Welcome To Our Office!

Pauline Lu D.D.S. Professional Corporation

Patient Information: (Confidential)

Name: (Last) _____ (First) _____Birthdate: _____

Check appropriate box: ☐ Minor ☐ Married ☐ Single ☐ Divorced ☐ widowed other: _____

Social Security #: _____ - _____ - _____ Driver's License #: _____ Sex: Male/Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell phone: ( ) _____

Email Address: _____ Best Way to Reach You: _____

Employer: _____ Address: _____

Spouse or Patient Guardian's Name_____ Phone Number_____

Responsible Party:

Name of person responsible for this account _____Relationship to patient_____

Social Security #:_____-_____-_____ Driver's License#:_____ Sex: Male/Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell phone: ( ) _____

Email Address: _____ Best Way to Reach You: _____

Employer: _____ Address: _____

How did you hear about our office? (Please circle that apply)

Name: _____ Newspaper Yellow pages Flyers Internet Other: _____

Emergency Contact

Name: _____ Relationship: _____ Contact Number: _____

Address: _____ City: _____ State: _____ Zip: _____

I have received the Dental Material Fact Sheet as required by law.
I have read and answered the above questions to the best of my knowledge. I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above patient. I also agree to assume full financial responsibility for all treatment rendered whether or not paid by insurance.

Patient Signature: X_____ Date: _____
(Signature of Parent or Guardian if Minor)

Patient Name: _____ Birth date: _____

Medical History:

Name of physician: _____phone number_____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
If yes, please explain when and what_____		
3. Are you taking any medications including non-prescription medication?	☐	☐
If yes, please list_____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates?	☐	☐
6. Do you smoke/have you ever smoked? When? _____ How much? _____	☐	☐
7. Do you use controlled substances? What type?	☐	☐
8. Have you ever had **complications** with medical or dental treatments?	☐	☐
9. Women only: Are you pregnant/may be pregnant?	☐	☐

10. Do you have allergy or unusual reactions to ☐ Penicillin ☐ Latex ☐ Local Anesthetics (e.g. Novocain) ☐ Sulfa ☐ Codeine ☐ Barbiturates ☐ Aspirin ☐ Other_____

11. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Diseases	☐	☐	Chest Pains	☐	☐	Heart Attack	☐	☐
Cardiac Pacemaker	☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Hepatitis/Jaundice	☐	☐	Fainting/Seizures	☐	☐	Tuberculosis	☐	☐	Asthma	☐	☐
Respiratory Problems	☐	☐	Radiation Therapy	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Low Blood Pressure	☐	☐	Cancer	☐	☐	Leukemia	☐	☐	Liver Disease	☐	☐
Epilepsy/Convulsions	☐	☐	Diabetes	☐	☐	Thyroid Problem	☐	☐	Lung Disease	☐	☐
AIDS or HIV positive	☐	☐	Anemia	☐	☐	Arthritis	☐	☐	Herpes	☐	☐
Mitral Valve prolapsed	☐	☐	Psychiatric care	☐	☐	Joint Replacement or Implant	☐	☐	Kidney Disease	☐	☐
Recent Cough or Cold	☐	☐	Organ Transplant	☐	☐	Sexually Transmitted Disease	☐	☐	Recent Weight Loss	☐	☐
Prosthetic Valve	☐	☐	Hay Fever/allergies	☐	☐	Stomach Problems/Ulcers	☐	☐	Other_____	☐	☐

Dental History

	Yes	No		Yes	No
1. Do your gums or teeth hurt now?	☐	☐	7. Are your teeth sensitive to hot/cold/sweet/sour liquids or food?	☐	☐
2. Do you clench or grind your teeth?	☐	☐	8. Have you been told you need take antibiotics before dental visits?	☐	☐
3. Have you ever had problems with tooth extraction?	☐	☐	9. Have you had any head, neck or jaw injuries?	☐	☐
4. Have you ever had orthodontic/braces treatment?	☐	☐	10. Do you like your smile?	☐	☐
5. Do you have problems in your jaw?			11. Do you wear dentures or partials?	☐	☐
(e.g. Clicking, pain, difficult opening or chewing)	☐	☐	12. Have you had complications with previous dental treatment?	☐	☐
6. Do you brush and floss regularly?	☐	☐	Please explain: _____		

Name of Previous Dentist _____ Where? _____

When was your last dental exam? _____ When were your last dental X-Rays taken? _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist/dental office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health care providers. I authorize and request my insurance company to pay directly to the dentist/dental office the insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature: **X**_____ Date: _____
(Signature of parent or guardian if minor)

OFFICE USE: BP: _____/_____ Pulse: _____ Doctor's Signature: **X** _____

Pauline Lu DDS Prof. Corp.
(408)260-0888

Financial Policy

This is an agreement between Pauline Lu DDS Professional Corporation, a California professional corporation, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The word "we", "us", and "our" refer to Pauline Lu DDS Professional Corporation.

By executing this agreement, you are agreeing to pay for all services that are received. Accepted payment methods are Visa, Master card and cash, **no checks**.

Cash Patient

Patients with no insurance are expected to pay with credit card or cash the day the service is rendered. For procedures that require multiple appointments, payment is due the day treatment starts.

Insurance Patient

Patients with insurance are expected to pay patient portion and deductible the day the service is rendered. We will estimate, as closely as possible, your coverage, but until we actually receive the payment from the insurance company, it is just an estimate. We will assist you in billing with the insurance company as a ***courtesy service,*** but ultimately the responsibility of payment and insurance problems lies with you. You agree to pay any portion of the charges not covered by insurance. If the insurance company has not paid after 45 days, the full balance is expected from you personally.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The Finance Charge will be computed at the rate of one percent (1%) per month or an Annual Percentage Rate of twelve percent (12%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $.50.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Santa Clara County, California.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and agreement will be in full force and effect.

We reserve the right to charge $25 for appointments cancelled or broken without 24 hours advanced notice.

Patient Name:_____

Name of Responsible Party (if not the patient)_____

Signature:_____Date:_____

Pauline Lu DDS Professional Corporation

1153 Saratoga Avenue

San Jose, CA 95129

Attendance Policy

Please initial each box

____ **24-Hour Advance Notice Cancelation Policy**

If you wish to change or cancel an appointment we require a minimum 24-hour advance notice. Anything less could result in a $25 fee charge. An appointment slot was reserved for you, whether you attend or not we still accrue the expenses. We don't charge you the actual cost for that appointment but rather a mere $25. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) to reserve that time slot. Please be courteous and responsible. Thank you.

____ **No shows**

If you fail to show for an appointment without notice all future appointments will be removed and a $25 fee would be charged. You may re-schedule appointments again on a "first come, first serve basis"

____ **Late Policy "10 Minutes"**

Being late by more than 10 minutes may require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable.

____ **Repeated No Shows, Cancelation without advanced notice, and lateness to scheduled appointment may result in termination of dental care service, and patient-doctor relationship.**

Acknowledgement:

I have read and understand the above policies.

_____ _____ _____

Patient or Responsible Party Signature Date

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)

Notice of Privacy Practices

This notice describes how your health information 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

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect. This notice takes effect January 25, 2013 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 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. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

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 disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment

We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Health Care Operations

We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of health care 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 health care 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 is 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. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Emails

We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

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 your 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 health care. 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 may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership

If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law

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

Public Health
We may, and are sometimes legally obligated to, disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative, we believe is responsible for the abuse or harm.

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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders
We may contact you to provide you with appointment reminders via voicemail, postcards or letters. We may also leave a message with the person answering the phone if you are not available.

Sign-In Sheet and Announcement
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

Notice of Video Surveillance
Areas of this practice are under video surveillance and recording is in progress. Images may be collected that allow an individual to be identified. The use of video surveillance is for the purposes of controlling theft, ensuring the safety of practice and staff and facilitating the identification of individuals who behave in a disruptive manner or cause damage to practice property.

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 contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate 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 for a full explanation of our fee structure.

Disclosure Accounting
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six years. 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 emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

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 of how payments will be handled under the alternative means or location you request.

Breach Notification
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

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.

Research
Your health information may be disclosed to researchers for research purposes. In this situation, written authorization is not required as approved by an Institutional Review Board or privacy board.

Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: Pauline Lu, DDS Telephone: (408)260-0888
Email: https://paulinelu.com/contact Address: 1153 Saratoga Avenue, San Jose, CA 95129

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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

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

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

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

Toxicity of Dental Materials

Dental Amalgam
Mercury in its elemental form is on the State of California's Proposition 65 list of chemicals known to the state to cause reproductive toxicity. Mercury may harm the developing brain of a child or fetus.

Dental amalgam is created by mixing elemental mercury (43-54%) and an alloy powder (46-57%) composed mainly of silver, tin, and copper. This has caused discussion about the risks of mercury in dental amalgam. Such mercury is emitted in minute amounts as vapor. Some concerns have been raised regarding possible toxicity. Scientific research continues on the safety of dental amalgam. According to the Centers for Disease Control and Prevention, there is scant evidence that the health of the vast majority of people with amalgam is compromised.

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-viewed scientific journals suggest that otherwise healthy women, children and diabetics are not at an increased risk from dental amalgams in their mouths. The FDA places no restrictions on the use of dental amalgam.

Composite Resin
Some Composite Resins include Crystalline Silica, which is on the State of California's Proposition 65 list of chemicals known to the state to cause cancer.

It is always a good idea to discuss any dental treatment thoroughly with your dentist

Dental Materials- Advantages & Disadvantages

Dental Amalgam Fillings
Dental Amalgam is a self-hardening mixture of silver-tin-copper- alloy powder and liquid mercury and it's 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, and 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, requires removal of some healthy tooth, remaining tooth may weaken and fracture, temporary sensitivity to hot and cold, and contact with other metals may cause occasional, minute electrical flow.

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 to enamel, does not corrode, hold up well to the forced of biting, 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 or tooth sensitivity, costs more then dental amalgam, material shrinks when hardened and could lead to further decay or temperature sensitivity, requires more than one visit for inlays, veneers, and crowns, may wear faster then dental enamel, and may leak over time when bonded beneath the layer of enamel.
Glass Ionomer Cement

Glass ionomer cement is a self-hardening mixture of glass and organic acid. It is tooth-colored and varies in translucency. Glass ionomer is usually used for small fillings, cementing metal and porcelain/metal crowns, liners, and temporary restorations.

Advantages
Reasonably good esthetics, may provide some help against decay because it releases fluoride, minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel, material has low incidence of producing tooth sensitivity, and usually completed in one dental visit
Disadvantages
Cost is very similar to composite resin, 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, and does not wear well; tends to crack over time and be dislodged.

Resin-Ionomer Cement
Resin ionomer cement is a mixture of glass and resin polymer and organic acids 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, and 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, and 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, and the material does not cause tooth sensitivity.
Disadvantages
Material is brittle and can break under biting forces, may not be recommended for molar teeth, and 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 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 fracture under stress, minimal amount of tooth needs to be removed, and 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, and 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, and resists leakage because it can be shaped for a very accurate fit.
Disadvantages
More tooth must be removed (then for porcelain) for the metal substructure, and 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, 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, and high cost; requires at least two office visits and laboratory services.

DENTAL BOARD OF CALIFORNIA
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www.dbc.ca.gov

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The Facts about Fillings