mixture in varying percentages of a liquid mercury and silver-tin alloy powder.	Mixture of powdered glass and plastic resin; self-hardening or hardened by exposure to blue light.	Sell-hardening mixture of glass and organic acid.	Mixture of glass and resin polymer and organic acid; sell hardening by exposure to blue light.
Principal Uses	Fillings; sometimes for replacing potions of broken teeth.	Fillings, inlays, veneers, partial and complete crowns; sometimes for replacing portions of broken teeth.	Small fillings; cementing metal & porcelain/metal crowns, liners, temporary restorations.	Small fillings; cementing metal and porcelain/metal crowns. and liners.
Resistance to Further Decay	High; self-sealing characteristic helps resist recurrent decay; but recurrent decay around amalgam is difficult lo detect in its early stages.	Moderate; recurrent decay is easily detected in early stages.	Low-Moderate; some resistance to decay may be imparted through fluoride release.	Low-Moderate; some resistance to decay may be imparted through fluoride release.
Estimated Durability (permanent teeth)	Durable	Strong, durable.	Non-stress bearing crown cement.	Non-stress bearing crown cement.
Relative Amount of Tooth Preserved	Fair; Requires removal of healthy tooth to be mechanically retained; No adhesive bond of amalgam to the tooth.	Excellent; bonds adhesively to healthy enamel and dentin.	Excellent; bonds adhesively to healthy enamel and dentin.	Excellent; bonds adhesively to healthy enamel and dentin.
Resistance to Surface Wear	Low Similar to dental enamel; brittle metal.	May wear slightly faster than dental enamel.	Poor in stress-bearing applications. Fair In non-stress bearing applications.	Poor in stress-bearing applications; Good in non-stress bearing applications.
Resistance to Fracture	Amalgam may fracture under stress; tooth around filling may fracture before the amalgam does.	Good resistance to fracture.	Brittle; low resistance to fracture but not recommended for stress bearing restorations.	Tougher than glass ionomer recommended for stress-bearing restorations in adults.
Resistance to Leakage	Good; self-sealing by surface corrosion; margins may chip over time.	Good if bonded to enamel; may show leakage over time when bonded to dentin; Does not corrode.	Moderate: tends to crack over time.	Good; adhesively bonds to resin, enamel, dentine/ post-Insertion expansion may help seal the margins.
Resistance to Occlusal Stress	High; but lack or adhesion may weaken the remaining tooth.	Good to Excellent depending upon product used.	Poor; not recommended for stress-bearing restorations.	Moderate; not recommended to restore biting surfaces of adults; suitable for short-term primary teeth restorations.
Toxicity	Generally safe; occasional allergic reactions to metal components. However amalgams contain mercury. Mercury in its elemental form is toxic and as such is listed on prop 65.	Concerns about trace chemical release are not supported by research studies. Safe; no known toxicity documented. Contains some compounds listed on prop 65.	No known Incompatibilities. Safe; no known toxicity documented.	No known incompatibilities. Safe; no known toxicity documented.
Allergic or Adverse Reaction	Rare; recommend that dentist evaluate patient to rule out metal allergies.	No documentation for allergic reactions was found.	No documentation for allergic: reactions was found. Progressive roughening of the surface may predispose to plaque accumulation and periodontal disease.	No known documented allergic reactions; Surface may roughen slightly over time; predisposing to plaque accumulation and periodontal disease if the material contacts the gingival tissue.
Susceptibility to Post-Operative Sensitivity	Minimal; High thermal conductivity may promote temporary sensitivity to hot and cold; Contact with other metals may cause occasional and transient galvanic response.	Moderate; Material is sensitive to dentist's technique; Material shrinks slightly when hardened, and a poor seal may lead to bacterial leakage, recurrent decay and tooth hypersensitivity.	Low; material seals well and does not irritate pulp.	Low; material seals well and does not irritate pulp.
Esthetics (Appearance)	Very poor. Not tooth colored: initially silver-grey, gets darker, becoming black as it corrodes. May stain teeth dark brown or black over time.	Excellent; often indistinguishable from natural tooth.	Good; tooth colored, varies In translucency.	Very good; more translucency than glass ionomer.
Frequency of Repair or Replacement	Low; replacement is usually due to fracture of the filling or the surrounding tooth.	Low-Moderate; durable material hardens rapidly; some composite materials show more rapid wear than amalgam. Replacement is usually due to marginal leakage.	Moderate; Slowly dissolves in mouth; easily dislodged.	Moderate; more resistant to dissolving than glass ionomer, but less than composite resin.
Relative Costs to Patients	Low, relatively inexpensive; actual cost of fillings depends upon their size.	Moderate; higher than amalgam fillings; actual cost of fillings depends upon their size; veneers crowns cost more.	Moderate; similar to composite resin (not used for veneers and crowns).	Moderate; similar to composite resin (not used for veneers and crowns).
Number of Visits Required	Single visit (polishing may require a second visit)	Single visit fillings; 2+ visits for indirect inlays, veneers and crowns.	Single visit.	Single visit.

Comparisons of Indirect Restorative Dental Materials

COMPARATIVE FACTORS	TYPES OF INDIRECT RESTORATIVE DENTAL MATERIALS			
	PORCELAIN (CERAMIC)	PORCELAIN (FUSED-TO-METAL)	GOLD ALLOYS (NOBLE)	NICKEL OR COBALT-CHROME (BASE-METAL) ALLOYS
General Description	Glass-like malarial formed into fillings and crowns using models of the prepared teeth.	Glass-like material that is "enameled" onto metal shells. Used for crowns and fixed-bridges.	Mixtures of gold, copper and other metals used mainly for crown, and fixed bridges.	Mixtures or nickel, chromium.
Principal Uses	Inlays, veneers, crowns and fixed-bridges.	Crowns and fixed-bridges.	Cast crowns and fixed bridges; some partial denture frameworks.	Crowns and fixed bridges; most partial denture frameworks.
Resistance to Further Decay	Good, if the restoration fits well.	Good, if the restoration fits well.	Good, if the restoration fits well.	Good, if the restoration fits well.
Estimated Durability (permanent teeth)	Moderate; Brittle material that may fracture under high biting forces. Not recommended for posterior (molar) teeth.	Very good. Less susceptible to fracture due to the metal substructure.	Excellent. Does not fracture under stress; does not corrode in the mouth.	Excellent. Does not fracture under stress; does not corrode in the mouth.
Relative Amount of Tooth Preserved	Good-Moderate; Little removal of natural tooth is necessary for veneers; more for crowns since strength is related to its bulk.	Moderate-High. More tooth must be removed to permit the metal to accompany the porcelain.	Good. A strong material that requires removal of a thin outside layer of the tooth.	Good. A strong material that requires removal of a thin outside layer of the tooth.
Resistance to Surface Wear	Resistant to surface wear; but abrasive to opposing teeth.	Resistant to surface wear; permits either metal or porcelain on the biting surface of crown and bridges.	Similar hardness to natural enamel: does not abrade opposing teeth.	Harder than natural enamel but minimally abrasive to opposing natural teeth, does not fracture in bulk.
Resistance to Fracture	Poor resistance to fracture.	Porcelain may fracture.	Does not fracture In bulk.	Does not fracture In bulk.
Resistance to Leakage	Very good. Can be fabricated for very accurate fit of the margins of the crowns.	Good - Very good depending upon design of the margin of the crowns.	Very good - Excellent. Can be formed with great precision and can be tightly adapted to the tooth.	Good-Very good - Stiffer than gold; less adaptable, but can be formed with great precision.
Resistance to Occlusal Stress	Moderate; brittle material susceptible to fracture under biting forces.	Very good. Metal substructure gives high resistance to fracture.	Excellent.	Excellent.
Toxicity	Excellent. No known adverse effects.	Very Good to Excellent. Occasional/rare allergy to metal alloys used.	Excellent; Rare allergy to some alloys.	Good; Nickel allergies are common among women, although rarely manifested in dental restorations.
Allergic or Adverse Reaction	None.	Rare. Occasional allergy to metal substructures.	Rare; occasional allergic reactions seen in susceptible individuals	Occasional; infrequent reactions to nickel.
Susceptibility to Post-Operative Sensitivity	Nol material dependent; does not conduct heat and cold well.	Nol material dependent; does not conduct heat and cold well.	Conducts heat and cold; may irritate sensitive teeth.	Conducts heat and cold; may irritate sensitive teeth.
Esthetics (Appearance)	Excellent.	Good to Excellent.	Poor - yellow metal.	Poor - dark silver metal.
Frequency of Repair or Replacement	Varies; depends upon biting forces; fractures of molar teeth and more likely than anterior teeth; porcelain fracture may often be repaired with composite resin.	Infrequent; porcelain fracture can often be repaired with composite resin.	Infrequent; replacement is usually due to recurrent decay around margins.	Infrequent; replacement is usually due to recurrent decay around margins.
Relative Costs to Patients	High; requires at least two office visits and laboratory services.	High; requires at least two office visits and laboratory services.	High; requires at least two office visits and laboratory services.	High; requires at least two office visits and laboratory services.
Number of Visits Required	Two - minimum; matching esthetics of teeth may require more visits.	Two - minimum; matching esthetics of teeth may require more visits.	Two - minimum.	Two - minimum.

INFORMED CONSENT

CASTAIC DENTAL CENTER
31886 N. Castaic Road, Castaic, CA 91384 • tel: 661-257-2300
www.CastaicDentalCenter.com

NAME _____

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings _____, Bridges _____, Crowns _____, Extractions _____, Impacted teeth removed _____, Root Canals_____ , Other _____ . (**Initials** _____)

2. DRUGS AND MEDICATION

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphalactic shock (severe allergic reaction). (**Initials** _____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (**Initials** _____)

4. **REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need furt11er treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (**Initials** _____)

5. CROWNS. BRIDGES AND VENEERS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that l must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. (**Initials** _____)

(a) It is possible a RCT may be needed in the future when a crown is placed and this is an additional fee and not included in the cost of the crown. (**Initials** _____)

(b) It is possible for porcelain to fracture off of the crown. If this occurs and the crown needs replacing there will be charges which will be the patient's responsibility. (**Initials** _____)

6. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit.
I understand that most dentures require relining approximately three to twelve months after initial placement.
The cost for this procedure is not included in the initial denture fee. (**Initials** _____)

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily effect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (**Initials** _____)

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that not undertaking any dental procedures may have a future adverse effect on my periodontal condition. (**Initials** _____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results.
I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.
I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me.
I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.

Signature:_____Date: _____

Doctor _____ Witness: _____