WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: ____________

E-Mail Address: ____________

Name: ____________
Last First Mi Mr Mrs Ms Dr

I prefer to be called: ____________ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ___ SS#: ____________

Home Address: ____________ Apt/Condo #

____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)________ Pager / Cell #: ____________

Wk #: (____)________ Ext: ____ DL #: ____________

Employer: ____________

Employer's Address: ____________

How long there? ______ Occupation: ____________

Where & when are best times to reach you? ____________

Whom may we Thank for referring you? ____________

Other family members seen by us: ____________

Previous / Present Dentist: ____________
(Please Circle)

Last Visit Date: ____________

2 SPOUSE INFORMATION

His / Her Name: ____________

Employer: ____________

Wk #: (____)________ Ext: ____ SS #: ____________

Birthdate: ___/___/___ DL #: ____________

Person Responsible for Account: ____________

Wk #: (____)________ Ext: ____ Hm #: (____) ________

Billing Address: ____________

Relationship: ____________ SS #: ____________

Employer: ____________ DL #: ____________

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: (____)____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: ___/___/___ Insured's ID #: ____________

Insured's Employer: ____________

Employer's Address: ____________

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: (____) ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: ___/___/___ Insured's ID #: ____________

Insured's Employer: ____________

Employer's Address: ____________

Neighbor or Relative not living with you.

His / Her Name: ____________ Relation: ____________

Wk #: (____)________ Hm #: (____) ________

Address: ____________

____
City State Zip

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ____________

Phone #: (____)________ Date of last visit: ____________

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ____________

CONTINUED ON BACK

4 MEDICAL HISTORY CONTINUED

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one: ______________________

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-Fen? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: ________

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y N Abnormal Bleeding
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Osteoporosis / Paget's Disease
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

____

____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs/materials that you are allergic to: ______________________

____

5 DENTAL HISTORY

Why have you come to the dentist today? ______________________

____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you have fears about going to the dentist? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ **Yes** ☐ **No**

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? ______________

Are your teeth sensitive to heat, cold, or anything else? ______________

Have you lost any teeth? ☐ Yes ☐ No If yes, why? ______________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____
Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

____
Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: ____________ Date: ____________

Doctor's Comments: ______________________

____

MEDICAL HISTORY UPDATE

I have read my medical history dated _______ and confirmed that it states past and present medical conditions. ______________ Signature Date

I have read my medical history dated _______ and confirmed that it states past and present medical conditions. ______________ Signature Date

I have read my medical history dated _______ and confirmed that it states past and present medical conditions. ______________ Signature Date

© 2011 Informs

Patient Name: ________________/______________________ *Date:* _____/_____/_____

Specific Fears Survey

(To Be Filled Out By the PATIENT)

We realize that many people are nervous or frightened about going to the dentist. If you have such feelings we would like to help you. Please answer these questions carefully. Please check the answer that best describes your feelings. Thank you.

1.) If you had to go to the dentist tomorrow, how would your feel about it?

- ☐ I would look forward to it as a reasonably enjoyable experience.
- ☐ I wouldn't care one way or the other.
- ☐ I would be a little uneasy about it.
- ☐ I would be afraid that it would be unpleasant and painful.
- ☐ I would be very frightened of what the dentist might do.

2.) When you are waiting in the dentist's office for your turn in the chair, how do you feel?

- ☐ Relaxed
- ☐ A little uneasy
- ☐ Tense
- ☐ Anxious
- ☐ So anxious that I sometimes break out in a sweat or almost feel physically sick.

3.) When you are in the dentist's chair waiting while the dentist his/her drill ready to begin working on your teeth, how do you feel?

- ☐ Relaxed
- ☐ A little uneasy
- ☐ Tense
- ☐ Anxious
- ☐ So anxious that I sometimes break out in a sweat or almost feel physically sick.

4.) You are in the dentist's chair to have your teeth cleaned. While you are waiting and the dentist is getting out the instruments, which he/she will use to scrape your teeth around the gums, how do you feel?

- ☐ Relaxed
- ☐ A little uneasy
- ☐ Tense
- ☐ Anxious
- ☐ So anxious that I sometimes break out in a sweat or almost feel physically sick.

I am interested in the Anxious Patient Program: ☐ **YES** ☐ **NO**

Patient's Name: ________________________/__________________ *Date:* ______/______/______

SMOKING ASSESSMENT FORM

1.) Do you use tobacco in any form? Yes _____ No ______

1a.) If no, have you ever used tobacco in the past? Yes _____ No ______

2.) Does the person closest to you use tobacco? Yes _____ No ______

If you are not currently a tobacco user, no other questions should be answered. Thank you for completing the form.

3.) If you smoke, what type? (check)
- Cigarettes _____
- Cigars _____
- Pipe _____

How many? (number)
- Cigarettes per day _____
- Cigars per day _____
- Bowls per day _____

4.) If you chew/use snuff, what type? (check)
- Snuff _____
- Chewing _____
- Other (describe) ________________

How many? (number)
- Days a can lasts _____
- Pouches per week _____
- Amount _____ per _____

5.) How soon after you wake up do you first use tobacco?
Within 30 minutes_____ More than 30 minutes_____

6.) How interested are you in stopping your use of tobacco?
Not at all ___ A little ____ Somewhat ____ Yes ____ Very much ____

7.) If you decided to stop using tobacco completely during the next two weeks, how confident are you that you would succeed?
Not at all ___ A little ____ Somewhat ____ Yes ____ Very much ____

8.) Have you, or a blood relative, ever been treated for alcoholism, addiction, or an eating disorder?
Yes ___ No ___

9.) In order to feel better, have you ever made a promise to yourself or others to stop drinking alcohol, using drugs, or overeating?
Yes ___ No ___

10.) Have you ever noticed that you can consume more alcohol than others without getting drunk?
Yes ___ No ___

11.) Have you ever experienced a complete loss of memory while drinking alcohol or using drugs?
Yes ___ No ___

12.) Do you experience episodes of craving for something when you are depressed or distressed?
Yes ___ No ___

VELSCOPE ORAL CANCER SCREENING CONSENT FORM

RISK FACTORS OF ORAL CANCER (UNCONTROLLABLE & CONTROLLABLE)
*TOBACCO USE
*ALCOHOL USE
*EXCESSIVE UNPROTECTED SUN EXPOSURE
*LOW INTAKE OF FRUITS & VEGETABLES
*HPV VIRAL INFECTION
*HEREDITY FACTORS
*HIGH CANCER RISK
*GENDER AND AGE

SIGNS AND SYMPTOMS
*RED AND/OR WHITE DISCOLORATION OF THE SOFT TISSUES OF THE MOUTH
*ANY SORE WHICH DOES NOT HEAL WITHIN 14 DAYS
*HOARSENESS WHICH LAST FOR A PROLONGED PERIOD OF TIME

ADVANCED INDICATORS
*A SENSATION THAT SOMETHING IS STUCK IN YOUR THROAT
*NUMBNESS IN THE ORAL REGION
*DIFFICULTY IN MOVING THE JAW OR TONGUE
*DIFFICULTY IN SWALLOWING
*EAR PAIN WHICH OCCURS ON ONE SIDE ONLY
*A SORE UNDER A DENTURE THAT WON'T HEAL, EVEN AFTER ADJUSTMENT OF THE DENTURE
*A LUMP OR THICKENING WHICH DEVELOPS IN THE MOUTH OR ON THE NECK

ORAL CANCER STATISTICS
ONE PERSON EVERY HOUR DIES OF ORAL CANCER IN THE USA. THE DEATH RATE FROM ORAL CANCER IS VERY HIGH, ABOUT HALF THOSE DIAGNOSED WILL NOT SURVIVE MORE THAN 5 YEARS. WITH EARLY DETECTION, SURVIVAL RATES ARE HIGH, AND SIDE EFFECTS FROM THE TREATMENT ARE AT THE LOWEST.

VELSCOPE
OUR PRACTICE BELIEVES IN EARLY DETECTION OF ORAL CANCER. WE CAN NOW OFFER A STATE OF THE ART CANCER EXAM CALLED THE **VELSCOPE ORAL CANCER SCREENING SYSTEM.** AS ALWAYS, WE WILL CONTINUE TO PROVIDE CONVENTIONAL ORAL CANCER SCREENING EXAMS, HOWEVER NOW WE ARE ABLE TO DO EVEN MORE!
ABOUT THE **VELSCOPE** EXAM
*THE EXAM TAKES APPROXIMATELY 3-5 MINUTES
*THE EXAM IS COMFORTABLE AND PAIN FREE
*COMPLETELY SAFE TO PERFORM

PATIENTS NAME____________________ PATIENT SIGNATURE_______________________ DATE _____
THE **VELSCOPE** EXAM IS AVAILABLE TO YOU FOR $20 AND IS GOOD FOR THE ENTIRE YEAR. UNFORTUNATELY THIS MAY NOT BE A COVERED BENEFIT UNDER YOUR INSURANCE THOUGH.

______________ I ACCEPT THE **VELSCOPE** EXAM

______________ I DECLINE THE VELSCOPE EXAM

LETTER OF ACKNOWLEDGMENT

Dear New Patient,

We would like to take a moment to welcome you to our dental practice. We are delighted to have you as a patient. We thank you for choosing us as your dental health care provider. We know your time is valuable as well as our time, and our patients' time.

Therefore to respect your time, our time, and other patients' time, we would appreciate at least a 24 hour advance notice of cancellation. Please be advised that you may be charged a $50 fee per hour of broken or cancelled appointments.

Signature ________________________ Date ____________

NOTICE OF PRIVACY PRACTICES

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT: OUR PRIVACY CONTACT

Dr. Kimberly Okumura D.D.S.

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN CONSENT
You will be asked by your dentist to sign a consent/acknowledgment form. By signing the consent/acknowledgment form, your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your PHI (protected health information) to pay your health care bills and to support the operation of the dentist's office.
Following are examples of the types of uses and disclosures of your protected health care information that the dentist's office is permitted to make once you have signed our consent/acknowledgment form.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. This includes the coordination or management of your dental care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected dental information will be used, as needed, to obtain payment for your dental services. This may include certain activities that your dental insurance plan may undertake before it approves or pays for the dental care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or

disclosure of the protected health information, then your dentist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your dental care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your dentist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your dentist or another dentist in the practice is required by law to treat you, and the dentist has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your dentist or another dentist in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the dentist determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

<u>We may use or disclose your protected health information in the following situations without your consent or authorization:</u>

When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement coroners, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

You have the right to inspect and copy your protected health information

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your dentist is not required to agree to a restriction that you request. If dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your dentist does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.
You may have the right to have your dentist amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON/OR AFTER <u>APRIL 14, 2003.</u>

ALL FORMS ARE FOR EDUCATIONAL USE ONLY AND DO NOT CONSTITUTE LEGAL ADVICE. ALL FORMS ARE SUBJECT TO CHANGES IN THE FEDERAL LAW AND APPLICABLE STATE LAWS. SEEK LEGAL ADVICE BEFORE USE.

ACKNOWLEDGMENT FORM

DR. KIMBERLY OKUMURA, D.D.S

THIS FORM IS USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.

NAME OF PATIENT (PLEASE PRINT)

SIGNATURE OF PATIENT DATE

YOU MAY REFUSE TO SIGN ACKNOWLEDMENT

BELOW THIS LINE FOR OFFICE USE ONLY

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY

EMPLOYEE SIGNATURE TITLE DATE

ALL FORMS ARE FOR EDUCATIONAL USE ONLY AND DO NOT CONSTITUTE LEGAL ADVICE, ALL FORMS ARE SUBJECT TO CHANGES IN THE FEDERAL LAW AND APPLICABLE STATE LAWS. SEEK LEGAL ADVICE BEFORE USE.

Comparisons of Direct Restorative Dental Materials

	TYPES OF DIRECT RESTORATIVE DENTAL MATERIALS			
COMPARATIVE FACTORS	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.	Self-hardening mixture of glass and organic acid.	Mixture of glass and resin polymer and organic acid; self hardening by exposure to blue light.
Principle Uses	Fillings; sometimes for replacing portions 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 & porcelain/metal crowns, and liners.
Resistance to Further Decay	High; self-sealing characteristic helps resist recurrent decay; but recurrent decay around amalgam is difficult to 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 of 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 Reactions	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-gray, 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 Patient	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 for fillings; 2+ visits for indirect inlays, veneers and crowns.	Single visit.	Single visit.