Procopio Towle Dental Office

2229 Olympic Blvd., Walnut Creek, CA 94595
(925) 933-5677 (Just dial "WE FLOSS)

DATE _____ / _____ / _____

PATIENT REGISTRATION

Patient Full Name		Birthdate _____ / _____ / _____	Age
Marital Status	Sex		Social Security #
If Patient is a Minor, Legal Guardian			Relationship
Street Address			
City		State	Zip Code
Phone Home	Work		Cell
Employer Name		Occupation	
Employer Address			Employer Phone
Full name of nearest relative not living with you			Relationship
Complete Address			Phone
Name of Physician			Phone
Former Dentist			Phone
Who referred you to our practice?			

FINANCIAL INFORMATION

Person responsible for this account	Relationship	Phone
Complete Address		

DENTAL INSURANCE INFORMATION

As a courtesy to you, we will gladly handle the paperwork and submit all insurance claims on your behalf. At the completion of each visit, we will calculate your ***estimated patient payment*** based upon the best information available to us and required payment of your ***estimated patient payment*** at that time. Ultimately, your dental insurance contract is between **YOU** and **YOUR** insurance carrier, and we cannot be responsible for what the insurance carrier will or will not pay. If your insurance carrier pays less than expected, or even nothing at all, your account balance is ***your responsibility***.

PRIMARY INSURANCE

Subscriber's Full Name	Birthdate	_____ / _____ / _____
Member ID	Social Security #	_____ - _____ - _____
Employer Name	Group Plan #	
Insurance Carrier	Phone Number	
Have you used any of this insurance this current year?		

SECONDARY INSURANCE

Subscriber's Full Name	Birthdate	_____ / _____ / _____
Member ID	Social Security #	_____ - _____ - _____
Employer Name	Group Plan #	
Insurance Carrier	Phone Number	
Have you used any of this insurance this current year?		

FINANCIAL RESPONSIBILITY: I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within thirty (30) days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance information and any charges thereto. **INITIALS: _____**

Please complete both sides.

PATIENT FULL NAME: _____ BIRTHDATE: _____

MEDICAL HISTORY: These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are associated with proper oral care.

Please answer each question. Mark Yes or No on each item.

Date of last physical examination Are you under the care of a physician? Yes _____ No _____

If yes, what are you being treated for

Are you taking any medications Drugs ____ Herbs ____ Other ____, please list

Are you using any recreational drugs? (Marijuana, Cocaine, etc.)? No ____ Yes ____ If yes, please list

Have you ever taken the diet drugs Fen-phen Redux Fosamax Zometa Actonel Boniva Aredia Yes ____ No____

Have you been told by your Medical Doctor to pre-medicated with antibiotics for your dental treatment? Yes ____ No____

Are you sensitive or allergic to any drugs or material? Aspirin__ Codeine___ Latex___ Penicillin___ Sulfa___ Tetracycline___

Metal _____ Other _____, please list

Have you ever had or do you have any of the following: **Circle Y for Yes and N for No – MUST answer all conditions listed below**

Y N Acquired Immune Deficiency Syndrome
Y N AIDS
Y N Anemia
Y N Angina Pectoris
Y N Arthritis
Y N Artificial Prosthesis
Y N Asthma
Y N Blood Disease
Y N Bruise Easily
Y N Cancer
Y N Chemotherapy
Y N Chicken Pox
Y N Cold Sores
Y N Congenital Heart Lesions
Y N Dental Phobia
Y N Diabetes
Y N Drug Addiction
Y N Emphysema
Y N Epilepsy or Seizures
Y N Excessive Bleeding
Y N Fainting Spells
Y N Glaucoma
Y N Gonorrhea
Y N Hay Fever
Y N Headaches
Y N Head Injuries
Y N Heart Ailment/Disease
Y N Heart Attack
Y N Heart Failure
Y N Heart Murmur
Y N Hepatitis or Jaundice
Y N Herpes
Y N Hemophilia
Y N High Blood Pressure
Y N High Cholesterol
Y N HIV+
Y N Implants (non-dental)
Y N Joint Replacement
Y N Kidney Disease
Y N Low Blood Pressure
Y N Low Blood Sugar
Y N Liver Disease
Y N Metal Disease
Y N Migraines
Y N Mitral Valve Prolapse
Y N Nervous Disorders
Y N Osteoporosis
Y N Pacemaker
Y N Pain in Jaw Joints
Y N Radiation Treatment
Y N Respiratory Disease
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Screws/Pins
Y N Seizures
Y N Sickle Cell Disease
Y N Sinus Trouble
Y N Sleep Apnea
Y N Snoring
Y N Stomach Ulcers
Y N Stroke
Y N Thyroid Disease
Y N TMJ (Temporomandibular Joint)
Y N Tuberculosis
Y N Tumors or Growth
Y N Ulcers
Y N Venereal Disease
Y N X-ray or Cobalt Treatment

Do you have any disease or condition not listed above, we should know about Yes ____ No____

Do you wear a cardiac pacemaker or have you had heart surgery? Yes ____ No____

Do you smoke? Yes ____ No____ If Yes, how much Cigarettes Cigars Packs per day

Women: *Are you pregnant? Y___ N___ If yes, how many months _____ Do you take birth control pills Y___ N___*

DENTAL HISTORY

Have you ever had local anesthetic (Novocain, etc.)? Yes ____ No____

Have you ever had any unfavorable reaction to anesthetic? Yes ____ No____

Are your teeth sensitive to Hot ___ Cold ___ Sweets ___ Pressure ___ Where and how long

How long since your last dental treatment? Are you nervous? Yes ____ No____

CONSENT FOR TREATMENT: I, hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedure, anesthetics and/or drugs. All services are rendered and accepted under the terms and conditions printed on the reverse hereof. Authorization must be signed by patient, or by the nearest relative in case of a minor or when patient is physically or mentally incompetent. **INITIALS: _____**

MISSED APPOINTMENTS: When you schedule an appointment, we reserve time ***exclusively*** for *you*. We understand that anyone can have an occasional emergency, car trouble, or simply forget, but a few patients routinely fail to keep their appointments, which increases costs to all our patients. **Therefore, there will be a fee for repeated missed appointments or short-notice cancellations without 48-hour notice. Your signature on this form indicates that you understand and agree to this policy. INITIALS: _____**

Date_____ Patient Signature_____ Provider Signature _____

Date_____ Patient Signature_____ Provider Signature _____

Date_____ Patient Signature_____ Provider Signature _____

Date_____ Patient Signature_____ Provider Signature_____

Procopio Towle Dental Office

2229 Olympic Boulevard, Walnut Creek, California 94595
(925) 933-5677 ♦ office@procopiodds.com

About our Office Guidelines

We appreciate your selection of our office to serve your dental needs. As such we are committed to providing the best dental care for all our patients. We want you to enjoy optimal dental health throughout your lifetime. This statement has been prepared to give you some information who we are and our guidelines. Please feel free to ask the front office team if you have any questions.

Estimate/Dental Insurance benefits: Before we begin your dental treatment, we will perform a **complete examination.** Based on that examination, we will give you an **estimate** of the total fee for your treatment. As we proceed with your restorative treatment, we may encounter additional diagnosis that may not be apparent to us at the time of the initial examination. In that event we will fully discuss the additional finding(s) with you, including the effects, if any, on your financial arrangements. We will not proceed without your approval. As a courtesy to you, we will process your dental insurance claims for you. We do, however require you to pay, on or before the date of treatment, the estimated portion of the fees that may not be reimbursed by your insurance. Also, your insurance agreement is between you and your insurance company, and regardless of your coverage status, **you are ultimately responsible for all fees incurred by you**; we are accepting assignment of your reimbursement benefit from your insurance company as a courtesy to you only. Please be aware that the actual amount your insurance reimburses may be different from the amount we estimate and that an **estimate of insurance reimbursement benefit** is not a guarantee of payment. Full payment of fees is due on the day of service, unless you have authorized insurance reimbursement benefits that have been assigned to our office. In that case, you must still pay the portion estimated to be not covered by your insurance benefits. We accept cash, checks and all major credit cards.

Cancel/Failed Appointment: Once an appointment is scheduled, we reserve that time exclusively for you. **We are committed to be ready and able to provide you with the highest quality of service at that appointment. We expect similar commitment from our patients.** Please arrive on time, so that we may best serve you and to prevent any need for rescheduling of the appointment. If you need to change your appointment due to some unforeseen event, please provide us with a **48 hour advance notice to avoid $80.00 per scheduled hour charge.** _____
(initials)

_____ _____

Signature of Patient/Responsible Party **Date**

Procopio Towle Dental Office

Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect May 31, 2018 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or

Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful

process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please read the following information then print and sign page.

Dental Materials Fact Sheet

by the
Dental Board of California
1432 Howe Avenue
Sacramento, Ce 95825
www.dbc.ea.QOv

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 Coda 1648.10-1648.20*

Allergic Reactions to Dental Materials: Components In dental fillings may have side effects or cause allergic reactions, just like other materials we may come in contact with in our dally Ilves. 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 Io composite resin, glass ionomer, resin ionomer, or porcelain. However, there have been rare allergic responses reported with dental amalgam (silver fillings), 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 (Silver): Mercury in its elemental form is on the State of California's Proposition 65 list of chemicals known to the state to cause reproduces toxicity. Mercury may harm the developing brain of a child or fetus.

Dental amalgam (silver) 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 (silver). 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 of Disease Control and Prevention, there Is scant evidence that the health of the vast majority of people with amalgam is compromised.

The Food and Drug Administration (FDA) and other public health organizations have Investigated the safety of amalgam used in dental fillings. The conclusion: no valid scientific evidence has shown that amalgams cause harm to patients with dental restorations, except in rare cases of allergy. The World Health Organization reached a similar conclusion stating, "Amalgam restorations are safe and cost effective".

A diversity of opinions exists regarding the safety of dental amalgams. Questions have been raised about Its safely in pregnant women, children, and diabetics. However, scientific evidence and research literature in peer-reviewed scientific journals suggest that otherwise healthy women, children, and diabetics are not at an increased risk from dental amalgams in their mouths. The FDA places no restrictions on the use of dental amalgam.

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

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

Dental Materials – Advantages & *Disadvantages*

DENTAL AMALGAM (SILVER) FILLINGS: Dental amalgam Is a self-hardening mixture of silver-tin-copper alloy powder and liquid mercury and is sometimes referred to as silver fillings because of its color. It is often used as a filling material and replacement for broken teeth.

Advantages
*Durable; long lasting
*Wears well; holds up well to the forces of biting
*Relatively inexpensive
*Generally completed in one visit
*Self-sealing: minimal-to-no shrinkage and resists leakage
*Resistance to further decay is high but can be difficult to find in early stages.
*Frequency of repair and replacement is low

Disadvantages
*Refer to 'What About the Safety of Filling Materials"
*Gray colored, not tooth colored.
*May darken as it corrodes; may stain teeth over time.
*Requires removal of some healthy tooth
*In larger amalgam fillings, the remaining tooth may weaken and fracture
*Because metal can conduct hot and cold temperatures, there may be a temporary sensitivity to hot and cold.
*Contact with other metals may cause occasional, minute electrical flow

The durability of any dental restoration is influenced not only by the material it is made from, but also by the dentist's technique when placing the restoration. Other factors include the supporting materials used in the procedure and the patient's cooperation during the procedure. The length of time a restoration will last is dependent upon your dental hygiene, home care, and diet and chewing habits.

COMPOSITE RESIN FILLINGS: Composite fillings are a mixture of powdered glass and plastic resin, sometimes referred to as white, plastic, or tooth-colored fillings. It is used for fillings. Inlays, veneers, partial and complete crowns, or to repair portions of broken teeth.

Advantages
*Strong and durable
*Tooth colored
*Single visit for fillings
*Resists breaking
*Maximum amount of tooth preserved
*Small risk of leakage if bonded only to enamel
*Does not corrode
*Generally, holds up well to the forces of biting depending on product used
*Resistance to further decay is moderate and easy to find
*Frequency of repair or replacement is low to moderate

Disadvantages
*Refer to 'What About the Safety of Filing Materials"
*Moderate occurrence of tooth sensitivity; sensitive to dentist's method of application
*Costs more than dental amalgam
*Material shrinks when hardened and could lead to further decay and/or temperature sensitivity
*Requires more than one visit for inlays, veneers, and crowns
*May wear fester than dental enamel
*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 add. It is tooth-colored and varies in translucency. Glass ionomer Is usually used for small filings, cementing metal and porcelain/metal crowns, liners, and temporary restorations,

Advantages
*Reasonable good esthetics
*May provide some help against decay because it releases fluoride
*Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
*Material has low Incidence of producing tooth sensitivity
*Usually completed in one dental visit

Disadvantages
*Cost is very similar to composite resto (which costs more than amalgam)
*Limited use because it is not recommended for biting surfaces in permanent teeth
*As it ages, this material may become rough and could increase the accumulation of plaque and chance of periodontal disease
*Does not wear well; tends to crack over time and can be dislodged

RESIN-IONOMER CEMENT: Resin ionomer cement is a mixture of glass and resto polymer and organic add that hardens with exposure tea 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 filings, cementing metal and porcelain metal crowns and liners.

Advantages
*Very good esthetics
*May provide some help against decay because it releases fluoride
*Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
*Good for non-biting surfaces
*May be used for short-term primary teeth restorations
*May hold up better than glass ionomer but not as well as composite
•Good resistance to leakage
•Material has low incidence of producing tooth sensitivity
•Usually completed in one dental visit

Disadvantages
*Cost is very similar to composite resin (which costs more than amalgam)
*Limited use because it is not recommended to restore the biting surfaces of adults
*Wears faster than composite and amalgam

PORCELAIN (CERAMIC): Porcelain is a glass-like material formed into filings or crowns using models of the prepared teeth. The material is colored and is used in Inlays, tooth-veneers, crowns, and fixed bridges.

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

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

NICKEL OR COBALT-CHROME ALLOYS: Nickel or cobalt-chrome alloys are mixtures of nickel and chromium. They are a dark silver metal color and are used for crowns and fixed bridges and most partial denture framework.

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

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

DENTAL BOARD OF CALIFORNIA
1432 Howe Avenue
Sacramento, CA 95825
www.dbc.ca.gov

Published by
California Department of Consumer Affairs
5/04

The Facts About Fillings

Acknowledgement of Receipt of Dental Materials Fact Sheet

I acknowledge that I have received from Procopio Towle Dental Office, the Dental Materials Fact Sheet that was updated on May 30, 2018.

Patient Name

Signature of Patient, Parent or Guardian Date

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgment if you wish.

I acknowledge that I have received a copy of the Notice of Privacy Practices from Procopio Towle Dental Office.

Patient Name

Signature of Patient, Parent or Guardian Date

Procopio Towle Dental Office

2229 Olympic Blvd., Walnut Creek, California 94595
(925) 933-5677 ❖ office@procopiodds.com

Patient Name: _____

Date of Birth: _____

❑ **I agree that Procopio Towle Dental Office may communicate with me electronically at the email address below.**

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. **I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by calling: (*925) 933-5677***

Email Address (Please Print Clearly):

_____

❑ **I decline to release my email address to Procopio Towle Dental Office.**

Patient Signature: _____

Date: _____