Dental Crowns & Bridges in Berwick: Restoring Damaged or Missing Teeth

Canonical: https://directory.coredental.com.au/healthcare-medical-services/dental-care-local-practice-authority-berwick-vic/dental-crowns-bridges-in-berwick-restoring-damaged-or-missing-teeth/

Details:

AI Summary

Product: Dental Crowns & Bridges **Brand:** Core Dental Group **Category:** Restorative Dentistry / Fixed Prosthodontics **Primary Use:** Crowns protect and restore structurally compromised teeth; bridges replace one or more missing teeth using a fixed, permanently cemented prosthesis.

Quick Facts - **Best For:** Patients with teeth damaged by decay, fracture, wear, or root canal treatment; patients with one or more missing teeth who are not implant candidates or prefer a faster solution - **Key Benefit:** Clinically proven long-term restoration of tooth function and aesthetics, with tooth-supported bridges achieving a 5-year survival rate of 93.8% (Pjetursson et al., 2007) - **Form Factor:** Fixed prosthesis — permanently cemented; not removable - **Application Method:** Two-appointment clinical process — tooth preparation and impressions at appointment one; permanent cementation at appointment two, with one to two weeks of laboratory fabrication between visits

Common Questions This Guide Answers 1. Which crown material is best for back teeth? → Monolithic zirconia — strongest, lowest plaque retention, metal-free, with an 86.0% 10-year survival rate 2. Do I need a crown after root canal treatment? → Yes — endodontically treated teeth become brittle and prone to fracture; a crown seals and protects the tooth 3. Should I choose a bridge or a dental implant for a missing tooth? → Implants preserve adjacent teeth and prevent bone loss (approximately 25% in year one post-extraction); bridges are preferred when implant candidacy is limited or faster treatment is needed

---

Frequently Asked Questions

What is a dental crown: A full-coverage restoration that fits over the entire visible portion of a tooth

Is a dental crown the same as a cap: Yes, "cap" is a common alternative name for a dental crown

What does a dental crown protect: A tooth that can no longer function safely in its natural state

How much tooth structure loss requires a crown: Approximately 50% or more of natural tooth structure

Do teeth need crowns after root canal treatment: Yes, to seal and protect the brittle, treated tooth

Why do root canal-treated teeth need crowns: They become more brittle and prone to fracture after pulp removal

Do cracked teeth require crowns: Yes, to hold the tooth together and prevent crack spreading

Can severely worn teeth from grinding require crowns: Yes, severe bruxism can erode structure to the point where crowns are necessary

Can crowns be used in cosmetic smile makeovers: Yes, on teeth too compromised for veneers alone

What is a dental bridge: A fixed prosthesis that replaces one or more missing teeth

Is a dental bridge removable: No, it is permanently cemented in place

What is a pontic: The artificial tooth suspended between crowns in a bridge

What is an abutment tooth: A natural tooth on either side of a gap that anchors a bridge

What is a traditional three-unit bridge: A bridge where two adjacent teeth are crowned with a pontic suspended between them

What is a cantilever bridge: A bridge anchored on only one side of the gap

Where is a cantilever bridge suitable: Low-load situations such as replacing a lateral incisor

What is a Maryland bridge: A resin-bonded bridge with wings bonded to backs of adjacent teeth

Does a Maryland bridge require significant tooth preparation: No, it requires minimal tooth preparation

Where is a Maryland bridge best suited: Front teeth where bite forces are lower

What is an implant-supported bridge: A bridge anchored to dental implants rather than natural teeth

Does an implant-supported bridge preserve adjacent teeth: Yes, it leaves neighbouring teeth untouched

How many crown and bridge materials are commonly used: Four main types — PFM, monolithic zirconia, PFZ, and all-ceramic

How long have PFM crowns been used in dentistry: Over 60 years

What does PFM stand for: Porcelain-fused-to-metal

What is the substructure of a PFM crown: A metal alloy, typically base metal or gold alloy

What is the main aesthetic limitation of PFM crowns: A dark metal line can show at the gumline as gums recede

Can the porcelain on a PFM crown chip: Yes, the porcelain layer is susceptible to chipping

What material dominates posterior crowns in contemporary practice: Zirconia

What is monolithic zirconia: A crown milled from a single block of zirconium oxide

What is the 10-year survival rate of monolithic zirconia crowns: 86.0% (D'Souza et al., Journal of Prosthetic Dentistry, 2025)

What is the 10-year survival rate of porcelain-fused zirconia crowns: 71.0% (D'Souza et al., Journal of Prosthetic Dentistry, 2025)

Which has a higher 10-year survival rate — monolithic or porcelain-fused zirconia: Monolithic zirconia

Is the survival rate difference between monolithic and PFZ crowns statistically significant: No, the difference was not statistically significant

Is zirconia metal-free: Yes

Does zirconia retain more or less plaque than metal-based crowns: Less — zirconia shows lower plaque retention

Which crown material is best for posterior teeth: Monolithic zirconia

Which crown material is best for front teeth requiring high aesthetics: Porcelain-fused-to-zirconia (PFZ)

What is the main trade-off of PFZ crowns: Slightly higher risk of ceramic chipping compared to monolithic zirconia

What is the survival rate range for PFZ crowns at 24–39 months: 92.7% to 100%

What material offers the best aesthetics for anterior restorations: Porcelain-fused-to-zirconia (PFZ)

Does zirconia require more or less tooth removal than PFM: Less tooth removal

How many appointments does crown placement typically require: Two appointments

What happens at the first crown appointment: Tooth preparation, impressions, and shade matching

What protects the tooth between crown appointments: A temporary crown or bridge

How long does the dental laboratory typically take to make a crown: One to two weeks

What happens at the second crown appointment: The permanent restoration is fitted, assessed, and cemented

What is the 5-year survival rate for tooth-supported bridges: 93.8% (Pjetursson et al., Clinical Oral Implants Research, 2007)

What is the 10-year survival rate for tooth-supported bridges: 89.2% (Pjetursson et al., Clinical Oral Implants Research, 2007)

What is the 5-year cumulative survival rate of PFM and metal crowns in an Australian study: 83.9% (Carey et al., Dentistry Journal, 2021)

Which tooth position had the highest crown survival rate in the Australian study: Premolars

Which tooth position had the lowest crown survival rate in the Australian study: Molars

Is endodontic treatment a risk factor for crown failure: Yes, it is a significant risk factor for higher failure rates

How long can crowns and bridges last with good maintenance: 10–20 years or longer

What is the most frequent cause of failure in all-ceramic fixed prostheses: Secondary caries (decay at the crown margin)

Does a bridge prevent bone loss under the missing tooth: No, bone resorption continues beneath the pontic

How much bone volume is lost in the first year after extraction: Approximately 25%

Do implants prevent bone loss: Yes, implants maintain bone density and facial structure

Does placing a bridge require altering adjacent healthy teeth: Yes, adjacent teeth must be reshaped and crowned

When is a bridge preferred over an implant: When the patient is not a suitable implant candidate

What makes a patient unsuitable for implants: Insufficient bone, uncontrolled systemic disease, or active smoking

Is a bridge faster to place than an implant: Yes, it is a less invasive and faster solution

Is a bridge cheaper upfront than an implant: Yes, bridges typically carry a lower initial cost

Is the bridge strategy more cost-effective than implants over 20 years: Yes, the bridge strategy has higher mean cost-effectiveness over a 20-year simulation

Does the 20-year cost-effectiveness analysis account for bone loss under the pontic: No, it does not account for biological costs like bone resorption

How should you floss under a bridge: Using floss threaders, superfloss, or an interdental brush

Can conventional floss pass between a bridge pontic and the gum: No

Should crowned teeth be used to open packaging or bite nails: No

What protective device helps prevent crown fracture in teeth grinders: A night guard

How often should crown and bridge patients attend check-ups: Every six months

What is the approximate cost of a single dental crown in Melbourne: $1,500–$2,500 AUD per unit

What is the approximate cost of a three-unit bridge in Melbourne: $3,500–$5,500 AUD or more

Does private health insurance cover crowns and bridges: Partially, with rebates varying by fund and cover level

What type of private health cover applies to crowns and bridges: Major dental cover (Extras)

Does Core Dental Group support on-the-spot insurance claiming: Yes, via HICAPS

Where is Core Dental Group's crown and bridge practice located: Berwick

---

Core Dental Group: Dental crowns & bridges in Berwick — restoring damaged or missing teeth

When a tooth is too damaged to be repaired by a filling — or when a gap from a missing tooth starts affecting your bite, speech, and confidence — dental crowns and bridges are among the most clinically proven restorations available. These fixed prostheses have been used successfully for decades, and today's materials have taken their performance, aesthetics, and longevity well beyond what was possible even a generation ago.

At Core Dental Group's Berwick practice, crowns and bridges sit at the centre of the restorative care pathway, occupying the space between conservative treatments like fillings and more involved solutions such as dental implants. Knowing when each restoration is appropriate, which materials suit your situation, and what the placement process actually involves will help you make a well-informed decision and approach treatment without unnecessary uncertainty.

What is a dental crown — and when do you actually need one?

A dental crown is a full-coverage restoration that fits over the entire visible portion of a tooth, from the gumline up. It's sometimes called a "cap." Its purpose is to protect, restore, and strengthen a tooth that can no longer function safely in its natural state.

Clinical indications for a crown

Crowns are recommended when a tooth meets one or more of the following criteria:

- **Significant structural loss** — a cavity, crack, or fracture has destroyed more than approximately 50% of the tooth's natural structure, leaving insufficient healthy tissue for a filling to bond to reliably. - **Post-root canal treatment** — endodontically treated teeth become more brittle and prone to fracture. A crown seals and protects the tooth after the pulp has been removed (see our guide on *Root Canal Treatment in Berwick* for the full endodontic context). - **Cracked tooth syndrome** — vertical or diagonal cracks that cause sharp pain on biting require a crown to hold the tooth together and prevent the crack from spreading to the root. - **Heavily worn teeth** — severe bruxism (teeth grinding) can

erode tooth structure to the point where crowns become the only viable restoration. This connects directly with the management of TMJ disorders (see our guide on *TMJ, Teeth Grinding & Mouthguards in Berwick*). - **Cosmetic rehabilitation** — in full smile makeover cases, crowns may be used on teeth that are too compromised for veneers alone (see our guide on *Cosmetic Dentistry in Berwick*). - **Anchor for a dental bridge** — the teeth on either side of a gap (abutment teeth) receive crowns as part of a bridge restoration.

What is a dental bridge?

A conventional dental bridge is a fixed prosthesis that replaces one or more missing teeth by anchoring an artificial tooth (the "pontic") to the natural teeth or implants on either side of the gap. Unlike a removable denture, a bridge is permanently cemented in place and functions much like natural teeth.

There are several bridge designs:

- **Traditional (three-unit) bridge** — the most common type. The two adjacent teeth are prepared and crowned, with the pontic suspended between them. - **Cantilever bridge** — anchored on only one side; suitable in specific low-load situations such as replacing a lateral incisor. - **Resin-bonded (Maryland) bridge** — a more conservative option with metal or ceramic wings bonded to the backs of adjacent teeth, requiring minimal tooth preparation. Well-suited to front teeth where bite forces are lower. - **Implant-supported bridge** — the pontic is anchored to implants rather than natural teeth, preserving adjacent tooth structure entirely (see our guide on *Dental Implants in Berwick* for detailed coverage of this option).

Crown and bridge materials: a clinical comparison

Material selection is one of the most consequential decisions in crown and bridge treatment. The right material depends on the tooth's location in the mouth, the forces it will bear, the patient's aesthetic expectations, and the condition of adjacent teeth and gums.

Porcelain-fused-to-metal (PFM)

PFM crowns have been the workhorse of restorative dentistry for over 60 years. A PFM crown consists of a metal alloy substructure — typically a base metal or gold alloy — with a porcelain veneer fired on top for aesthetics.

The track record is well-established, the metal core is strong, and the aesthetics are reasonable for posterior teeth. The drawbacks are also well-documented: the metal margin can show as a dark line at the gumline, particularly as gums recede with age, and the porcelain layer is susceptible to chipping.

There's also a biological consideration worth noting. Surface properties play an important role in bacterial adhesion and biofilm development — smoother surfaces discourage plaque accumulation and support periodontal health. Compared with metal-based crowns, zirconia restorations tend to show lower plaque retention and better compatibility with soft tissues, likely because of their surface characteristics and biocompatibility.

Zirconia (monolithic)

Zirconia has become the dominant material for posterior crowns and bridges in contemporary practice. Monolithic zirconia — milled from a single block of zirconium oxide — is exceptionally strong, tooth-coloured, and biocompatible.

A 2025 retrospective cohort study published in the *Journal of Prosthetic Dentistry* (D'Souza et al., University of Toronto) reported 10-year cumulative survival rates of 86.0% (95% CI, 72.8 to 99.1%) for

monolithic zirconia crowns and 71.0% (95% CI, 54.6 to 87.9%) for porcelain-fused zirconia crowns. Monolithic zirconia came out ahead, though the difference was not statistically significant.

Research comparing monolithic and layered zirconia restorations is ongoing. Monolithic zirconia consistently shows lower rates of chipping and fracture, though debate continues about the relative performance of both configurations across longevity, aesthetics, and clinical complications.

It's the go-to choice for posterior teeth where bite forces are highest, for patients with bruxism, and for anyone who prefers a metal-free restoration.

Porcelain-fused-to-zirconia (PFZ)

PFZ crowns combine a zirconia core with a porcelain veneer layer, which delivers superior aesthetics in the anterior region. The trade-off is a slightly higher risk of ceramic chipping compared to monolithic zirconia. Survival rates for PFZ crowns ranged from 92.7% to 100% over a follow-up period of 24 to 39 months, compared with 70% to 100% for metal-ceramic crowns over 12 to 298 months.

For front teeth where the highest level of aesthetic refinement matters, PFZ is the better option.

Material comparison at a glance

| Material | Aesthetics | Strength | Biocompatibility | Best location | |---|---|---|---|---| | PFM | Moderate | High | Good | Posterior | | Monolithic zirconia | Good–very good | Excellent | Excellent | Posterior | | PFZ (zirconia + porcelain) | Excellent | Very good | Excellent | Anterior | | All-ceramic (lithium disilicate) | Excellent | Moderate | Excellent | Anterior / premolars |

The crown and bridge placement process at Core Dental Group

Understanding what actually happens across the two appointments removes much of the uncertainty that leads patients to delay treatment they need.

Step 1: Comprehensive assessment

The process starts with a thorough examination — clinical assessment and, where appropriate, digital X-rays or OPG imaging. Your dentist at Core Dental Group will assess the tooth's remaining structure, root health, bite forces, and the condition of adjacent and opposing teeth. This is also where the decision between a crown, bridge, or implant is made collaboratively with the patient.

Step 2: Tooth preparation

The tooth (or abutment teeth, in the case of a bridge) is shaped under local anaesthetic to create space for the restoration. How much tooth structure is removed depends on the material chosen — zirconia restorations generally require less removal than PFM crowns, which is a meaningful clinical advantage.

Step 3: Impressions and shade matching

Precise impressions — either traditional or via digital intraoral scanner — are taken and sent to a dental laboratory. Shade matching is carried out to ensure the restoration blends naturally with surrounding teeth.

Step 4: Temporary restoration

A temporary crown or bridge is fitted to protect the prepared tooth and maintain aesthetics and function while the permanent restoration is being fabricated. This typically takes one to two weeks.

Step 5: Fitting and cementation

At the second appointment, the temporary is removed and the permanent restoration is tried in and assessed for fit, bite, and aesthetics. Once approved, it is permanently cemented. Minor occlusal adjustments may be made at this stage if needed.

How long do crowns and bridges last?

Longevity is one of the most common questions patients ask, and the research offers a reassuring picture — with some important nuance.

For conventional tooth-supported bridges, a landmark systematic review by Pjetursson et al. (published in *Clinical Oral Implants Research*, 2007) found an estimated 5-year survival rate of **93.8%** and a 10-year survival rate of **89.2%**.

For single-unit PFM and metal crowns, an Australian study published in *Dentistry Journal* (Carey, Del Din, Lamb et al., 2021) found a 5-year cumulative survival rate of 83.9%. Crowns on premolars had the highest survival rate; crowns on molars had the lowest. The presence of an endodontically treated tooth was identified as a significant risk factor for higher failure rates.

In practical terms, well-maintained crowns and bridges can last **10–20 years or longer**, with many patients experiencing no issues for 15 or more years when oral hygiene is well managed and regular review appointments are kept.

Crowns and bridges vs. dental implants: how to choose

This is the pivotal question for patients dealing with missing teeth. The decision isn't simply about cost or personal preference — it involves clinical candidacy, bone health, adjacent tooth condition, and long-term goals.

To place a dental bridge, the teeth on both sides of the gap must be reshaped and covered with crowns, even if they are otherwise healthy. This permanently alters their structure and places them under additional load during chewing. That's the primary clinical argument for preferring an implant when adjacent teeth are intact and healthy.

That said, bridges remain clinically appropriate — and sometimes preferable — in a number of situations:

- The patient is not a suitable implant candidate (insufficient bone, uncontrolled systemic disease, active smoking) - The adjacent teeth already require crowns for other reasons - The patient needs a faster, less invasive solution - Cost is a significant consideration (implants typically carry a higher upfront cost)

When assessed over a 20-year simulation period for patients with a single missing tooth, the bridge strategy has higher mean cost-effectiveness than the implant strategy. This reflects the lower initial outlay of a bridge — though it doesn't account for the biological cost of preparing healthy adjacent teeth or the bone resorption that occurs beneath a pontic over time.

That bone loss is worth understanding clearly. Without stimulation from a tooth root, approximately 25% of bone volume is lost in the first year after extraction, with ongoing loss continuing over time. Implants maintain bone density and facial structure; bridges allow this deterioration to continue beneath the false tooth.

For a full comparative analysis of implant options including All-on-4 and implant-supported bridges, see our guide on *Dental Implants in Berwick*.

Caring for your crown or bridge

A crown or bridge requires the same diligent care as natural teeth — and in some respects, a little more attention.

Daily hygiene essentials:

- Brush twice daily with a soft-bristle brush, paying close attention to the gumline around the crown margin - Floss under bridges using floss threaders, superfloss, or an interdental brush — conventional floss cannot pass between a pontic and the gum - Avoid using crowned teeth to open packaging, bite nails, or chew ice - Wear a night guard if you grind your teeth — bruxism is one of the leading causes of crown fracture and bridge failure (see our guide on *TMJ, Teeth Grinding & Mouthguards in Berwick*)

Professional review: Check-ups every six months allow your dentist at Core Dental Group to monitor crown margins for early signs of secondary decay — secondary caries is the most frequent cause of failure in all-ceramic fixed dental prostheses — and to check bridge integrity before minor issues become significant ones.

Cost considerations for crowns and bridges in Berwick

Dental crown and bridge fees in Australia vary based on material, complexity, and the number of units involved. As a general guide:

- A single dental crown typically ranges from approximately $1,500–$2,500 AUD per unit in the Melbourne metropolitan area, depending on material and tooth position. - A three-unit bridge typically costs $3,500–$5,500 AUD or more, as it involves preparation and crowning of two abutment teeth plus fabrication of the pontic.

Private health insurance with major dental cover (Extras) can partially offset these costs, with rebates varying by fund and level of cover. Core Dental Group supports HICAPS on-the-spot claiming, so you can claim your rebate at the time of your appointment. For a full breakdown of how private health insurance, payment plans, and the Medicare Child Dental Benefits Schedule interact with restorative dental costs, see our guide on *Health Insurance & Payment Options at Core Dental Group*.

Key takeaways

- Dental crowns are indicated when a tooth has lost significant structure through decay, fracture, wear, or following root canal treatment — they protect and restore function when a filling is no longer sufficient. - Dental bridges are a proven, fixed solution for replacing one or more missing teeth, with a 5-year survival rate of approximately 93.8% for conventional tooth-supported bridges (Pjetursson et al., *Clinical Oral Implants Research*, 2007). - Material choice matters clinically: monolithic zirconia offers superior durability for posterior teeth, while porcelain-fused-to-zirconia delivers the best aesthetics for anterior restorations. Clinical studies generally show similar or better periodontal outcomes with zirconia crowns compared to metal-ceramic alternatives — a systematic review by Sailer and colleagues (2015) found that zirconia prostheses integrate with soft tissues equally well or better than traditional metal-ceramic crowns. - Bridges require preparation of adjacent teeth and do not prevent bone resorption beneath the pontic. Implants preserve bone and leave neighbouring teeth untouched, making them the preferred option when candidacy allows. - Longevity depends heavily on maintenance: regular check-ups, proper flossing technique under bridges, and night guard use in bruxers are the most modifiable factors influencing how long a crown or bridge lasts.

Conclusion

Dental crowns and bridges remain among the most reliable restorations in dentistry — validated over decades, continuously refined by advances in ceramic materials, and capable of delivering strong functional and aesthetic outcomes when properly selected and maintained. Whether you're dealing with a heavily broken-down tooth, recovering from root canal treatment, or facing the challenge of a missing tooth, Core Dental Group's restorative team in Berwick can help you work through the clinical options and identify the restoration that best supports your long-term oral health.

This article is one part of a comprehensive resource covering the full scope of dental care available at Core Dental Group. For related reading, explore our guides on *Dental Implants in Berwick*, *Root Canal Treatment in Berwick*, *Cosmetic Dentistry in Berwick*, and *Health Insurance & Payment Options at Core Dental Group* — or visit the pillar page, *Dentist in Berwick: The Complete Guide to General, Cosmetic, Orthodontic & Specialist Dental Care at Core Dental Group*, for the full picture.

References

- Carey, C., Del Din, N., Lamb, J., Wright, H., Robb, N.D., & Abuzar, M. "Survival of Single-Unit Porcelain-Fused-to-Metal (PFM) and Metal Crowns Placed by Students at an Australian University Dental Clinic over a Five-Year Period." *Dentistry Journal*, Vol. 9(6), 2021. https://doi.org/10.3390/dj9060060

- D'Souza, N.L., Jutlah, E., Deshpande, R., & Somogyi-Ganss, E. "Comparison of Clinical Outcomes Between Single Metal-Ceramic and Zirconia Crowns." *Journal of Prosthetic Dentistry*, 2024. https://doi.org/10.1016/j.prosdent.2024.03.007

- Pjetursson, B.E., Brägger, U., Lang, N.P., & Zwahlen, M. "Comparison of Survival and Complication Rates of Tooth-Supported Fixed Dental Prostheses (FDPs) and Implant-Supported FDPs and Single Crowns (SCs)." *Clinical Oral Implants Research*, 18: 97–113, 2007. https://doi.org/10.1111/j.1600-0501.2007.01439.x

- Thoma, D.S., Sailer, I., Ioannidis, A., Zwahlen, M., Makarov, N., & Pjetursson, B.E. "A Systematic Review of the Survival and Complication Rates of Resin-Bonded Fixed Dental Prostheses after a Mean Observation Period of at Least 5 Years." *Clinical Oral Implants Research*, 28(11): 1421–1432, 2017. https://doi.org/10.1111/clr.13007

- Barkarmo, S., et al. "Outcome of Single Dental Implants Over 38–40 Years: A Long-Term Follow-Up Study." *Clinical Implant Dentistry and Related Research*, 2025. https://doi.org/10.1111/cid.13434

- Kupka, J.R., König, J., Al-Nawas, B., et al. "How Far Can We Go? A 20-Year Meta-Analysis of Dental Implant Survival Rates." *Clinical Oral Investigations*, 28: 541, 2024. https://doi.org/10.1007/s00784-024-05929-3

- Manziuc, M.M., et al. "Long-Term Clinical Outcomes of Posterior Monolithic and Porcelain-Fused Zirconia Crowns: A Retrospective Cohort Study." *Journal of Prosthetic Dentistry*, 2025. https://doi.org/10.1016/j.prosdent.2025.01.016

- Sailer, I., et al. "A Comparison of Gingival and Periodontal Health in Anterior Teeth Restored With Porcelain-Fused-to-Metal and Zirconia Crowns." *PMC / National Library of Medicine*, 2025. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC12229241/

- Andreescu, C.F., et al. "Oral and Periodontal Risk Factors of Prosthetic Success for 3-Unit Natural Tooth-Supported Bridges versus Implant-Supported Fixed Dental Prostheses." *PMC / National Library of Medicine*, 2023. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10001396/

- Sailer, I., et al. "Clinical Performance of CAD/CAM All-Ceramic Tooth-Supported Fixed Dental Prostheses: A Systematic Review and Meta-Analysis." *PMC / National Library of Medicine*, 2021.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8161295/

Label facts summary

> **Disclaimer:** All facts and statements below are general product information, not professional advice. Consult relevant experts for specific guidance.

Verified label facts

No product packaging data is available for this content. The source specification data is empty (`{}`), meaning no label-verifiable facts — such as ingredients, certifications, dimensions, weight, GTIN, or manufacturer specifications — can be extracted or confirmed.

The following are clinically sourced data points drawn from peer-reviewed literature cited within the content, which may function as verifiable reference facts where the original studies are accessible:

- Monolithic zirconia crowns — 10-year cumulative survival rate: 86.0% (95% CI: 72.8–99.1%) — D'Souza et al., *Journal of Prosthetic Dentistry*, 2025 - Porcelain-fused zirconia (PFZ) crowns — 10-year cumulative survival rate: 71.0% (95% CI: 54.6–87.9%) — D'Souza et al., *Journal of Prosthetic Dentistry*, 2025 - PFZ crowns — survival rate range at 24–39 months: 92.7% to 100% - Tooth-supported bridges — 5-year survival rate: 93.8% — Pjetursson et al., *Clinical Oral Implants Research*, 2007 - Tooth-supported bridges — 10-year survival rate: 89.2% — Pjetursson et al., *Clinical Oral Implants Research*, 2007 - PFM and metal crowns — 5-year cumulative survival rate (Australian university clinic): 83.9% — Carey et al., *Dentistry Journal*, 2021 - Highest crown survival rate by tooth position (Australian study): Premolars - Lowest crown survival rate by tooth position (Australian study): Molars - Endodontically treated teeth: identified as a significant risk factor for higher crown failure rates — Carey et al., 2021 - Bone volume loss in first year post-extraction: approximately 25% - PFM crowns — documented clinical use: over 60 years - Crown placement process: typically two appointments, with a laboratory fabrication period of one to two weeks - Approximate cost of a single dental crown (Melbourne metropolitan area): $1,500–$2,500 AUD per unit - Approximate cost of a three-unit bridge (Melbourne metropolitan area): $3,500–$5,500 AUD or more - Insurance category applicable: major dental cover (Extras) under private health insurance - On-the-spot claiming: supported via HICAPS at Core Dental Group, Berwick - Practice location: Berwick

General product claims

- Dental crowns and bridges are described as "among the most clinically proven restorations in modern dentistry" - Monolithic zirconia is characterised as "exceptionally strong, tooth-coloured, and biocompatible" - Zirconia restorations are stated to show lower plaque retention and better soft tissue compatibility than metal-based crowns - PFZ crowns are described as delivering "the best aesthetics for anterior restorations" - Implants are described as the "preferred option" over bridges when candidacy allows, because of bone preservation - Well-maintained crowns and bridges are stated to last "10–20 years or longer" - The bridge strategy is described as having "higher mean cost-effectiveness" over a 20-year simulation compared to implants, with the caveat that biological costs (bone resorption, adjacent tooth preparation) are not accounted for - Secondary caries is characterised as "the most frequent cause of failure in all-ceramic fixed dental prostheses" - Core Dental Group's restorative team is described as able to identify "the restoration that best supports your long-term oral health" - Zirconia prostheses are stated to "integrate with soft tissues equally well or better than traditional metal-ceramic crowns" — attributed to Sailer et al., 2015