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LETTER FROM THE EDITOR

Dear Readers,

I am thrilled to welcome you to the latest issue of our publication. Our Fall issue will showcase the diverse and dynamic continuing education that we offer at the Washington AGD Global Learning Center.

In addition, we have curated a diverse range of articles that highlight the ever-evolving landscape of oral health. Our team of experts, contributors, and industry professionals have worked diligently to ensure that you receive valuable insights and knowledge that can benefit both your professional practice and personal well-being.

Here are some of the highlights you can expect in this issue:

T TEAM:
Articles that will help dentists be more effective leaders and better their teams.

E ESSENTIALS:
Articles on must-know clinical and management information.

E ENVIROMENT:
Articles on outside factors that impact dentistry, including legislative changes and insurance.

T TECHNOLOGY:
Technology that can impact and improve the way you practice.

H HEALTH:
Systemic Diseases and Dental Impact.

I would like to extend my gratitude to our authors and our editorial board: Dr. Melissa Ramsey, Dr. Carl Youngquist, Dr. Ana Wannarka, Dr. Christopher Shyue, and Valerie Bartoli, who made this issue possible. Their commitment to excellence is evident in the quality of the content you will find within these pages.

Sincerely,
Teresa Kang, DDS

Navigating the Path as a Young Dentist:

CLINICAL PEARLS AND PROFESSIONAL GROWTH

BY DR. DAVID CHI

Dr. David Chi grew up in Kirkland and is happy to return to practice dentistry in his hometown. After receiving his Bachelor of Science from Northwestern University, Dr. David pursued a career in management consulting before returning to Seattle to attend the prestigious University of Washington School of Dentistry. Dr. David invests heavily in his dental education, spending 100+ hours on continuing education each year. His training has allowed him to perform many advanced procedures, including dental implant placements and surgical extractions of impacted wisdom teeth.

Outside the office, Dr. David enjoys spending time with his wife and friends, traveling, and enjoying the outdoors. He has a passion for tennis, golf, hiking, skiing, scuba diving, and all else the beautiful Pacific Northwest has to offer.

As a young dentist who graduated within the past five years, I have experienced a transformative journey filled with both triumphs and challenges. In this essay, I would like to share several valuable clinical pearls that have served me well ever since dental school and a difficult encounter that provided a profound professional learning opportunity.

Clinical Pearl 1: Build the Right Professional Network

Dentistry is an ever-evolving field, and it is crucial for young dentists to invest in building a robust professional network. The people we surround ourselves with greatly influence our professional growth and mindset. Thus, I sought to connect with like-minded, ambitious dentists who shared my passion for continual improvement. By actively participating in organizations like the Washington Academy of General Dentistry (Washington AGD), attending courses at renowned institutions such as the Kois Center, and seeking mentorship from experienced practitioners, I cultivated a network of colleagues early on who constantly challenge and inspire me. This network not only provides opportunities for collaborative learning but also serves as a support system during challenging times, allowing me to navigate the complexities of dentistry with confidence.

Clinical Pearl 2: Knowing When to Refer to a Specialist

One of the crucial lessons I learned early on is to recognize the limits of my expertise and knowing when to refer patients to specialists. In dentistry, there are cases that require specialized knowledge and skills beyond our scope of practice. While it may be tempting to take on every case to prove our abilities, especially early in our careers, having the maturity and foresight to refer at times demonstrates our commitment to providing optimal patient care.

Clinical Pearl 3: Embracing an Attitude of Lifelong Learning

Continual learning is a hallmark of a successful dental career. I have come to appreciate the significance of investing time and resources in expanding my knowledge and honing my skills. Organizations like the Washington AGD offer an array of educational opportunities that empower dentists young and old to stay abreast of the latest advancements and techniques. Through courses and workshops, I have gained valuable insights into emerging technologies, evidence-based practices, and patient-centered approaches. These experiences have not only enriched my clinical acumen but have also instilled a sense of fulfillment and purpose in my professional journey.

The Learning Opportunity: Recognizing Limitations

While growth and success are important goals, it is equally essential to acknowledge our limitations. Early in my career, I would periodically encounter cases that challenged my abilities and tested my judgment. One case in particular really left a strong impression on me. My last patient of the week was an ER new patient in severe pain. We quickly worked her up and planned for a "simple" extraction, which by all accounts it appeared to be. The patient reported no history of traumatic dental experience, difficulty with anesthesia, and even told us the case "should be an easy one." While hindsight is 20/20, what unfolded essentially came down to a tug of war between my pride and the patient's hysteria. We could not achieve profound anesthesia, the patient refused for us to terminate the procedure, and what I envisioned as a 5 minute appointment lagged on. Ultimately, I swallowed my pride, and humbly came to recognize that sometimes the

patient's best interests lay in the hands of another provider. This experience taught me the significance of humility highlighted the value of collaboration. Understanding that we cannot be heroes for everyone enables us to prioritize patient welfare and foster trust with our dental colleagues.

As a young dentist, I have gained valuable insights during my journey thus far. Three clinical pearls in particular have guided me: building a strong professional network, recognizing when to refer patients, and embracing an attitude of lifelong learning. Moreover, I have learned the vital lesson of knowing when to seek the expertise of specialists, putting patient welfare above personal pride. By integrating these pearls into practice, I have witnessed personal growth, improved patient outcomes, and the building of a thriving dental community. As we continue to evolve, let us embrace the opportunities for learning and collaboration that await us on this rewarding path. ◊

One Pitfall to Avoid in Clinical Dentistry

BY DR. ROBIN HENDERSON

Robin Henderson graduated from the University of Michigan School of Dentistry in 1998 and returned to her rural hometown where she has owned her private practice ever since. She has been a member of the WAGD for 25 years. She is a Fellow in the ACD, ICD and PFA. Dr. Henderson serves as the Editor for the Washington Section of the ACD and was recognized as Editor of the Year for ACD in 2020. She is Regent-elect for Regency 8 of the ACD. She serves on the Member Advisory Panel for Delta Dental of Washington and has held many leadership positions at the WSDA and in her component society, including acting as Chair of the PNDC in 2013. Dr. Henderson received the 2019 ADA Design Innovation Award for her office remodel which incorporates a fully digital workflow. As a proponent for advancing education, not only her own but also that of others, she is an Emeritus Board Member of the Lewis-Clark State College Foundation and endows a scholarship in Dental Hygiene there.

I have fully embraced comprehensive treatment planning and multidisciplinary care during my 25 years as a general dentist. I have also immersed myself in continuing dental education and invested heavily in technology to utilize a fully digital workflow. As much as I have had transformational learning moments, such as realizing the power and importance of incisal edge position, learning to trust that my intra-oral scans and digital designs are even more accurate than I could get with conventional technologies and, finally experiencing what I long believed to be possible, seeing a dramatic and predictable improvement in outcomes with digitally planned and guided implant placement are a few of the topics that come to mind. As AGD dentists, you too are committed to gaining more information and techniques for better clinical outcomes.

For the purpose of this article, I was tasked with sharing one pitfall to avoid in clinical dentistry. When first discussed, I thought it would be a relatively easy topic to identify. As the deadline drew nearer, I realized I was struggling to answer the question and I kept returning to my biggest weakness in clinical practice: effective communication.

In my experience, the single most significant factor in successful patient experiences and clinical outcomes is my team. My team allows me to do my best work and provides comfort to the patient in the process. If I fail to hire team members who don't share the core values, the mission, and the vision of my practice then we will have team turnover and disharmony and we definitely won't be able to provide the best outcomes or experiences for our patients. Even assuming I am fortunate to be connected with a team who shares the same core values, we are a practice committed to growth, which often requires change, and change can feel either exciting or terrifying to team members. Positive growth comes out of trusting relationships, and trusting relationships are built on strong communication where expectations are identified and shared. I bought my practice right out of dental school and as a new practice owner, I didn't realize how much team members appreciate clearly defined expectations. When team members are educated about how they can contribute to the outcome you are striving for, their confidence grows and opens the door for even higher level communication in ways your team can elevate outcomes and patient experiences.

As our treatment plans almost always involve multidisciplinary care and work with specialty disciplines, our team is oftentimes extended outside of our practice walls. We work to communicate clearly with periodontists, endodontists, oral maxillofacial surgeons, and oral medicine and oral radiology specialists, who we view as part of our extended team. We also strongly communicate the value of the specialists that we work with to our patients to maintain high treatment acceptance and help patients enjoy a trusting relationship with the specialty offices.

Communication skills aren't only helpful to best support your team and extended team, it is what determines if you actually get to do the dentistry that you diagnose. Your patients are only going to benefit from what you are able to provide them with if they say "Yes!" to your plan. I have found photography an invaluable tool to help communicate needs to patients and it is especially rewarding to share before and after outcomes with patients and team members.

As a newer dentist, my burning questions were more procedural and materials-based, like what to use for core buildups and how to manage occlusion for the most predictable outcome. As I have more experience, the one area where I have had the most failures is in communication that is either not specific enough or it is delivered in such a way that it is misunderstood. Although, not essentially a technical skill, communication may have even more power than the technical skills we work so hard to improve in clinical dentistry. ◊

The Good, the Bad, and the Utterly Fantastic Profession

BY DR. DAN LAIZURE

Dr. Laizure is a dentist, speaker, author and the founder of Walla Walla Dental Care in Walla Walla, Washington. He is an honor graduate of the Oregon Health Sciences School of Dentistry and is the recipient of several citations and recognitions. He served in the armed forces in both the Army National Guard and the U.S. Navy. His practice received congressional recognition for volunteer treatment of US military veterans. Dr. Laizure is a Fellow of the Academy of General Dentistry (FAGD) and has served as board member and President of WAGD. He has been a clinical instructor at the Kois Center, and served on the Washington State Board of dental examiners.

I appreciate this opportunity to review and organize my thoughts regarding a long and joyful life with dentistry. My hope is that I can share some aspects of my experience that will be useful to the reader. Last week I had to see my own health care provider to personally deal with one of the physical issues of aging. He asked, "Are you still working?" I replied that I was very lucky because I did not feel as if I had ever worked a day in my life. I love what I do and plan on doing it until I am disabled, or I become a liability to those I serve. I attempt to live up to the observation of François-René de Chateaubriand, a 19th century philosopher who said, "A master in the art of living draws no sharp distinction between his work and his play; his labor and his leisure; his mind and his body; his education and his recreation. He hardly knows which is which. He simply pursues his vision of excellence at whatever he does, leaving others to decide whether he is working or playing. To him he's always doing both."

So, with that preamble let me review a couple of aspects of practice that I believe have helped me maintain the joy of practice I experience. It seems to me there are basically two general aspects of dental practice that must be addressed successfully to allow for enjoyment. First is the clinical aspect and second is the business side of a practice. Neither is more important than the other and both are intertwined so deeply as to be inseparable. Further, each has two "subsections" that I will attempt to explore satisfactorily.

First is the clinical challenge of performing what we have learned and know and second is the challenge of maintaining and growing in our clinical ability via continuing education and experience. As I recall at graduation ceremonies, a speaker said something that has stuck with me for 45 plus years. He said something like, "After four years of advanced and intense education, I have good news and bad news for the graduates. The good news is that at least half of what you have been taught is true; the bad news is that we do not know which half." He went on to admonish us to keep an open mind and continue our lifelong journey of seeking excellence and improvement clinically by being active in continuing education and curious about new and advancing technology. That last one was and is still an incredible challenge if you consider at the time Panorex was just beginning acceptance as diagnostically reliable, the air turbine handpiece was new technology, early macro fill composites were just starting to replace silicate cements as filling materials, "rubber base" impression materials

were replacing reversible hydrocolloid impressions, implants didn't work and computers, even office software applications, were wonders of the future. Today, here we are in the future where some of you are wondering what "stone age" materials I am speaking of. It is a wonderful time to be in practice and I admit that I am a bit jealous of you young practitioners and the wonders you will see as the profession progresses. I believe technology will outstrip most of our abilities to even remotely keep up, but we must strive and selectively choose that technology and those techniques that complement our own path to excellence.

The second general area of practice is the business or administrative side of the practice. Few of us are familiar with the business of business and few dental schools address private practice administration. Just as the technology and techniques of the clinic have become more robust and challenging, the administrative issues have multiplied through government intervention and legal complexities. To be sure many of the interventions are the result of our own choosing or, in some cases, shortcomings but they are in fact complications that we must endure and address. There are multiple aspects of the administrative side of practice. There are the legal aspects of employee relations, the fact that as much as we would all like to provide services to every needy individual, we still must meet payroll and accounts payable, thus requiring us to pay attention to accounts receivable. I suspect there are very few, if any, practices in our state or country that are in complete compliance with all agencies and protocols. That said we are obligated to make every effort to meet each requirement. There are several models for us to follow and each of us must decide which to embrace. The straight up individual, private practice may be the most difficult and have the potential of the highest personal risk and reward for some, the DSO concept is growing in popularity and acceptance, while government service at some level might be the "easiest" with perhaps less economic reward. It becomes a matter of risk tolerance and personal philosophy for the practitioner. What seems to be universal aids in all of the administrative models are communication and leadership skills. No matter how good we are at these skills we can all improve and that improvement, while not necessarily a directly measurable quality, seems to have a direct impact on our success and joy in practice.

As newly minted practitioners or even those who have been around long enough to have a little tarnish or patina on our degrees and licenses, the interest in the administrative part of the business of dentistry may not be at the forefront of interest. Let me relate that the biggest, most economically costly and humiliating mistake I have made in my 42 years of private practice was in this arena. I have not, cannot, completely recover from this mistake no matter how long I practice. In September of 2013 I discovered a trusted "friend" and business associate had been embezzling from my practice for over 5 years. Upon discovery I employed a forensic accountant who tore into my books and discovered $1.2M had been stolen. The perpetrator took me and my practice to the brink of bankruptcy and while the practice recovered solvency very rapidly, because of the nature of the loss there is and will never be a recovery of the funds. Look at your own retirement accounts and imagine the personal impact this type of loss would have. Further, this event affected my relationship with future employees, business associates and perhaps life in general for a number of years. Recovery from the emotional wound as well as the economic injury has been slow. An old man's advice; "Trust but verify." Make sure all monetary transactions involve at least two people and then have unannounced audits performed periodically by outside auditors. While this event had significant negative affect on me, it is my nature to be optimistic and to learn from every experience whether negative or positive. He only stole money and that can be replaced if not recovered. He did not get anything truly important.

So, what about the good stuff. I think the most overriding universally valuable assets any practitioner can have at any phase of practice, perhaps life, are mentors. I will caution the reader that as time passes your mentors are likely to pass too. That part of the relationship is tough. Many of mine are with me in spirit only at this point, but their impact is immortal if I live up to my commitment to at least one of them which is to be a mentor to the next generation of seekers. Mentors are more than teachers or coaches, although that is a big part of the package. Mentoring is an interactive affair and is not just admiration of one's skills or abilities but a symbiotic interaction involving mutual respect. Mentors should be at least as passionate as you, the mentee, are or want to be about the central subject of the relationship. They accept you as a friend or even family and the mentee must at least gravely consider their advice even in disagreement. I believe mentors are the single most important assets necessary to finding joy and fulfillment in practice. Have several.

I think the next important factor to success or failure in practice is attitude. A positive attitude, even in the face of adversity, will make a tremendous difference in the outcome of a situation in time. Does one's attitude instantly insure sunshine and roses? Not at all but perseverance and positivity will get you closer than you might imagine. Be willing to fail, make mistakes and recover. Learn from each misstep. A coach once said, "Success isn't forever, and failure isn't fatal." While we need to make every effort to achieve positive results, we must be adaptable to the negatives that are inherent in our environment. Our attitude is genuinely an internal affair, and we control it. There are hundreds of books and slogans and posters that address this fact of life, and I will not attempt to recite them all or even the tiniest portion of them, but they all encapsulate the truth around attitude and how we adjust to the world rather than thinking for an instant that the universe is going to adapt to us.

Perhaps I have become too philosophical for some but as I reviewed what was or is really important to my life and practice of dentistry these are my thoughts. It is not a specific tool, technology or technique, it is much more personal and controllable. I do not believe there is any tool, technology or technique that can make up for failure or insufficient application of the more fundamental personal efforts discussed.

In closing, let me return to my visit with my own health care provider. After, my opening comment to him regarding not retiring, he asked, "If you had a son (daughter) who was looking for a professional career would you recommend dentistry?" Without reservation or hesitation, I answered in the affirmative. What a great way to make a life! ◊

From Mild to Wild:

TREATING BOTH SIMPLE AND EXTREME BLACK TRIANGLE CASES WITH BIOCLEAR

BY DR. DAVID CLARK

Dr. Clark is director of Bioclear Learning Centers International. He founded the Academy of Microscope Enhanced Dentistry, creates curriculum for dental schools, and has lectured in twenty-seven countries. He developed the Bioclear Matrix System for placement of biologically appropriate, esthetically pleasing direct composite restorations for facilitating Injection Molding of the Clark Class I and Class II preparations, diastema closure and black triangle elimination combined with papilla regeneration. He is actively collaborating with schools to move beyond GV Black cavity preparations. Dr. Clark is a 1986 graduate of the University of Washington School of Dentistry.

BY DR. CHARLES REGALADO

Dr. Charles Regalado graduated from the University of Washington in 1991. He has over 20 years of clinical teaching experience in advanced cosmetic dentistry, advanced composite techniques and full mouth comprehensive treatments. He has published articles about Cad Cam dentistry and the Bioclear Method. Dr. Regalado is full faculty at the Bioclear Learning Center in Tacoma, WA teaching dentists from all over the United States, Canada and many areas of the world. He has served as the the supervising dentist at the EWU Dental Hygiene program in Spokane, WA and continues as part-time restorative faculty. He has lectured and taught groups as part of the Seattle Study Club. He resides and practices in Spokane, WA.

Treatment of Black Triangles has recently reached a significant threshold of consciousness for both patients and clinicians. Additionally, most orthodontists have begun to acknowledge that post-operative black triangles that appear after adult orthodontics is a real concern

Prevalence and Patient Attitudes. One third of adults suffer from black triangles, or more appropriately referred to as open gingival embrasures.[1] Besides being unsightly and prematurely aging the smile, black triangles are prone to accumulate food debris and excessive plaque.[2,3] Black Triangle occurrence after adult orthodontics is very common, and upsetting enough to the patients that some orthodontists are gun-shy to treat adult crowding cases or adults in general.[4-8] Age of the patient, duration of active treatment, crown morphology and degree of crowding are involved in black triangle manifestation and can readily be predicted before orthodontics is initiated.[9-14] In a landmark study, Dr. Joanne Cunliffe analyzed patient concerns and showed that patients are more concerned about black triangles than they are about dark teeth or crowded teeth, which is surprising to many esthetic-minded clinicians that prescribe whitening and adult orthodontics.[15] A quick internet search of dental black triangles will lead the reader to a seemingly never ending trail of patient questions, patient complaints, and now even lawsuits resultant from adult orthodontic cases and post-periodontal therapy papilla loss. Instead of sweeping these problems under the rug, this clinical and esthetic dilemma is a unique opportunity for us as cosmetic dentists to improve the functionality, confidence, health, and esthetics of these patients' oral condition.

In this article we will present two case reports. First, a life-changing, fairly extreme black triangle treatment is shared. This case was treated with the original anterior Bioclear matrix system. Second, a single, simple black triangle treatment is presented. In the second case the newer BT system was utilized. Both of these treatments utilize a recipe-based method which includes injection over-molding of the teeth utilizing special patented matrices, gauges, heated composite, and to remove both biofilm and the protein pellicle and simplified polishing to achieve a super-glossy finish.

Case #1: Extreme Black Triangle Treatment

Patients are often at a crossroads when it comes to their desire for a better smile. When options are financially beyond their ability, the dentist must seek a result that can provide a satisfactory solution while maintaining or even improving existing health conditions.

This 38-year-old female presented with severe bone and tissue loss with resultant extreme black triangles between several teeth. Most important to her was her upper smile. She was referred by her periodontist, who confirmed that the patient had excellent compliance over a course of prescribed treatment that included full mouth Scaling and Root Planing, LANAP, and had maintained consistent periodontal maintenance appointments at 3-month intervals. Inflammation was under control, and despite the severe loss of the periodontium, she had relatively low mobility with nothing beyond a 1 or 1+ designation. Her motivation was high, and she was eager to proceed with having her black triangles closed. The extreme amount of unfamiliar negative space (black triangles) presents a challenge both to the patient who must endure the emotional impact this creates and to the dentist who must treat the case.

Fig 1: Pre-operative full-face image demonstrates her discomfort showing her smile and esthetically crippling black triangles

Fig 2: Fig 2: Pre-operative smile presents a complex spatial challenge. Will adding such significant volume create pleasing tooth proportions?

Figs 3-4: Lateral views show that the black triangles between the canines and laterals were much smile, so the decision was made to close that space partially and unilaterally by not adding to the canines.

OPTIONS

Patients presenting with a severe degree of bone and tissue loss have been treated with invasive procedures, including extractions, block grafts, and implants.[16] Often, a prosthesis utilizing pink porcelain is needed to hide the remaining negative space. [17] If implants are not affordable or not deemed predictable, then extractions and removable prosthetics can be considered. Alternatively, full crowns are often recommended. Each of these options carries its own risk to reward, and the cost of treatment extends over a wide range and, in many cases, is out of reach financially for many of our patients.

This is an excellent case, in principle, for the Bioclear Matrix System and method. In principle, because with such large negative spaces to be closed, there are concerns about how that will affect tooth size and shape, and final proportions. [18] These issues must be relayed to the patient to avoid an embarrassment to the doctor and a disappointed patient. Two questions arise: Can the spaces be closed, and should all the spaces be closed? The former could result in unacceptable tooth proportions, and the latter may miss the mark from the patient's perspective and desired outcome. However, in the clinician's experience, most patients more often take the option resulting in the least invasive procedure and find the results more than satisfactory. The perception of a beautiful smile is what matters most, even when there are some compromises that must be made. [19]

After consulting with the patient, she chose to proceed with Bioclear Black Triangle restorations and to have as much space closed as possible since her condition was a major obstacle and had a negative impact on her public interactions. Her goal was a confident and pleasing smile, untethered to the often-used norms in dentistry used to evaluate "ideal" smiles. [20]

TREATMENT

The proper shade was chosen to match her existing color at the beginning of the appointment, followed by matrix selection. The key to correct matrix selection is to do a simple try-in of the various sizes of Bioclear matrices prior to placement of the rubber dam. A rubber dam is highly recommended to achieve total isolation and to expose more tooth structure below the visible gingival margin. The goals in matrix selection are to preview that the black triangle will indeed be closed adequately and to have no hindrances to being able to seat the matrices completely into the sulcus of each tooth. If this step is done after the rubber dam is placed, the dam compresses the tissue apically, and false information about the actual space needed to close would result in a selection of too large a matrix and excess lateral pressure to the papilla after injection molding. Excess pressure can distort the shape of the papilla that will be formed with this procedure. The correct matrix size and shape will allow just enough composite to close the black triangle and apply side pressure to support the papilla, enhancing long-term results.

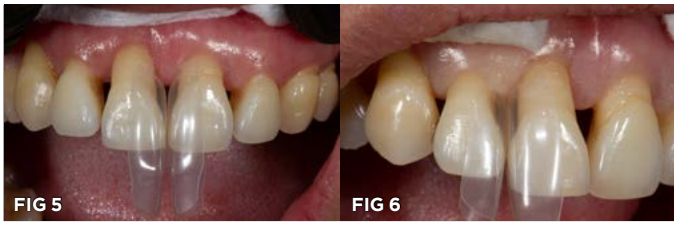


Fig 5: Matrix try-in before the rubber dam is key when using these dedicated space closure matrices to determine soft tissue displacement.

Fig 6: Matrix try-in affords a "diagnostic wax-up to predict final tooth shapes.

The Bioclear® DC-201 matrix was chosen as ideal to close the spaces between the central incisors and for the distal surfaces of the centrals as well. The smaller DC-203 matrix was used for the mesial and distal surfaces of the lateral incisors. All matrices were then set aside into designated and marked containers. (This case was done using classic Bioclear Matrices. At the time of the procedure, the Black Triangle Matrix Kit was not yet developed.)

The rubber dam was then placed over the anterior segment, and after properly tucking the dam into the sulci, the teeth were dried, disclosed with Bioclear® Disclosing Solution, and rinsed after 30 seconds. Teeth 7-10 were then cleared of all biofilm and protein pellicle with the use of the Bioclear Blaster® using aluminum tri-hydroxide powder under a high-pressure water spray. Prior to placing the matrices, interproximal contacts were entered with the Tru-Contact® serrated handheld strip and then lightly sanded with Tru-Contact® diamond sanders. This allows further removal of biofilm in these tight areas and allows complete seating of the matrices as contact tightness is reduced. The final amount of black triangle closure can be visualized by placing the matrices before rubber dam is applied. The dentist is able to assess whether the matrices are correct to close the space. If not, the matrix can be either customized or replaced with another that might improve the outcome.

Tooth #8 was chosen to be injection-molded first. The designated matrices for the mesial and distal were placed and seated into the sulcus. This forms a full 360º envelope or "aquarium" around the tooth. The matrices chosen for the mesial of #9 and the mesial of #7 were placed on their respective surfaces to act as "shield" matrices. These "shields" guard against over encroachment of composite into the interproximal space during the injection-molding process, eliminating accidental curing of composite beyond the desired shape as given by the matrix. Then, 37% Phosphoric acid was used to etch the entire tooth #8, rinsed after 15 seconds, and excess water was removed. 3M® Scotchbond Universal Adhesive was scrubbed into exposed dentin areas for 20 seconds, and air thinned. Then the entire tooth was copiously wetted with more adhesive to act as a surfactant for the composite as it is injection-molded. No pre-curing was done to the adhesive.

Warmed 3M® Filtek Supreme Flowable Restorative was slowly injected into the matrices around tooth #8 by placing the tip of the syringe into one interproximal area on the facial side, allowing the composite to flow slowly to the lingual half of the tooth. The same process was repeated to the other interproximal area. The lingual half of the tooth was then filled to completion. Great care is taken to ensure that void-free flowable composite has filled much of the matrix system prior to adding the paste composite. Heated 3M® Filtek Supreme Ultra Universal paste composite was then injection-molded into the matrix system. The heated paste composite displaces excess adhesive as well as much of the flowable composite leaving a dense monolithic mass composed chiefly of the paste composite. After cleaning up excess with the Bioclear Paddle Instrument and dry brushes along the gingival areas, the composite was light-cured on both facial and lingual surfaces for a minimum of 20 seconds per side.


FIG 7

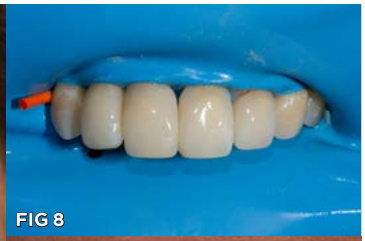


FIG 8


FIG 9

Fig 7: After the entire tooth is ensconced with the injection over-molding, it is rapidly sculpted and polished creating a margin-free and stain resistant surface.

Fig 8: Esthetic reveal after rubber dam is removed. Elimination of unfamiliar negative space is nearly always a dramatic improvement.

Fig 9: Post-operative full-face view highlights this life-changing treatment.

Using a Komet®coarse diamond flame-shaped bur and 3M® Soflex Coarse discs, the cured composite was shaped to roughly 80% of the final desired tooth contours. Once this is achieved, the same process was done to tooth #9 and subsequently to the lateral incisors.

Final shaping was completed with the 3M® Soflex Coarse disc, followed by a final polish using Bioclear Magic Mix pre-polishing paste and the Bioclear Rockstar Polishing cup. (Figure 7) Rubber dam was removed, and the smile was evaluated for facial harmony. Adjustments were not needed for this patient as she was pleased with all aspects of her smile. (Figures 8- 9) Post operative radiographs were taken to assess for excess composite and quality of technique and can be compared to the pre-operative x-rays. Post operative radiographs are useful for quality control. Notice how a smooth "infinity edge" can be created with the Bioclear matrices and technique. This is essential for a healthy tissue response. (Figures 10-11)

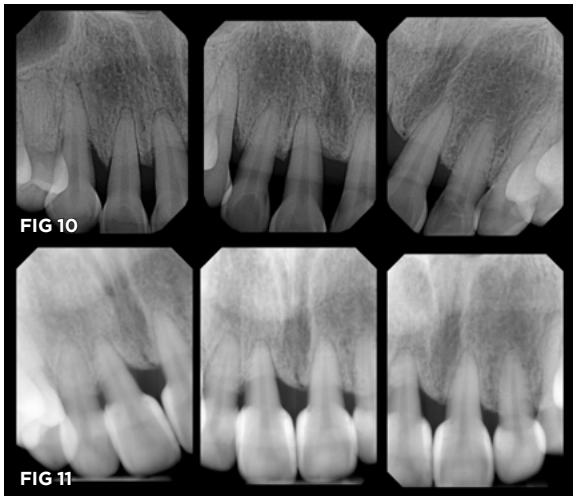


FIG 10

FIG 11

Figs 10 and 11: Pre- and Post-operative radiographs demonstrate an aggressive yet healthy and precise change in contour that both orthodontists and periodontists are grateful to see.

Final Result: While there was great concern over the effect of the added volume of composite and how it may negatively affect the tooth contours and thus the overall smile, it is shown that the results were highly acceptable. The patient was more than happy and was pleased that she opted for Bioclear to solve her dilemma. With wide variations of perceived beauty in a smile, this is not surprising. [20, 21]


FIG 12


FIG 13

Figs 12-13: Four year follow-up demonstrates both stain resistance of restorations and stability of the restoratively-driven papilla regeneration.

One of the greatest benefits of using Bioclear in closing black triangles is the added stability that periodontally weak teeth can obtain. In this case, stability was improved further at the two-year mark. (Figures 12, 13) The 4-year results are proving to be color stable and free of inflammation (not shown). As often seen following cosmetic dentistry, the improvements are dramatic and result in a more relaxed and confident smile.

Fig 14) Pre-operative view with pursed lips

Fig 15) Retracted view of the mandibular incisors and black triangle #24-#25

Fig 16) Lateral view showing the smaller black triangle #23-#24 not visible in the straight on view

Fig 17) Lateral view showing the smaller black triangle #25-#26 not visible in the straight on view

Case #2: A Single Black Triangle Treatment

This 34-year-old male contacted the Bioclear Clinic in Tacoma WA USA after doing an internet search on treatment of black triangles. Like many adult patients who complete orthodontics, he had black triangles that appeared during adult orthodontic treatment. (Figs 14,15) The patient received a complete examination including necessary radiographs and photographs. Although the patient had five black triangles present, he elected to just have the larger midline area single black triangle treated. The patient received a full explanation regarding the limitations of treating just the single area in lieu of a more comprehensive treatment. Proper photographs from a lateral view are critical in these cases because a frontal view which is what the patient sees, is different from lateral views which is what everyone else sees. (Figs 16, 17) In the author's significant experience treating these types of cases, it is rare to treat a single black triangle. This case will therefore provide a rare and enlightening contrast of treated versus untreated areas when we view the two-year follow-up.

The Bioclear (Tacoma WA USA) BT kit used in case one is shown in figure 18 with the four important components: small and large BT matrices in four different and color-coded emergence profiles, dual color

Fig 18) The Bioclear BT kit is shown with both large and small matrices each with four colors of matrices, gauge, sanders, and disclosing solution.

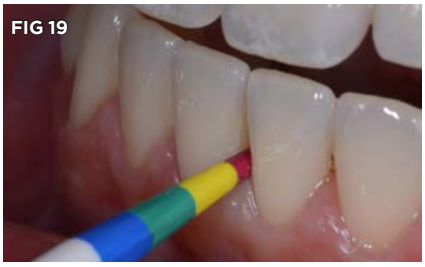


Fig 19) Black Triangle sizing gauge inserted from facial. Instructions in the kit recommend inserting gently below the contact from buccal to lingual, and also lingual to buccal (not shown).

disclosing solution, the black triangle sizing gauge, and the TruContact sanders. Additional materials and instruments are explained in the body of the article. First, the Black Triangle gauge is inserted buccal-lingually below the contact to assess the mesio-distal size of the black triangle. (Fig 19) The gauge will bind at one of the four colors. In this case the gauge binds in the pink zone then a pair of correspondingly color-coded Black Triangle matrices are tried in for each embrasure. Before the rubber dam is placed, the TruContact sanders are used to groom the contact area to remove calculus and to lighten the tension of the contact areas to allow the matrices to seat fully. (Fig 20) Once the rubber dam is placed, the teeth are disclosed (Fig 21) and then blasted with an air/water/abrasive slurry of aluminum try-hydroxide (Fig 22) (Bioclear Blaster). The 37% phosphoric acid used to condition the teeth does not remove the soft, sticky biofilm that covers the tooth. It is therefore imperative that the teeth be aggressively cleansed before

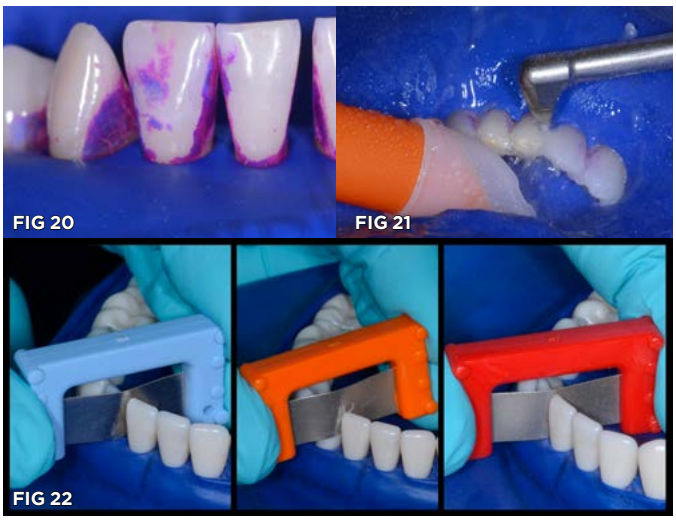


Fig 20) Disclosing solution (also in the Bioclear kit) is placed on the dry teeth to aid in identification and removal of biofilm and the protein pellicle.

Fig 21) Bioclear blaster is utilized and sprayed from both buccal and lingual directions.

Fig 22) The contacts are lightly sanded to allow full insertion of the matrices.

acid-etching. Additionally, we now understand that the protein pellicle that coats the tooth must be removed to achieve an ideal bond. The interproximal area is extremely difficult to access with scalers and prophy cups and is of course the exact area that we are attempting to bond to when treating black triangles.

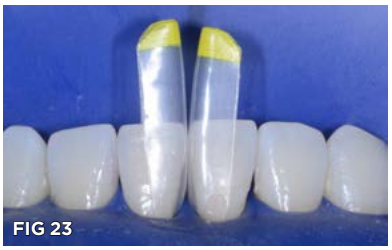


FIG 23

Fig 23) The "yellow" small BT matrices were selected in lieu of the less curvaceous pink matrices. In the author's experience, the gauge is an important starting point for matrix selection, but clinical try in of the matrices is the ultimate indicator.

In general, the BT gauge will match the profile of the corresponding matrices, but in this case the more aggressive emergence profile matrix, or yellow BT matrices are chosen because of the unique shape of the teeth even though the gauge suggested the pink color. (Fig 23)

The first tooth is injection molded with a 3-step process. First an adhesive such as Scotchbond Universal Plus is placed on the previously etched enamel, it is air-thinned but not light cured. Next, warmed flowable composite is carefully injected using the uncured adhesive as a wetting agent, or surfactant, to minimize air entrapment and maximize flow into the acute matrix-tooth interface. The flowable composite is injected from both the facial and lingual directions. The flowable is not light-cured yet. Finally, warmed paste composite, in this case Filtek Supreme Ultra Shade B-1B is injected from the facial direction. The paste easily displaces the flowable composite to the lingual and incisal vent areas. The goal is that the final percentage of paste composite versus the flowable composite is 90% /10%.


FIG 24


FIG 25


FIG 26

Fig 24) After the first tooth is injection molded, the matrix from #25was removed. Note the Mylar finish. Half of the embrasure is rejuvenated.

Fig 25) The second tooth is then injection molded.

Fig 26) Immediate post operative view of the finished treatment incorporating the Rock Star Polish method (Bioclear).

The matrix is removed from tooth #25, (Fig 24) and then #24 is injection molded. This to ensure a snug contact. The teeth are then rapidly sculpted together for sake of symmetry and efficiency. The final step is the Rock Star Polish. Invisible infinity edge margins are placed at mid-tooth. (Figs. 25, 26) At one-year recall, the treated area is essentially bacteria and calculus-free, and the neighboring untreated embrasure is filled with calculus. The obvious health and quality of life of the treatment are a bonus to the esthetic benefits. (Fig 27) Pre- and post-operative radiographs demonstrate the imperceptible interface of composite to tooth and the void -free quality of the composite which is the goal if injection over-molded heated monolithic composite. (Figs 28, 29)

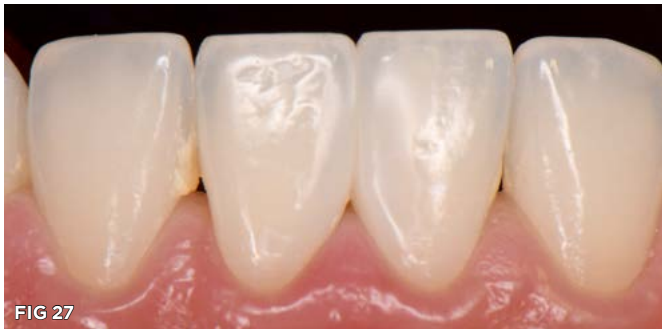


FIG 27

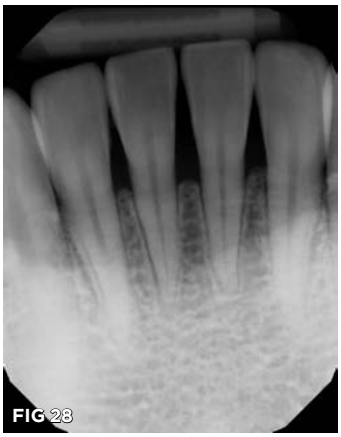


FIG 28

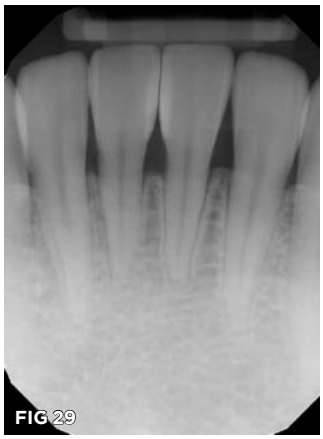


FIG 29

Fig 27) Two-year postoperative view. Note the Infinity Edge finish line, lack of calculus build-up, and excellent soft tissue response #24-#25 and at the same time calculus in the untreated embrasure #25-#26

Fig 28, 29) Pre- and post-operative bitewing demonstrate the marginal integrity and the lack of voids.

Summary: Traditional hand-spackled composite placement for treatment of Black Triangles has historically been viewed with skepticism by many restorative dentists, orthodontists, and periodontists. Until now, our confidence as clinicians to treat "Black Triangle Disease" is so guarded that that most patients are told that there is no healthy option. Patients are often told that either nothing should be done or are offered aggressive and physiologically costly procedures such as crowns, veneers, physiologically inappropriate interproximal reduction (IPR) during or at the end of orthodontic treatment. Surgeries and dermal fillers are rarely a predictable, long-term solution. The problem should not be underestimated as one third of adults suffer the esthetic and functional dilemmas associated with "Black Triangle Disease. [3] ◊

Article references can be found on the Washington AGD website's home page at www.washingtonagd.com

Interdisciplinary Relationship of Orthodontic Treatment with Periodontal Health

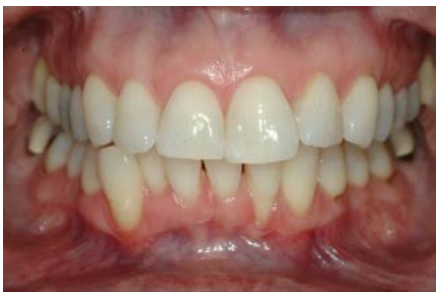
WHAT TO LOOK FOR IN AN ORTHODONTIC INVISALIGN PATIENT TO AVOID RECESSION - A STEP BY STEP GUIDELINE TO EVALUATE THE ALVEOLAR BONE AND THE GINGIVA FOR THE GENERAL PRACTITIONER

BY DR. MINOU KARBAKHSCH

Dr. Minou Karbakhsch completed her dental education in Göttingen, Germany, where she practiced general dentistry and was an assistant professor at the Medical University in Hannover, Germany, where she also completed her Doctoral Dissertation (Ph.D.).

Dr. Karbakhsch completed the Postdoctoral Program in Periodontics/Implants at the University of Washington in Seattle. In addition, she also completed a one-year Implant Prosthetic Residency with special emphasis on anterior implant restorations and aesthetics at the Graduate Prosthodontics Department of the same university.

Upon completion of her training, Dr. Karbakhsch taught at the University of Washington. She has been in private periodontal practice since 1999, with her current office located in Tacoma.



We were asked to write an article about "the latest in periodontics" for our dental community. We thought long about what would be the "latest"and of clinical importance for our colleagues – what would be worth the readers time and most importantly, what could they incorporate in their daily dental practice immediately.

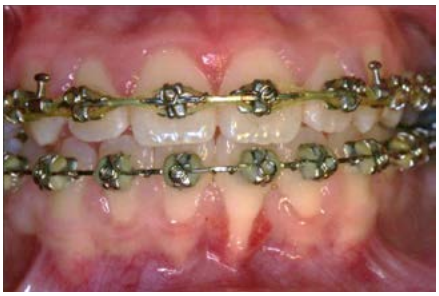
In order to be of any therapeutic relevance, new treatment approaches and techniques are commonly the result to a preexisting clinical challenge. Thus, we started to think about our recent observations and challenges in a periodontal practice, both in Germany and the United States.

And there it was: Gingival recession secondary to aligner treatment. This has become a common dental problem and we feel strongly that the "post orthodontic recession" can be avoided by considering the following clinical steps prior to treatment.

The purpose of this article is to provide you with clinical guidelines on how to predictably plan your orthodontic cases and to avoid gingival recession in your orthodontic patients. We will review basic biological facts and treatment principles for patients suffering from malocclusion and wanting to undergo orthodontic treatment.

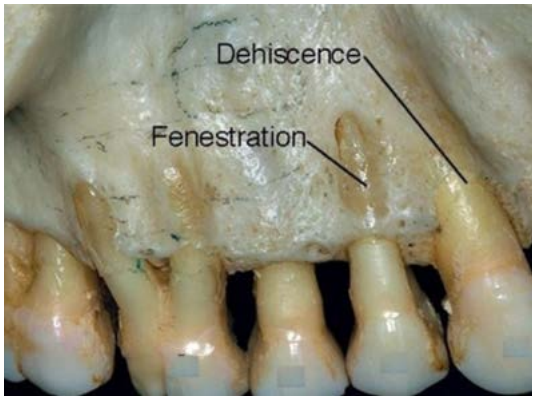
What happens during orthodontic tooth movement?

Bone resorption occurs in the direction of tooth movement causing a reduction of bone volume and an apposition of bone on the "pull" or back side of the tooth. It is important to understand the biologic concept of "bone remodeling" for the evaluation of the orthodontic treatment endpoint with respect to gingival stability.



Recession #24 : developed spontaneously overnight in this 16 year old orthodontic patient

The clinician should evaluate the proposed treatment endpoint of the aligner application with respect to the present alveolar bone volume and ask: Will the teeth in their new, post orthodontic position remain within the alveolar bone or would they be outside of the alveolar housing? When tooth



movement exceeds the natural volume of the alveolar volume, the patient will be at risk for the development of gingival recession.

What are the causes of gingival recession?

To avoid confusion, we like to share the current definition as defined by the world workshop on the classification of periodontal and peri-implant disease 2017.

a. **Periodontal biotype:** Gingival thickness and keratinized tissue width

b. **Bone morphotype:** Buccal bone plate thickness

c. **Periodontal phenotype:** Combining both, the gingival thickness and keratinized tissue width and the buccal bone plate thickness. Periodontal phenotype can be evaluated through clinical or radiographic assessments and may be divided into invasive/non-invasive (for gingival thickness), static/functional (for keratinized tissue width), and bi/tridimensional (for buccal bone plate thickness) methods.

The following factors play a role in the development of gingival recession :

- Position of the tooth in the alveolar housing
- The bone volume of each jaw in relationship to tooth/root size
- Oral hygiene status
- Low level and long-lasting chronic trauma: ie. Tooth brush trauma

Let's start by looking at the soft tissue as it relates to the development of recession. Considering the gingival biotype, the gingival morphology, has been defined as thin scalloped, thick scalloped and thick flat.

Patients with a thin biotype (<1.5 mm) have been considered to be more susceptible to gingival recession than those with the thick biotype. Bony dehiscence's and fenestrations are often associated with a thin alveolar bone plate compared to a normal or thick bone plate.

How do alveolar defects look, where are they located and how common are they in your patients?

Alveolar bone defects are classified as:

Dehiscence: a "V" shaped boney defect extending from the most coronal alveolar crest , the crown oft he tooth to the apex oft the alveolar ridge. There is no alveolar crest present in a dehiscence defects.

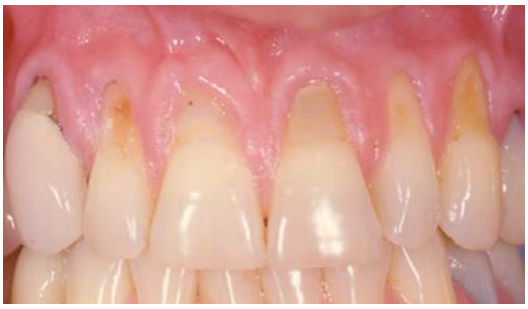
Fenestration: Usually occurs in the middle or apical third of the root. The alveolar crest remains intact resembling a "boney window"

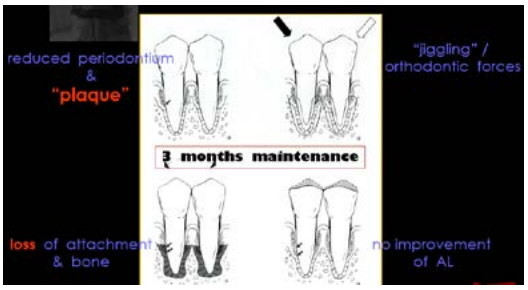
Alveolar bone dehiscence's and fenestrations are present in all ethnic groups and all types of malocclusion. Dry skull studies and later studies on CBCT (cone beam computer tomograph) have shown the following prevalence with respect to malocclusion.

Angle's Classification	Class I	Class II	Class III
Dehisence & Fenestrations	51,09%	36,51%	42,64%

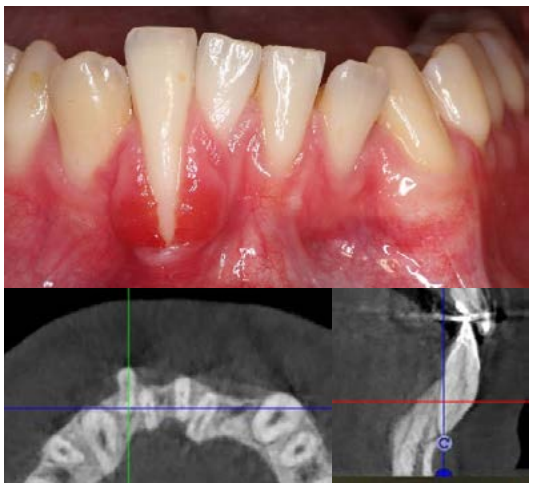
The presence of alveolar bone defects is closely related with gingival recession. Tooth movement in the presence of alveolar bone defects will increase the risk of gingival recession.

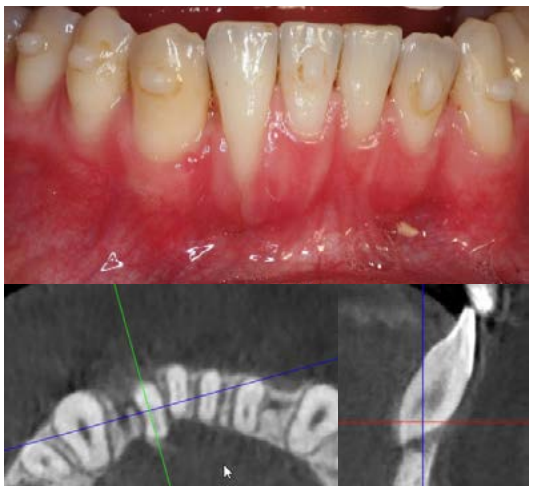
Since the prevalence of alveolar bone defects is present amongst all types of malocclusion, considering the type of malocclusion is an important criteria in the orthodontic planning of your cases.





The picture above shows how periodontal bone and attachment loss occurs in the presence of plaque and orthodontic forces - keep patients on a 3 months periodontal maintenance and good oral hygiene to avoid attachment loss.





We strongly recommend to assess the bone volume under consideration of the direction of tooth movement. Using the CBCT, the root to bone relationship should be assessed prior to any tooth movement to avoid the immediate or delayed development of recession.

The effect of tooth inclination on the periodontium

Gingival recession occurs with proclination of the tooth. The retroclination of teeth is not associated with recession. Gingival recession increases 0.2mm with every 1 degree of labial inclination. Clinically, this is relevant in patients with a thin alveolar bone plate which is susceptible to alveolar bone resorption and subsequent gingival recession.

Oral hygiene status

Dental biofilm left at the dento-gingival junction leads to gingival inflammation. Chronic inflammation, causes enzymatic digestion and disorganization of the underlying connective tissue and bone, once again resulting in bone resorption and gingival recession.

Improper tooth brush technique, results in gingival trauma and inflammation and with time can cause recession and attachment loss.

Occlusal trauma in the presence of bacterial plaque and biofilm

Primary occlusal trauma can cause pain and increase tooth mobility. Clinically, the continued stretch of the fibers is association with increased tooth mobility and crestal bone resorption . Radiographically a widened PDL is visible.

The loss of cervical alveolar bone in the presence of inflammation causes a 'V'- shape defect. The gingiva follows the bony contours and results in gingival recession.

For patients suffering from occlusal trauma in the area of recession, eliminating the interference is an important treatment step in recreating periodontal stability for the patient.

In orthodontic patients, tooth movement in the presence of dental biofilm / plaque will lead to bone and attachment loss. Placing your orthodontic patients on a 3 month periodontal maintenance therapy and effective oral hygiene will maintain the periodontal attachment level.

Putting it all together ... clinical steps for your patients demonstrated on a clinical case

Prior to orthodontic treatment the periodontal parameters (soft and hard tissue) should be assessed and evaluated.

The initial labial gingival thickness (IGT) can be measured in different ways:

a. Visual inspection for probe transparency

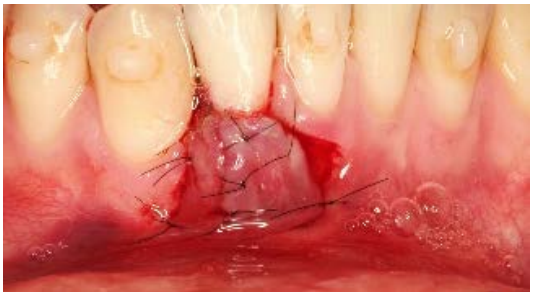
b. Sounding with a periodontal probe

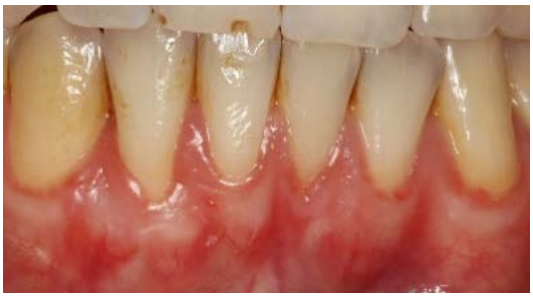
c. Cross-sectioned image of digital model scanning and a superimposed image with the CBCT.

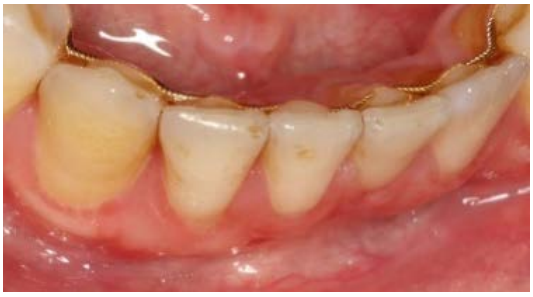
The initial labial alveolar bone thickness (IBT) can be measured via a sectional image of a CBCT Scan.

Case example: The patient received previous orthodontic treatment and relapsed. The patient is now planned for corrective orthodontic and was referred to a periodontist for pre – orthodontic clearance.

Clinical presentation 3 years after completion of orthodontic therapy – CBCT scan shows complete lack of buccal bone #26, and 24 , lack of lingual bone #25,23. Clinically: thin scalloped gingiva with advanced recession #26.







PRE – ORTHODONTIC CHECK LIST	RISK FACTORS
Customized oral hygiene instructions	
3 months periodontal maintenance at GP or periodontist	
Gingival inflammation	
Labial gingival thickness	
Labial bone thickness |CBCT	
Direction of tooth movement	
Proclination of incisors	
Orthodontic retention |fixed or removeable	
Pre – orthodontic evaluation |referral to periodontist	
Planned surgical procedures before, throughout or after orthodontic treatment	
Discuss the risks and possible periodontal treatment needed prior to starting the orthodontic treatment- process - obtain patient consent.	

Clinical scenario after alignment of mandibular anterior and prior to soft tissue augmentation for root coverage.

Clinical follow up 3 months post operative: Healing after connective tissue augmentation using a double papilla technique . The orthodontic alignment and soft tissue repair was managed successfully and maintained stable for this high risk orthodontic patient.

Prior to orthodontic treatment the anticipated tooth movement and force applied needs to be evaluated. The use of virtual treatment software provides you with a suggestion of the final treatment outcome . Often the software simulation does not reflect clinically achieveable results. Your orthodontic knowledge here is crucial , often requiring your input and correction of the simulation to create an achievable and stable treatment outcome . Please do not hesitate to object and correct here remembering the biologic and physical limitations to tooth movement.

The nature of orthodontic tooth movement:

To make orthodontic treatment possible bone resorption takes place in the direction of tooth movement, leading to reduction in the alveolar bone volume. As long as the tooth movement stays within the alveolar housing, bodily tooth movement does not cause recession.

The rotational movement of teeth progressing in the same pattern as the bodily movement does not cause significant gingival recession.

Be careful with proclination of teeth. Gingival recession increases 0.2mm with every 1 degree of labial inclination.

For a predictable treatment on your patient, please use the following summarized checklist:

Evaluate for Periodontal referral

Depending on the dento – alveolar and mucogingival parameters of your patient, the following procedures may be recommended by your periodontist prior to tooth movement:

- Mucogingival procedures: Gingival autograft (Free gingival graft) , connective tissue graft for allograft procedures for gingival augmentation and / or to create band of thick keratinized tissue and a vestibule.
- Surgically facilitated orthodontic treatment (SFOT)/also known as periodontally accelerated osteogenic orthodontics (PAOO). This procedure has the potential of allowing safer orthodontic treatment in vulnerable periodontium with thin phenotypes.

SFOT/PAOO is a phenotype modification therapy (PhMT) approach where thin bone morphotype and/or gingiva are surgically augmented to convert a fragile-thin to a robust-thick periodontal environment without the adverse effects such as development and exacerbation of bony dehiscence or fenestration defects, which can manifest itself as loss of periodontal support and gingival recession

Remain mindful of late occurrence of recession. Eventhough recession might not be present at time of orthodontic completion, studies have reported that they can develop 3 years and later after treatment completion and retention.

An interdisciplinary approach consistent of a thorough periodontal examination and evaluation of the hard tissue with a CBCT are considered the golden standard for adult patients prior to their orthodontic treatment.

We have created a pre-orthodontic check list as a clinical reference for you. We hope that this will be of good use to you and your patients. ◊

Treatment of Partial Edentulism

BY DR. CHANDUR WADNWANI

Chandur Wadhwani, BDS, MSD, is a prosthodontist in Bellevue, WA. He is an assistant professor in prosthodontics at the University of Washington, as well as Loma Linda University. He is an associate professor at Oregon Health Sciences University. He has been recognized by the American College of Prosthodontics with their highest award, Distinguished Lecturer, as a result of all his research, teaching, and publications. He can be reached at Nwprosthodontics.com.

Article references can be found on the Washington AGD website's home page at www.washingtonagd.com

The use of dental implants in the treatment of partial edentulism is fast becoming a treatment of choice, in fact, worldwide millions of implants are expected to be placed and restored in the coming year.[1] However, implants are not without issue, peri-implant disease (both mucositis and peri-implantitis) is expected to occur in around 50% of all implants. Restorative issues affecting a significant number of implant restorations is also becoming recognized, with the most common issue being implant-abutment (IA) screw loosening. [3] Multiple studies have reported the incidence of IA at around 5-12% within the first 5 years post restoration of the implant [4-7] There are several reasons why screw loosening is such a common event in dentistry that should be addressed if the risk is to be reduced. The most common reason for this joint failing is operator error, either due to misunderstanding how the joint functions or misuse of the tools or components.[8]

Firstly, dentists are not well founded in engineering concepts as they relate to screw joints, and how to optimize them. When the screw is tightened to the manufacturers recommended torque it is being stretched in a manner that produces tension within the screw, pulling it together and optimizing the screw joint. If under-tightened the screw joint fails prematurely, if over tightened and lateral forces (such as cyclic chewing forces) are placed on the joint it also fails. Therefore, the screw torque must be carefully controlled. To do this several devices are available, known as torque limiting devices. They can be electric or manual wrench types. Electric devices have been shown to be inaccurate and manual wrenches are preferred.[9]

However, these too can present with issues such as speed of activation, where toggle type wrenches must be used slowly over 2-4 seconds otherwise the target torque will not be reached. [10,11] The beam type wrenches, although not affected by speed of use, must be viewed exactly at 90 degrees to both beam arm and marker otherwise inaccuracies due to parallax occur.[12] Maintenance is also important, the toggle type wrench must be completely disassembled, cleaned and oiled after each use to prevent the internal mechanism from sticking, which could cause the device to under-read by upto 400% [13]. It should be stored in a zero torque state so the spring does not work harden. (Fig. 2)

To ensure the torque devices are functioning correctly they should be calibrated and checked very regularly as set out in the International organization standards (ISO) 6789. Unfortunately, in a survey of over 400 dentist only 6% of dentists have checked their torque wrench for accuracy and precision. [14]. The author has published several papers on how to check and calibrate implant torque wrenches by the clinician.[15-17] These are available on request by contacting: NWProsthodontics. com.

If in doubt there are companies available on the internet that check torque wrenches, alternatively contact your implant manufacturer for further advice. Componentry is also part of the screw joint, it is not just the screw that functions to stabilize the joint. Multiple studies have shown that original manufacturers components have the advantage

nakanishi

IMPLANT TORQUE SPECIFICATION GUIDE CONT.

Manufacturer	Implant	Torque (Ncm)	Torque Settings	Driver & Head
Nobel Biocare®				
	ASC	35 Ncm	Nobel Biocare®Omnigrip	●
	Nobel™3.0	15 Ncm	Nobel Biocare®Unigrip	✱
	NobelReplace™ / Conical Connection / Brånemark	35 Ncm	Nobel Biocare®Unigrip	✱
Straumann®				
	Bone Level / Tissue Level	35 Ncm	SCSScrewdriver	✱
Thommen				
	SPI®	25 Ncm	Four Lobe	
Zimmer Dental				●
	Tapered Screw-Vent	35 Ncm	(.050) 1.25 mm Hex	●

Table 1. A sample of implant torque specifications. Available from Nakanishi Dental Laboratory. www.nakanishidentallab.com

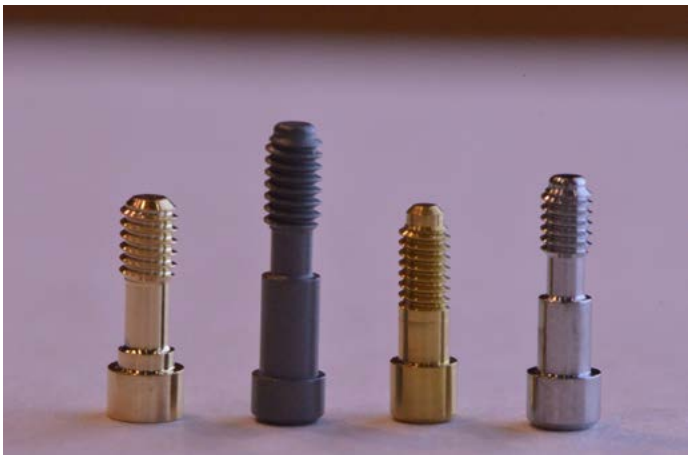


Fig. 1 Screws with different surfaces require different tightening protocols. From left to right: Anodized, DLC (diamond like coating), 23 Carat Gold, Titanium Alloy

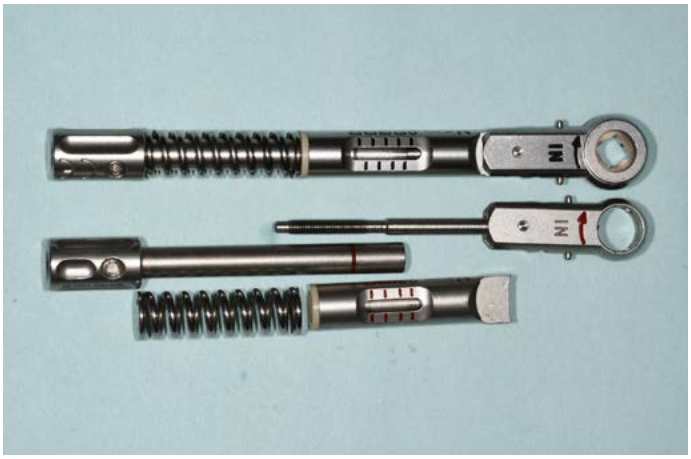


Fig. 2 Manual toggle wrench. Post use it must be disassembled, oiled, then re-assembled and stored in a zero torque state.

over third party components when evaluating tolerance, rotation and displacement within the joint. [18-20] Although third party components are generally less expensive to use, one must weigh this against the sequela of screw failure which include: peri-implant mucositis, peri-implantitis, abutment wear or fracture, implant wear or fracture and the economic cost of chair time spent having to retighten a screw.

Many different theories have been developed regarding the screw tightening process, unfortunately some have no merit. For example, some studies suggest that the screw should be tightened with a "waiting" period between successive tightening.[21] The study that first advocated this was in 2002 where a single tightening event was compared to tightening, waiting 10 minutes and retightening. The study was poorly done with a sample size of 2, and there was no reasoning why 10 minutes wait was used- it could have been any time from1 second to hours. Many studies have disputed the wait period- in fact if one considered other industries, for example Formula 1 racing- the time taken to change 4 wheels, each held with one screw is 1.83 seconds, never do they wait another 10 minutes and retighten!

What has come to light is that the screw material determines the tightening protocols due to friction, gold plated screws should be tightened to target torque, untightened, tightened again to target torque, untightened and finally retightened to target torque. [22] Anodized titanium screws need only be tightened 1 time, and DLC (black diamond like coated screws) are optimized by tightening 2 times to target torque without a need to wait.

Screws can on occasion be reused, if they have not loosened prematurely [23] and are not made with a gold coating [22], again consider what happens when your car has its tires changed -the technician never uses old screws and sells you new ones.

Other factors that are not under the control of dentists also factor into why the IA joint fails, primarily due to the dynamic nature of the stomatological system. Teeth continually move, both with mesial drift and dento-alveolar growth which is a life-long event. [24] Mesial drift and occlusion account for approximately 50% of teeth adjacent to implants having a lighter or open contact within 3months- 11 years [25]. Relative infra-occlusion of implants compared to teeth due to facial growth is also known to occur in approximately 50% of the population[26]. To counter this, a retainer similar to that provided by orthodontists should be provided to the patient at the completion of implant restoration.

Finally, with so many dental implant systems available today, many using different screw driver designs as well as having systems with differing screw system torque values, it is useful to have a chair side chart available. Some dental laboratories provide these as a quick reference an example shown in Table 1. These can be obtained on request by contacting Nakanishi Dental laboratory directly. [27]◊

Opioid Training and the New DEA Requirements

BY DR. MICHAEL D. SILVERMAN

Dr. Michael D. Silverman is a globally recognized lecturer, educator, author, and patient rights advocate. A graduate of the University of Pennsylvania School of Dental Medicine and a passionate believer in lifelong continuing education, he has changed the way tens of thousands of dentists practice. Having appeared in front of numerous dental boards to advocate for the right of dentists to provide sedation in an environment of safe and reasonable regulations, Dr. Silverman continues to impact dentistry as a champion of safe and effective minimal and moderate sedation.

In response to the ongoing opioid epidemic, the Federal Drug Enforcement Agency (DEA) has updated its requirements for practitioners who write prescriptions – including dentists. In accordance with the Medication Access and Training Expansion (MATE) Act, all DEA-registered clinicians must complete a one-time eight hours of training on the treatment and management of patients with opioid or other substance abuse disorders.

Beginning on June 27, 2023, dentists will be required to check a box on their online DEA registration form – for either initial registration or renewal – confirming they have completed this new requirement to earn or maintain their DEA license. Dental professionals are already familiar with the protocols necessary to screen and treat patients for substance abuse concerns; there is, even more we can learn when addressing pain management.

Fulfilling the DEA MATE Requirements

In response to this change, Meharry Medical College – a DEA-certified CERP provider – partnered with the Washington AGD through its affiliation with DOCS Education to create a new 8-hour online course that fulfills this new one-time opioid course requirement for DEA registration. Through a comprehensive understanding of the history and pharmacology of opioid addiction, practitioners will better recognize the signs of use, dependency, and abuse, as well as a framework for prescribing opioids.

The training will help dentists review the risks and benefits of opioid prescribing, explore alternative pain management, and understand the mechanics of addiction. By examining substance abuse disorders and alternate solutions, doctors can confidently approach pain medications without contributing to the problem of drug addiction. "The level of detail was scientific and factual. All of the information was useful for any practitioner in business. This was an experience was beyond reproach," according to Dr. Perry Jeffries, who recently met the DEA-required training.

Alternative Solutions for Pain Management

In addition to learning how to identify and treat patients with substance abuse disorders, it's vital to manage dental pain and explore alternative methods. Therefore, this course specifically addresses how to optimize the use of non-narcotic painkillers, including different types of NSAIDs in combination with acetaminophen. Dentists can also identify new local anesthetics that may reduce the amount of pain medication needed after surgery.

Additionally, it's important to review the necessary steps to remain DEA-compliant through proper recordkeeping and dispensing, storing, and destroying controlled substances in the dental office. While it may seem as though the dental profession is facing constant updates in rules and regulations, the Washington AGD is confident that the continued collaboration with Meharry Medical College, and its affiliation with DOCS Education, will help dentists meet and exceed the new DEA requirements. And potentially save lives.

People from all walks of life – people we know – can develop an opioid addiction following surgery or medical treatment. As dentists, we have a responsibility to not only understand substance abuse but to ensure that we don't become part of the problem. ◊

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Dr. Linda Edgar Set to Tackle ADA Presidency

BY DR. LINDA EDGAR

Dr. Linda Edgar, one of the most prominent alumni of the University of Washington's School of Dentistry, has been chosen to be the president-elect of the American Dental Association (ADA). She will become the first UW dental graduate to hold the organization's presidency when she assumes the office in 2023.

Dr. Edgar, a resident of Federal Way, Wash., was elected during the ADA's annual House of Delegates meeting in Houston. An ADA member since 1992, she served in the House of Delegates from 2005 to 2018. She also served as the ADA's Eleventh District trustee and on the ADA's Council on Dental Practice, Business Innovation Committee, and Budget and Finance Committee.

From 2013 to 2014, she was president of the national Academy of General Dentistry. She was president of the Seattle-King County Dental Society from 2010 to 2011. She practiced privately with her husband, fellow UW dental alumnus Dr. Bryan Edgar, for 27 years in Federal Way before they retired in 2020. Before entering dentistry, Dr. Edgar was a teacher in Auburn, Wash., for 15 years, and she holds a master's degree in education.

She and her husband have been two of the dental school's leading supporters. From 2000 to 2008, they co-chaired the school's Campaign UW fund-raising drive, which garnered $22 million and substantially exceeded its goal.

Dr. Edgar's involvement with organized dentistry has also included organizations such as the Washington State Dental Association, Pierre Fauchard Academy, American College of Dentists, International College of Dentists, Academy of Dentistry International, and Washington Academy of General Dentistry.

Dr. Edgar was a top-level distance runner who completed at least 45 marathons and competed in the first Women's Olympic Marathon Trials. She also completed two full Ironman races.

"I believe collaboration is very important, and I know it can move dentistry forward into more new and innovative programs and ideas," she said in 2021 when she disclosed her plans to run for the ADA presidency-elect. At that time, she also noted the country's rising dental workforce shortage and said, "I would like to see ADA be more proactive helping young people and diverse groups choose careers in dentistry." Since winning the American Dental Association (ADA) presidency-elect last October, Dr. Edgar ('92) has conducted a whirlwind national series of visits with ADA component units and other dental groups. Scarcely a day has gone by when she hasn't popped up on Facebook after another meeting to hear dentists' concerns that will help inform her yearlong presidency, which begins in October. Slated to be the first UW dental graduate to hold organized dentistry's most prominent office, she set forth her goals in a speech to the ADA House of Delegates last October. She focused on three big themes: "Connect, collaborate, communicate."

"I believe to grow the ADA and keep the profession strong, we must do these things better," she told the Dental Alumni News this spring. "We must connect with our members so they feel that ADA is a big organization that feels like a small organization and has a personal connection with our members, so they really feel they are listened to and their opinion matters. It should be there to help dentists when they need us the most, whether that be through our wellness or mentor programs or the close to $2 million a year ADA spends to help states with insurance laws. We need to get back to the personal touch of helping each other. We are hard-wired to connect with other humans and help each other. That is when we are the happiest.

As for collaboration, she noted her 30-year record of service elsewhere in ADA, as president of the Academy of General Dentistry, and on our School's Dean's Club Board of Trustees: "I have seen the power of groups coming together for a cause. I would love to see all our dental groups, all our specialty organizations, and the Department of Education and dental supply corporations come together and support education to the public.

If we all come together, we could bring forth programs like Lessons in a Lunchbox, created by [pediatric dentist] Dr. Winifred Booker for second- and third-graders to encourage nutritious eating and brushing during the day. We could also encourage children to enter the dental field by putting a little white coat on a first grader – taking their picture and saying 'You too can be a dentist or hygienist or assistant.' Discussing communication, she said, "We need to tell our ADA story better and answer the question 'What does ADA do for me anyway?' Just imagine for a moment if there were no tripartite ADA!

"During Covid, ADA had an entire Science, Legislative and Practice Council fighting for protocols to keep you safe. Our legislative team fought for PPE and for loans to keep you open and put together a tool kit to help you reopen safely. We spend $10 million a year on science to develop new products and guidelines and we test every product you use in your practices to help your patients stay safe. ADA spends countless hours and over $2 million a year to help states with legislation on insurance issues. We have recently heard the question 'What dollar value does the ADA give me?' I would like us to do a better job communicating this answer. She urged ADA members: "Let's care for each other, educate each other, support each other, and continue to strengthen our profession by coming together and talking to non-members about how vital it is to join and keep the profession in which some of them are investing over $400,000 strong for their futures."

Finally, Dr. Edgar shared two of her favorite quotes: "Many baby steps can make one giant footprint" and "It is amazing what you can accomplish when you don't know what you can't do." Now she is about to take a giant step into the future – and is clearly primed to accomplish a great deal. ◊

Choosing the Right Lender for Your Practice Loan

BY AARON PERSHALL

After 15+ years as a dental practice broker, proudly serving the dental community in the Pacific Northwest, the time has come for me to explore new career opportunities. I have accepted a position with Provide Practice Finance to be their Regional Director of Practice Finance for the Pacific Northwest (WA, OR, ID and AK). While I will certainly miss helping sellers achieve their retirement goals, I am thrilled to be part of the team at Provide.

The industry's only digital finance company, Provide financially empowers healthcare providers to achieve their practice ownership dreams through personalized customer service and a streamlined, online finance experience. Provide offers dentists, veterinarians and other healthcare practitioners an integrated suite of financial products that makes opening, running and expanding a healthcare practice easier. We're giving providers back their time and energy to focus on what matters most: their patients.

From very competitive practice acquisition loans, to commercial real estate financing, practice equity cash outs, equipment purchases, project/remodel financing and more, we can help! Please contact me for more information. I look forward to serving you!

Provide

So you've found the perfect practice to purchase or the perfect location for a startup and you're ready to start looking into financing options. Now you just need to find the lender with the lowest interest rate and apply for financing. Simple right? Not necessarily! The process of obtaining a practice loan can be stressful and overwhelming for many first time practice owners and the fact is that choosing the wrong lender can have serious long-term consequences for your practice and your financial future. Here are some important factors to consider when seeking financing for your dental practice.

1. Think of your lender as a long-term partner. Your lender is the only advisor on your team that is going to take the long-term financial risk of buying or starting a practice alongside you. All of your other advisors are paid based on the work they do for you, whereas your lender is paid over the next 10 to 15 years as you make your loan payments. Additionally, since this isn't likely going to be the last time you borrow money in your career, you want to think about your lender's ability to support your future growth. Is the lender easy to deal with, responsive and service oriented? Do you like how they do business? Have your colleagues had good long-term success with the lender you are considering?

2. Think beyond interest rates alone. As Benjamin Franklin once said, "The bitterness of poor quality remains long after the sweetness of low price is forgotten." Most aspiring new practice owners view practice loans the same way they do an auto or home loan, with interest rate being the sole focus. This is a mistake. While finding a fair interest rate for your practice loan is certainly important, blindly choosing the lowest interest rate can leave you exposed to other issues down the road. When a lender teases a rate that is significantly lower than their competition, you have to ask yourself where they are making their money. Typically, they are making up the difference on all of the other products and services after the loan has funded. Beware of higher fees for credit card processing, business banking services, remote deposit check scanners, low interest rates paid on business savings accounts, etc. Instead of focusing on the loan rate alone, consider the overall value that your lending partner is providing you.

3. Consider the bigger picture. Working with a lending partner that will support your long-term goals and plans is exceptionally important to your future success. The strategic benefits far outweigh paying a little more in interest. Does your lender have the products, processes, speed, expertise and flexibility, to help you capitalize quickly on future business opportunities? When you're ready to purchase a home, another practice or a building will your lender be a help or a hindrance? Sadly, I have seen many buyers chase a low rate loan only to find that their lender is unable to support their plans down the road. And because of the pre-payment penalties on their loan, they are essentially stuck. The Pacific Northwest has some of the highest price points for practice acquisitions and highest construction costs for startups in the nation. Is your lending partner able to adapt and think outside the box to support you with longer loan terms, higher loan amounts and innovative products? Most of the issues I see first time practice owners run into are centered around the factors above. I highly encourage you to do your research and think deeply about your plans and choose the lending partner that is best able to help you achieve your goals both now and into the future. This will help you avoid pitfalls and position you for long-term success throughout your career. As a former dental practice broker and certified business appraiser for over 15 years, I could have worked at nearly any lender in the dental space. I choose to work at Provide because I believe in what we do for our clients and more importantly believe in what we do for our clients and more importantly how we do it! ◊

The Dental Group Joins Benton Bray PLLC's Dental Practice Group and Dental Accounting Pros

TO CREATE WASHINGTON'S LEADING DENTAL CPA FIRM

BY KEVIN J. BRAY

Dental Accounting Pros was founded by Brian Bray and Kevin Bray in 2016 to create a spinoff of Benton Bray P.S. that offers bookkeeping, EFT recon, payroll and bill pay accounting services for dental practice owners. Our mission is to provide an expert, streamlined bookkeeping solution with accurate financial statements at an affordable price. Our workflow process is designed by CPAs and offers valuable analytics for practice owners so that they can better monitor, manage and improve their operating performance and profitability. Dental Accounting Pros joined forces with The Dental Group in May of 2022 to become Washington State's largest dental CPA firm providing leading advisory, bookkeeping and tax services to practices across the Pacific Northwest!

Rival dental CPA firms in Washington State merge to provide dentists with a more comprehensive solution for their bookkeeping, tax and consulting needs.

We are excited to announce that effective May 1st, 2022, Dental Accounting Pros, and the Dental Practice Group of Benton Bray PLLC, have joined forces with The Dental Group, LLC to become Washington's leading dental CPA firm providing tax, bookkeeping and advisory services. For nearly three decades our companies have been friendly competitors. We completed this strategic merger to better serve the dental community in the Pacific Northwest. Dental Accounting Pros brings a team of strong bookkeeping support while The Dental Group adds additional advisory and consulting abilities. Moving forward, our knowledge in tax planning and advisory is stronger than ever with a deeper bench of talent and drive to continue to be the go-to accounting solution for dentists in Washington State.

Established in 1989 & reimagined in 2022. The newly merged partnership will be known as the Dental Accounting Group. Brian Bray and Kevin Bray will continue alongside Maggie Boyle and Yianni Cardaras to grow the firm, advising clients, and adding new accounting service offerings. We will continue to raise the bar on service and business tax planning strategies for practice owners.

Sam Martin is a founding member of The Dental Group, providing tax and financial planning services to dentists and specialists since 1990. He now leads the Seattle office of Buckingham Strategic Wealth with a continuing focus on dentists and their families and continues to provide comprehensive transition services to dental practice sellers through DG Transitions. Although Sam is not a partner in the new Dental Accounting Group, he has played an integral role in the firm's history and continues to be present in our organization.

Want to learn more? Reach out to us today: DentalAccountingGroup.com

When You Come To A Fork In The Road, Take It

A JOURNEY IN TRANSITIONS

BY ROD JOHNSTON

Rod's background in accounting, finance, sales, and real estate make him one of the most well-rounded practice transition consultants in America. Rod has an MBA from Seattle University and is a Certified Management Accountant. He is also an Accredited Business Appraiser by the Institute of Business Appraisers. Rod's experience and background include stints as a financial planner, as Assistant Treasurer and Director of Accounting for AT&T Wireless, and as a Commercial Broker for Keller-Williams and Omni Healthcare Real Estate.

Rod started Omni in 2004 with two things in mind; provide a Nordstrom-like service to help doctors with their transition, and to be an expert resource to medical professionals in the fields we work in. He has developed systems and processes in the brokerage industry that are mimicked and copied throughout the nation. He and his company has transitioned hundreds of practices with great success while maintaining a "win-win" relationship between his clients.

"The future ain't what it used to be" is a quote by the great Yankee baseball catcher Yogi Berra. It also seems to be true in dentistry. I've been working with dentists helping them transfer out of and/or into practices for almost 20 years now. It's not like it used to be when I first started selling practices.

Dental transitions used to be straight forward. A seller would contact us to help him or her sell their practice. They were selling because they had reached an age where they wanted to retire or at least slow down. We would do a valuation to find out what it was worth and then we would market the practice to find a buyer. Buyers would look at the practice and then decide if it was a good fit for them or not. If they liked it, they would make an offer and go to one of the three or four banks that loaned for dental practice sales, the bank would quickly approve the loan and we'd close in about 4 to 6 weeks.

Today, things have changed. Practice sales have become harder. Sellers are now selling because they're tired of staffing issues and managing staff. Or they are fed up with the insurance reimbursements continuing to be cut. More and more sellers want to stay and work back in their practice for a period as they still enjoy dentistry. Valuations flow with interest rates and demand for certain practices. As interest rates go up, practice values go down due to the increase in debt payments to the buyer. Demand for practices in downtown areas has gone down. It's been harder and taken longer for practices in metropolitan areas to sell due to crime, homeless issues, and the dentists desire to be in a more rural area.

Buyers have also changed. Buyers used to look at a practice and if it was in the right location, they'd move forward with acquiring the practice. Today, buyer's want to have practices analyzed by advisors and if the practice doesn't have certain parameters in the practice, the advisor advises them to look for a different practice. Dental Service Organizations (DSO's) are also now playing a role in influencing practice transitions. The promise of a higher price and bigger return if you sell to a DSO has pushed some practice owners to go that route and work back in their own practice instead of selling to an individual. Truth be told, in the Northwest, it's rare for a DSO to pay more than the market price. You also risk not getting market price as they take over management of your practice and you're required to maintain your production or profitability, or you don't get full payment of your purchase price.

"You can observe a lot by just watching" is another Yogi-ism. We've observed the changes over the years, some for the good and some for the not so good. We are still selling a lot of practices. It's just taking a bit longer than it used to and requires more analysis and scrutiny. If you're in that boat, remember another phrase by Yogi – "it ain't over till it's over". So, start your preparation for your practice sale early and be ready for the sale to take a little longer than it used to. ◊

Dental Practice Transitions: Exploring the Parties and Process

BY SCOTT HENDERSON

Scott Henderson is a partner with Keller Rohrback L.L.P. in Seattle. Scott represents dentists in such matters as practice transitions, employment agreements, partnerships, and leases.

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The most common path to practice ownership in the state of Washington is through the purchase of an existing dental practice (as opposed to a startup). There is an active marketplace in Washington for dental practices and banks are financing up to 100% of the purchase price.

THE PARTIES

Banks — Most practice sales in Washington are financed by local and national banks who have bankers focusing on dental practice transitions. Since a bank is essentially an investor in the practice, the bank will review practice financials, market conditions, seller's background, buyer's background, etc. to protect their investment. A buyer benefits from this level of review as the bank, like the buyer, will also be looking for any concerns with the practice and taking steps necessary to ensure the future success of the buyer. The banks will also review the practice purchase agreements and the lease – and remain an active participant in the purchase and sale process.

Brokers — Many practice sales in Washington are brokered through dental specific brokers. Typically, brokers are hired by the seller and are either paid a commission or some form of fixed fee. The range of fees can depend on the marketability (ex., location, profitability, patient base) of the practice as well as the purchase price. A broker is responsible for listing the practice to potential buyers as well as determining a reasonable purchase price for the practice. Once a buyer and seller have agreed to move ahead with a practice transition, brokers will typically assist with the preparing of a letter of intent which outlines the deal terms. That letter of intent will be shared with the attorneys and the bank. After the letter of intent has been signed, brokers will assist with the practice transition – coordinating with the bank, the landlord, attorneys, accountants, assisting with staff meetings, etc.

Consultants — Buyers may elect to engage a dental practice consultant to assist in the sale process, which can include such things as helping with the review of financials and other due diligence, getting the buyer credentialed with the dental insurance companies that the practice is a provider under, and meeting with the practice employees. A consultant will also assist the buyer after closing with practice management.

Accountants — A buyer needs an accountant is both to assist with the practice purchase but also, after closing, to handle the reporting of taxes. An accountant will also be able to assist a buyer with reviewing financial records, practice valuations, cash flow projections, etc. So, along with a dental-specific bank, and a consultant, a buyer would have another yet another party reviewing the practice financials and other due diligence items. An accountant will also assist the buyer with incorporating, applying for business licenses, and handling other business start-up matters.

Insurance — As part of the purchase, a buyer will need to get different layers of insurance covering the various risks associated with owning a dental practice – ex.,

malpractice, general liability, employee-related liability. A buyer will also be required to maintain life and disability insurance as a condition of the bank's loan – although this is something any dentist should maintain even if it were not required. An insurance broker with experience handling dental practices will be able to give a range of insurance options for a dental practice.

Attorneys — A buyer and seller of a dental practice will each have their own attorney. One attorney will draft the agreements (customarily, the seller's attorney) and the other attorney will review. Attorneys typically charge by the hour for their time spent representing a buyer or seller – though attorneys can give a range of expected fees. Most attorneys working on dental practice transitions have a background in business and real estate law and work on healthcare-related business transitions.

THE PROCESS

The time frame from when a practice is first listed for sale to when a letter of intent has been signed can vary quite a bit depending on the marketability of the practice. For example, a rural practice with declining profits and fewer new patients will likely take longer to sell than an urban practice with steadily increasing profits, and a sizable number of new patients each month. In some cases, a letter of intent might be signed within weeks of it first being listed. Once a buyer and seller have agreed to move ahead and a letter of intent is signed, the typical time frame to then complete the sale is three to six months.

While the buyer had some basic financials provided along with the initial practice listing, after the letter of intent has been signed, the buyer will be able to continue their due diligence by reviewing additional financial information, doing a patient chart audit, inspecting the equipment, reviewing employment records, and having discussions with the broker and the seller about the practice transition.

Once the letter of intent has been signed, and a bank has given preliminary approval for financing, the attorneys will begin working on the practice purchase agreements and negotiating the terms of the purchase. That process might take two to four weeks on average though sometimes longer depending on any issues.

The landlord will have also been contacted (if the seller is not the landlord) and introduced to the buyer. Most commercial landlords will also do their own financial review of the buyer, which may take 30-60 days. Typically, the existing lease for the practice will be assigned from the seller to the buyer. If the practice seller is the building owner, then there will be a new lease prepared.

The closing of the practice sale occurs when the purchase agreements have been signed, the landlord has approved an assignment of the lease, and the bank is ready to wire funds to the seller. After closing, the seller is typically available for a month or so to answer questions regarding the transaction and the practice, but the seller typically does not work back for the seller. ◊

Patterns

BY DR. AARON STEVENS

Dr. Stevens has an innate ability to relate to others, making every effort to help each individual reach his or her preferred level of health. He's honest and direct, letting his patients dictate their own desired outcomes and goals. He then lays out a practical path for reaching those, providing non-judgmental answers and explaining everything in plain terms. Dr. Stevens chose Willamette Dental Group for its collaborative practice setting where he could work alongside colleagues he would feel comfortable treating his own family.

In his leisure, he can be found canyoneering or swimming, attending church, or staying home with family.

When you love your children, you want the best for them. You want to help them succeed and avoid the rougher things in life. In that endeavor, while teaching my brilliant teenagers, there is a recurring theme of "if you do (insert wise course of action), you can avoid (insert unpleasant experience)."

Life has trends and fundamental principles and patterns, and understanding these can reduce problems. Sometimes they heed it and skip the pitfall, and sometimes they opt for "firsthand experience". It makes for great photo opportunities!

I was recently asked by a fellow dentist about trends and how to "avoid DQAC cases". I don't have hard data on trends, but I do have lessons from what I've experienced. Having a DQAC case can be stressful and unpleasant (I've had one myself and investigated hundreds), and nothing would make me happier than to help dentists avoid the need for an investigation. DQAC is a complaint driven entity. The principal source is patients, but we also get them from the national practitioner databank which reports civil case settlements as well as other state's disciplining authority. Though there are no guarantees of avoiding an investigation (anyone can complain at any time), here are patterns I've seen that may help you reduce the risk of your own investigation:

- **People complain when they are angry or if they feel deceived.** Be upfront about risks and make sure to under-promise and over-deliver. Documenting the risks in such a way that the patient knows it is in their chart is a great way to avoid the "you didn't tell me" issue. I dictate a lot of my notes to my assistant to type in while the patient is in the chair. Be very clear about costs and potential changes to the procedure plan. Information before the procedure is "information." Information after the procedure is an excuse. If things don't go well, being reasonably liberal with an apology and a refund would drastically reduce the number of cases.
- Complainants aren't only patients. Disgruntled staff (and ex-spouses) are especially effective complainants. They know you well and the areas where you aren't as good as you should be. They have access and inside information. They can point things out or even create problems for which you are then responsible.
- Cases that involve more money are more likely to be investigated or end up in a civil case. If you engage in high-cost cases, you should pick ones that have predictable outcomes.
- Red-flag patients usually show signs of being such. If that Spidey-sense starts tingling, back away. Find a way out. Refer them to your favorite colleague.
- Be kind and respectful to everyone, regardless of what they do. This doesn't mean skimping on boundaries, but how you do it matters. Besides being the right thing to do, you'll feel better too. If you are kind and respectful, it can help your staff back you up if investigations happen.
- Document well enough in your charts that someone (in our profession could understand clearly what happened. Good documentation helps those auditing or investigating to understand why you did what you did. Write a thorough and easy-to-follow PARQ summary and SOAP notes. Include details of the thorough risk/benefit discussion with the patient. Include which of the presented options the patient chose.
- Stay current on the laws that govern the profession. Stuff changes. Please keep up. It is possible to do everything right and still get complaints (if you have a spouse, kids, or in-laws, you already know this). But, if you do these things well, you can reduce your chance of going through what can be a stressful DQAC investigation. ◊

Hiring Success for Dental Professionals:

5 TIPS TO BEAT THE MARKET SHORTAGE

BY TRINA POULSEN

Trina has 35 years in Dentistry. Her career evolved from dental-assisting in a general dental office, to 27 years experience as a Dental Hygienist. These experiences have provided her with an extremely diverse and expansive knowledge of internal business operations and intricacies, around which dental professional environments evolve.

Trina has been a leader and a facilitator in her roles as an advisor to hygiene students, and a former President of the Washington Dental Hygienists' Association. Also, a proven leader in her community, her experience as an educator prepared her to inspire other individuals to feel a sense of purpose, autonomy, competence and desire for life-long learning. Trina continues to grow professionally with her skills and knowledge by applying infinite solutions for individuals and dental teams.

BY SANTIAGO VALDEZ

Dental Business Coach Santiago ValdezSantiago has 25 years in Dentistry. His career started out in periodontics in the capacity of dental assistant and evolved into a career of 16 years as a clinical Dental Hygienist. His passion for Dentistry also motivated him as a dental hygiene educator where his dynamic personality inspired and facilitated limitless potential.

Having experiences with dental professionals who've thrived by providing top-level care for their patients, Santiago benefited greatly from such environments. He is incredibly grateful for the opportunity to influence a team through growth mindset and helping them realize their goals.

The dental industry is facing a serious workforce shortage, especially in the wake of the COVID-19 pandemic. Many dental professionals have retired, left the field, or reduced their hours due to health and safety concerns, burnout, or personal reasons. This has created a high demand for qualified and experienced dental team members, such as dentists, hygienists, assistants, and office managers. However, finding and hiring the right candidates can be challenging in the current market. In this article, we will discuss five key points to consider when hiring dental professionals during the workforce shortage, as well as some of the missed opportunities and barriers that may arise.

1. Know your why! When a practice needs a new team member it is not just about filling a position, it is about adding a team member that understands your vision and mission and can add value and be the missing puzzle piece. At Infinite Hygiene Consulting, we like to say- "Hire for the vision not the position." Identify what it is that separates your practice from the one down the street. Have a clear vision and mission of what your practice is and why you come to work every day. Create a practice that has both purpose and belonging at the core and you will see increased retention. Create and identify that in your culture so that the applicant can say- "That's me, I want to work there!"

2. Define your hiring needs and goals. Before you start looking for candidates, you need to have a clear idea of what kind of dental professionals you need, how many you need, and what skills and qualifications they should have. You also need to set realistic and measurable goals for your hiring process, such as how long it will take, how much it will cost, and how you will evaluate the candidates. Having a well-defined hiring plan will help you focus your search and avoid wasting time and resources on unsuitable applicants.

3. Use multiple sources and methods to attract candidates. The dental workforce shortage means that there is a lot of competition for talent among dental practices. You need to use various strategies to reach out to potential candidates and showcase your practice as an attractive employer. Some of the methods you can use include:

- Posting job ads on online platforms such as Indeed, LinkedIn, Kolligate, Craigslist. Join Infinite Hygiene Consulting's Facebook group Washington State Dental Jobs-the largest dental professional social media platform in Washingtons State with almost five thousand members.
- Creating a career page on your website that highlights your practice's mission, vision, values, culture, benefits, and opportunities.
- Leveraging your existing network of contacts, such as colleagues, peers, mentors, associations, or schools, to get referrals or recommendations.

- Attending or hosting career fairs, events, webinars, or workshops that target dental professionals or students.
- Offering incentives or bonuses for signing up, staying on board, or referring others.

4. Streamline your hiring process and make it candidate friendly. Provide a positive candidate experience: A positive candidate experience can help you attract top talent and build a positive reputation in the industry. Be transparent about the hiring process and communicate with candidates throughout.

Once you have attracted some candidates, you need to make sure that your hiring process is efficient and effective. You don't want to lose qualified candidates because of a lengthy, complicated, or unclear process. Some of the ways you can streamline your hiring process and make it candidate-friendly include:

- Using online tools such as resume screening software, video interviews, or assessment tests to save time and resources.
- Communicating clearly and frequently with the candidates about the status of their application, the next steps, and the expectations.
- Providing feedback and constructive criticism to the candidates who are not selected or who need improvement.
- Making the job offer as soon as possible after the final decision and negotiating the terms and conditions.

5. Retain and develop your existing staff. Hiring new dental professionals is not enough to solve the workforce shortage. You also need to retain and develop your existing staff to ensure that they are happy, motivated, and productive. You don't want to lose your valuable employees to other practices or industries because of dissatisfaction or lack of growth. Some of the ways you can retain and develop your existing staff include:

- Providing regular recognition and appreciation for their work and achievements.
- Offering competitive compensation and benefits that match or exceed the market standards.
- Creating a positive and supportive work environment that fosters teamwork, collaboration, and respect.
- Providing opportunities for learning and development, such as training courses, mentoring programs, or career advancement paths.

Hiring is a team event. Everyone has a role to play. People will always be the biggest asset and differentiator in a dental practice. Invite the highest caliber of candidate to a seat in your practice. Invite the team into the hiring process so that the culture of the practice is shared not only by the practice owner but by the team. Hiring is not just the responsibility of the Office Manager or Doctor. When a team is committed to the hiring process, they are vested in the process of hiring great talent and will be more engaged in the onboarding process and committed to the long-term success of the individual as a well as the practice.

Hiring dental professionals during the workforce shortage can be a daunting task for any dental practice. However, by following these four key points: defining your hiring needs and goals; using multiple sources and methods to attract candidates; streamlining your hiring process and making it candidate-friendly; and retaining and developing your existing staff; you can increase your chances of finding and hiring the best talent for your practice. You can also avoid some of the missed opportunities and barriers that may hinder your hiring success, such as:

- Missing out on qualified candidates who are not actively looking for jobs or who are unaware of your practice.
- Losing candidates to other practices that offer better pay, benefits, or work conditions.
- Wasting time and money on unqualified or unsuitable candidates who do not meet your standards or expectations.
- Complaints from candidates who feel discriminated against or mistreated during the hiring process.

By following these best practices in hiring dental professionals during the workforce shortage, you can overcome these challenges and build a strong and loyal team that will help you grow your practice and serve your patients better.

Need help? Infinite Hygiene Consulting's Trina Poulsen and Santiago Valdez are trained facilitators for organizational mindset and culture with over 60 years of clinical dental experience. They help expose blind spots that are self-limiting, create strategies for growth and unlock infinite opportunities for your team's success- Contact Infinite Hygiene Consulting for a complimentary consultation. ◊

Having the Disability Insurance You Need at the Right Coverage Amount

BY MATTHEW FRENCH

Matthew French is the Director of Insurance Services for Washington Dentists' Insurance Agency (WDIA) which is a for-profit arm of the Washington State Dental Association (WSDA). He has been with WDIA since 2008 and previously worked for WSDA for five years. Matt is an expert in the dental insurance industry and can help dentists meet all of their professional insurance needs including: Disability, Life, Medical, Business Loan Protection, Business Owners Coverage, Professional Liability and Long Term Care Insurance. Matt received a BA in Communication from Western Washington University with a concentration in Public/Interpersonal and Organizational Communication.

If you would like to review your current Disability Insurance or get quotes for additional coverage, please contact WDIA at 1-800-282-9342 or info@wdiains.com.

Although Disability Insurance does not seem like a necessary expense compared to the mortgage on your home or your electric bill, it is still crucial to have disability insurance in force and in step with your needs. Disability protects your family and you if the worst should happen, but if you do not have policies that cover both personal and professional expenses and are at the needed coverage amounts, the gaps in coverage may cost you.

The best way to protect yourself, your family and your practice is to make sure your insurance policies have the full protection you need. Ask yourself: how much money do I need on a monthly basis to pay all my personal expenses and for my practice to run effectively? If the amount you need is less than what you currently have in monthly benefit on your disability coverage or if you are not covered at all, then you will want to consider increasing your existing coverage and/or obtaining other types of disability coverage.

Below are some important types of disability policies and how they protect you. Although each type provides coverage for a different aspect of your life, the benefits on each policy are triggered by you no longer being able to perform the duties of your profession. Having multiple policies at the correct coverage amounts ensure that every part of your life will be protected.

Personal Disability. Personal Disability is the most common type of disability coverage. Benefits from a Personal Disability policy are meant as personal income replacement to cover your loss of earned income if you become disabled. This coverage would be used to pay your home mortgage, water and electric bills, car payment, groceries, gas, children's tuition: anything that your paycheck covers for your family. Without Personal Disability, all your monthly expenses would have to be paid from your savings.

Overhead Expense. Business Overhead Expense is specific to covering your business expenses if you become disabled. This coverage allows your business to continue to run while you are recovering from a disability or in the process of selling your practice. Expenses that are covered by this policy include: rent, staff salaries, electricity, dental supplies, janitorial and maintenance work, etc. Without Overhead Expense coverage, you may not be able to keep your business running while you are recovering from a disability.

Business Loan Protection. Business Loan Protection specifically covers your mortgage or equipment loan payments to the bank if you become disabled. A practice loan is thousands of dollars per month and without Business Loan Protection, you would be paying for your loan out of your pocket.

Although savings may cover the costs in one aspect of your life, it is unlikely that you would have enough funds to cover your personal and business expenses indefinitely. Washington Dentists' Insurance Agency encourages dentists to acquire different types of disability insurance to ensure that all personal and professional expenses will be covered for the well being of themselves and their families. ◊

Innovative Ways to Recruit Dental Assistants

BY DR. DZON NGUYEN

Dr. Nguyen is an expert at taking care of his patients. He loves his work and is determined to make each patient raving fans.

His goal is to provide quality services for his patients to achieve long term good dental health. He believes healthy and beautiful smiles can be possible with regularly scheduled appointments and proper preventive dental care. Dr. Nguyen is trained in the most advanced techniques. Dr. Nguyen features CEREC CAD/CAM porcelain crowns in one appointment.

He enjoys skiing, snowboarding, wake boarding, wake surfing road and mountain biking with his college sweetheart and their three girls.

If you need at least one new assistant, you are not alone. More than 80% of dental offices are reporting the desire to hire. At the Washington Academy of General Dentistry, we've heard your pain and we have been working for 2 years to solve this issue. By opening the quickest, most efficient and affordable way to attract people into the profession and train them well for you to be able to utilize them immediately, we have set in motion the solution to the problem. Our collaboration with Dr. Mark Holifield, the creator of the #30dayRDA program, has allowed us to bring a proven curriculum to the state of Washington where we are already graduating students.

So how do use this to your advantage in hiring that next great chairside assistant or perhaps even an RDA trained front desk person? As you well know, the employee market is insane right now. Every industry is scrambling for employees offering outrageous wages and sign on bonuses. The current unemployment rate for King County is under 3% but in reality, it feels like it's in negative territory. This has even translated to our school because every one of our students has gotten a job before the first day of class and we have a waiting list full of dentists. But there are ways to separate yourself from the other industries.

Dental offices that are being successful at hiring and retaining employees currently focus on culture. There are many ways to impart culture into your business but one that dentists are utilizing the most to their success has been the willingness to spend on employee education. When an employee, especially a new or potential employee, sees that an employer is willing to invest in them, it forms a bond of trust. Several dentists are using the lure of education in their advertising for assistants. The common theme is, come work for us and we will pay for you to become an RDA. Truthfully, that's a powerful message. Dentistry is not just a job but a profession. We make a difference in people's lives. An extremely effective ad could say something to the effect, "Come work for us and in 30 days, we can get the title of RDA for your name." Everyone wants to be proud of what they do and the dental profession has that advantage over other businesses like fast food, retail or manufacturing. Take advantage of this in your ads. Ask the question, "do you want to be just another employee or a health professional?"

Fortunately, we have a school that isn't a stumbling block in time or cost to help people join the profession. The model that we see being most commonly used right now is for the dental office to pay for the employees' education with the promise of an amount of time that the employee will work for them. The dentists most desperate for assistants make that time period repayment low of just a few months. The average time we see is a year. That's usually enough time for the employee to get comfortable in their jobs and gain loyalty.

Together, we will solve this assistant shortage issue. The WA AGD is committed to improving the lives of our members. If you would like more information about the program, please visit our website waagddentalassistantschool.org #30dayRDA. The beginning of an education for life! ◊

The Right Timing for Bright Inviting Practices

BY BIG SKY NORTHWEST

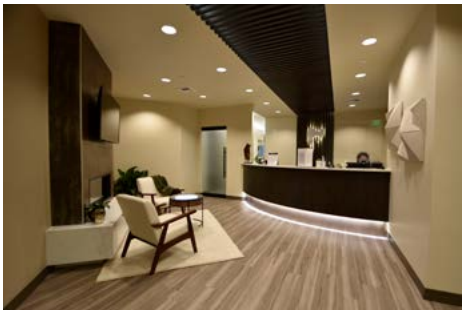
We are a General Contractor that specializes in Dental Construction in the beautiful Pacific Northwest.

We know how a sustainable, functional, affordable dental office is created, and would love to be a part of making your dream office a reality!

BIG NORTHWEST SKY

Recently many of our dental builds have designs that take technology by the hand, allowing us to construct spaces more thoughtfully than ever. Building bright beautiful offices with bespoke components, plumbed medical gasses, and surgical suites is something Big Sky Northwest has always done, and we are enjoying expanding our experience with every high-tech dream office we put together. LED accent lighting has been becoming a new norm. Lighting up soffits and trim on the floor and ceiling, bringing the eye to unique design elements in the practice. Frosted glass wall dividers that allow for patient privacy without losing light, glass doors, and glassed-in consults and conference rooms have been testing our team's creativity in our shop. A round custom X-ray window in a nautical theme is the latest first for us!

While providing these more complicated elements, and partially due to post-Covid manufacturing material shortages, we've been focused on our timing. City's permitting offices have been busy, so we're working to ensure permitting is seamless, ironing out timing details with vendors and ordering materials at the immediate onset. When necessary, we help to provide alternatives to materials that do not meet the schedule or budget, without compromising aesthetics of the design. Actively engaging our clients during routine site visits to enjoy the building process and answer questions helps us prevent miscommunications that can bring the build to a standstill. Following progress throughout the schedule allows us to tackle challenges before they impact the schedule or budget. Providing the right timing for bright inviting practices in the Pacific Northwest. ◊

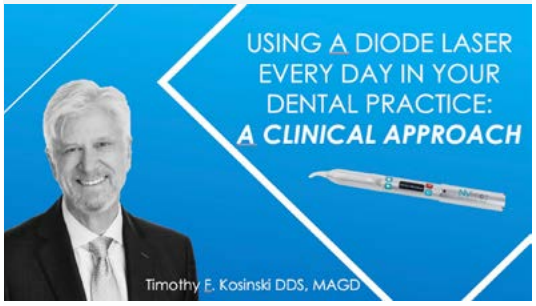


Latest in Diode Laser Dentistry

BY DR. TIMOTHY KOSINSKI

Dr. Timothy Kosinski is an Affiliated Adjunct Clinical Professor at the University of Detroit Mercy School of Dentistry currently serves as the Editor of the AGD journals and Editor of Dentistry Today Implants. He is a Past-President of the Michigan Academy of General Dentistry.

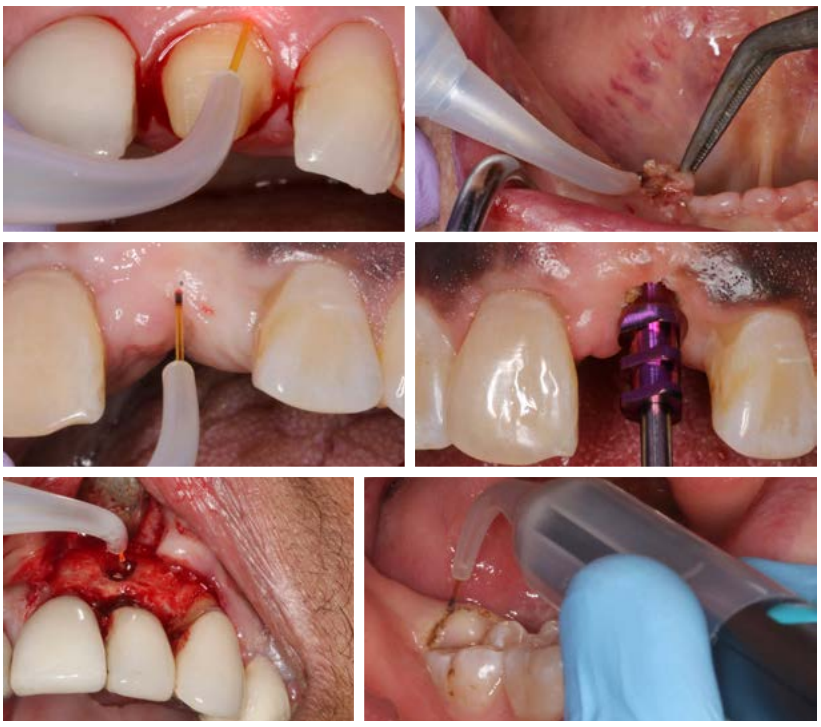
Dr. Kosinski received his DDS from the University of Detroit Mercy Dental School and his Mastership in Biochemistry from Wayne State University School of Medicine. He is a Diplomat of the American Board of Oral Implantology/Implant Dentistry, the International Congress of Oral Implantologists and the American Society of Osseointegration.

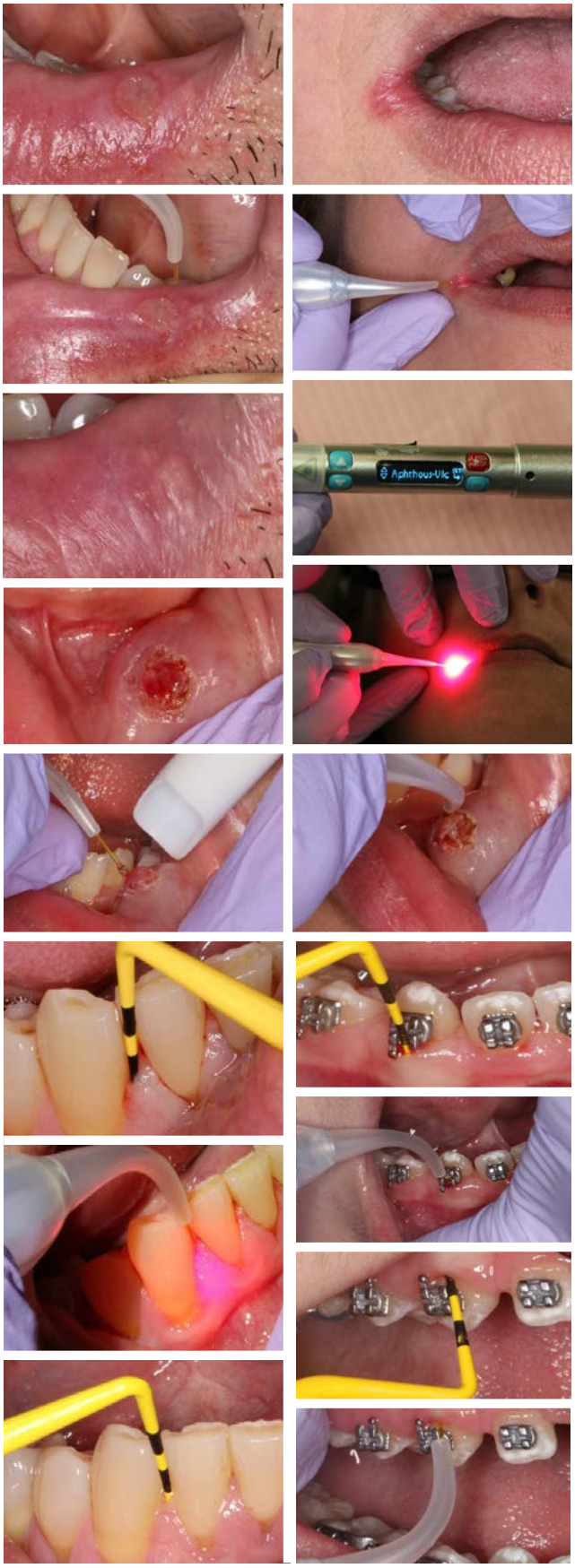


Soft tissue diode lasers offer many benefits to the general dentistry practice. The laser is routinely used to achieve hemostasis, perform incisions, ablations, vaporization, and coagulation of tissue. Gingival retraction is a common procedure completed using the diode laser. This technique is especially helpful during digital scanning of prepared teeth since no bleeding is noted around the tissue of the prepared margins.

Bleeding caused by conventional retraction cord use may inhibit an accurate result. Crown margins are, therefore, easily visualized. Uncovering dental implants, especially in those patients who may be on some type of blood thinner, is often accomplished without any anesthesia and allows the practitioner to impress the body of the implant immediately upon exposure.

Absorbed energy is used for cutting, and the energy created is absorbed by hemoglobin, melanin, and pigmentation. Laser light is turned into heat, creating the photo-thermal reaction. Thus, there is localized vaporization around the treatment zone. The technique is duplicated in coagulating blood during a class V restoration, removing tissue around erupting teeth, relatively simple frenectomy procedures, and reducing orthodontic hyperplastic tissue. Patients often present with herpetic lesions or apthous





ulcerations. When the lesion presents early in the process, the diode laser provides an excellent tool to expedite healing and minimize the discomfort experienced.

The diode laser can be used around metal margins, metal restorations, and even used to decontaminate around ailing/failing dental implants, unlike an electro surge.

Periodontal applications of the diode laser are impressive. As an adjunct to traditional scaling and root planning, laser-assisted periodontal therapy is designed to selectively target dark, necrotic tissue while preserving healthy tissue and promoting healing. The dentist or dental hygienist uses the soft tissue laser energy to reduce bacterial count in a pocket, which reduces the risk of bacteria entering the patient's bloodstream and can also encourage healthy reattachment of the gingiva, thus reducing pocket depth in many cases.

Laser Bacterial Removal is recommended to patients after noting increased pocket depths and bleeding in the mouth. Time is not typically added to the appointment since it only takes an average of eight minutes to treat the entire mouth. Diode laser therapy is especially helpful to those patients who complain of soreness following any hygiene procedure. Aside from periodontal uses, laser-assisted hygiene can also include the treatment of hypersensitive tooth surfaces.

The treatment modality is a modern-day marvel that offers many practical applications in dentistry. From restorative to periodontal care, the implementation of lasers in dentistry offers myriad benefits, limited patient discomfort, and the ability to uphold minimally invasive treatment standards. The positive patient experience is the best marketing tool, as patients who undergo relatively non-invasive procedures are more likely to continue treatment and tell their family and friends.

The responses from our patients are positive and certainly reinforce other treatment plans. Workflow is maximized as therapy can flow from hygiene to restorative, and patient satisfaction is strengthened. As efficiency and proficiency improve, valuable chair time is saved, and net production increases exponentially.

Dentists who wish to deliver minimally invasive treatment to their patients are wise to learn more about soft tissue lasers. ◊

Ivoclar Academy

BY DR. SHASHI SINGHAL

Dr. Shashikant Singhal, B.D.S., M.S., graduated with Bachelor of Dental Surgery from the College of Dental Sciences, India. After graduation, he maintained a successful dental practice in Delhi, India. However, his passion towards dental materials research and learning about materials science inspired him to enroll in the Advance Clinical Dentistry Program (Biomaterials) at the University of Alabama at Birmingham, AL. During his program, he concentrated his research on contemporary dental materials and presented his research work at both national and international scientific meetings. He was awarded with the Graduate Fellowship Award in 2010. In 2012, Dr. Singhal started his career at Ivoclar Vivadent, Inc. at a position of Clinical Specialist where he directed academic research studies, new product developments/evaluations of dental materials, troubleshooting clinical questions and education. He is an active member of various dental organizations, presents his research at many scientific meetings and lectures significantly at national/international venues. Currently, Dr. Singhal serves at a position of Director of Education and Professional Services at Ivoclar Vivadent Inc., Amherst, NY and manages education initiative of Ivoclar Vivadent in United States.

Innovation and education are inseparable partners in a profession where continuous change offers dental professionals the opportunity to raise the bar of dental care and elevate what is clinically and technically possible. Ivoclar Inc. understands the critical role education plays in inspiring dental professionals to provide the best possible oral health care and quality of life for their patients across the globe. As one of the world's leading-edge dental industry innovators for the last 100 years, our integrated oral solutions continue to advance the state of oral care throughout the world and our commitment to education elevates the profession by providing patients with best-in-class dentistry.

To further strengthen our commitment to innovation and education, we created the Ivoclar Academy. At the Ivoclar Academy, we support dental professionals by expanding their clinical and technical knowledge and expertise in honing their skills. We are committed to offering clinicians, technicians, and hygienists, across all levels of experience, first-class courses and resources specifically designed to elevate your careers and, and in turn, the standard of dental care through cutting-edge educational programs and resources spread across multiple learning platforms.

We understand the busy daily schedules of dental professionals and your individual preferences for learning. To help leverage your time and maximize your learning experience, the Academy has created educational opportunities that are easily accessible and fit any educational learning preference. Whether you are looking for in-person learning or for virtual education, the Ivoclar Academy offers multi-channel opportunities that allow you to learn at home, in the classroom, in the office or on the go. From clinical and technical articles and publications to on-demand, technique-specific videos, interactive webinars or in-person courses, the Ivoclar Academy is a one-stop education resource center where you can access best-in-class education on the latest research, innovations and techniques when, where, and how you want it, all from one easy-to-navigate web site. Our team of global experts and trusted partners stand by to help you meet your educational goals.

To help dental professionals meet annual accreditation requirements, the Ivoclar Academy offers myriad CE-accredited learning opportunities. You can receive a certificate of attendance for each CE-eligible program, latest research or training course completed from the Ivoclar Academy. The ADG PACE-approved certificate can be used toward meeting your annual CE credit requirements.

Visit the Ivoclar Academy (www.ivoclar.com) today to unlock your potential by learning from the experience and knowledge of dental experts from across the globe. Annually, the Academy participates in more than 500 learning programs to connect with dental professionals at every level to provide dental professionals with learning solutions that will help you achieve efficient, esthetic, reliable results in a completely repeatable way. ◊

Enhancing Patients' Quality of Life:

THE ROLE OF SLEEP DENTISTRY AND THE AMERICAN ACADEMY OF DENTAL SLEEP MEDICINE (AADSM)

BY DR. KATHARINE CHRISTIAN

Dr. Katharine Christian is a Fellow of the American Academy of Orofacial Pain and is a Diplomate of the American Academy of Dental Sleep Medicine. Originally from the central coast of California, Dr Christian went to Tufts for dental school. She practiced general dentistry for 9 years before limiting her practice in 2014 and is currently the Dental Director of the Sleep & TMJ Group in Seattle, Washington. Dr Christian has been treating OSA with oral appliances since 2006.

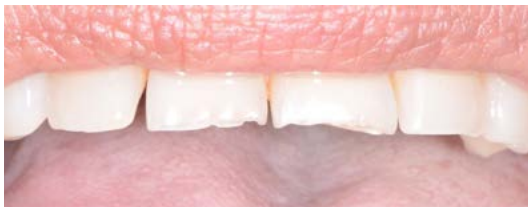
Dr Christian is currently the President-Elect for the Seattle King County Dental Society and is active in her specialty organizations.

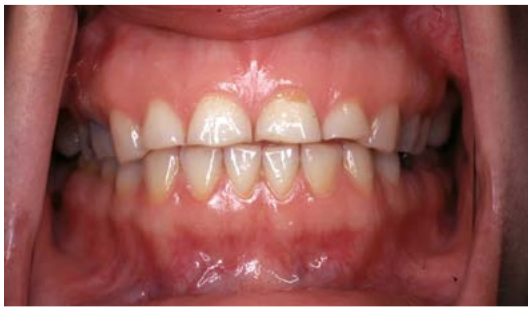
Sleep disorders, such as sleep apnea and snoring, can significantly impact an individual's overall health and well-being. The American Academy of Dental Sleep Medicine (AADSM) and the field of sleep dentistry offer valuable solutions to address these issues and improve patients' quality of life. In this article, we will explore the background of the AADSM, the importance of dental sleep medicine, how dentists can assist in enhancing patients' well-being, screening methods for sleep apnea and snoring, as well as criteria for referral and treatment options.

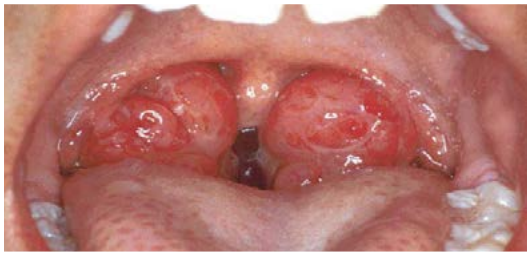
The AADSM is the leading organization dedicated to advancing the field of dental sleep medicine. Founded in 1991, there are now over 2000 dentists considered either Qualified or an AADSM Diplomate. Dental Sleep Medicine (DSM) refers to the specialized practice that focuses on managing sleep-related breathing disorders, such as sleep apnea, through dental interventions. Dentists trained in DSM work closely with physicians and sleep specialists to provide comprehensive care for patients experiencing sleep-related issues.

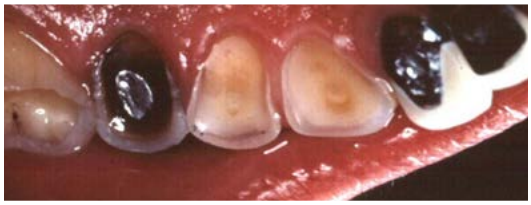
Quality sleep is essential for optimal health and cognitive function. Sleep disorders, if left untreated, can lead to an increased risk of cardiovascular problems, diabetes, and other chronic conditions. Dentists, as part of the healthcare team, play a crucial role in identifying and treating sleep-related issues. They can significantly improve patients' quality of life by identifying patients who could benefit from a sleep study and offering effective interventions that alleviate sleep disturbances and promote better overall health.

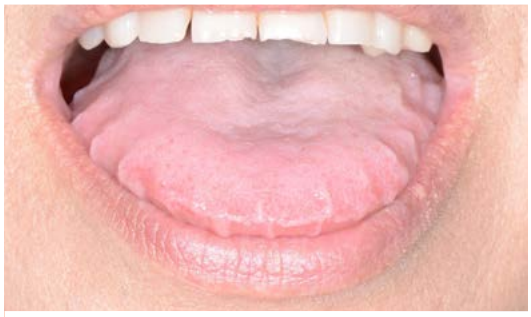
Sleep apnea is a common sleep disorder characterized by recurrent pauses in breathing during sleep, leading to fragmented sleep and reduced oxygen levels. Snoring often serves as a symptom of sleep apnea, caused by the vibration of relaxed throat tissues. Dentists should screen for these conditions by evaluating patients' medical history, performing a clinical examination, and utilizing tools such as questionnaires and home sleep tests. Studies show that while 76% of dentists do some screening for sleep apnea, only 14% of dentists screen all their patients. Common tools like the STOP-BANG and the Epworth Sleepiness Scale can easily be added to a health history update form and are widely available online.

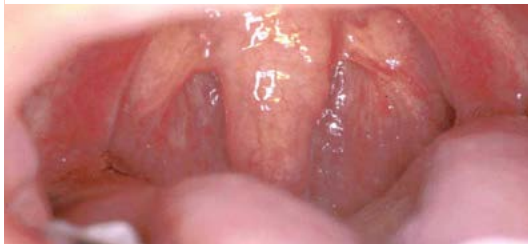












When looking intra-orally, signs to look out for include the following:

Narrow arches – Most adults who have an intramolar distance at the first molars of less than 29mm will have a hard time with proper tongue posture and may be inclined to mouth breathe.

Retrognathia – Obstrucitive sleep apnea is more likely when the airway is more closed and constricted due to growth deficiency.

Large Tonsils – Tonsils touching the uvula or totally obscuring the uvula are both signs of a narrow airway. In addition, the soft palate and uvula can become inflamed and elongated from snoring and attempting to breathe.

Tongue scalloping – Scalloping on the lateral surfaces of the tongue can indicate that either the tongue is too large for the available space or the mandibular arch is too small to accommodate the tongue.

Lingual acid erosion – This is a sign of GERD which often is concurrent with OSA.

Dentists should refer patients to sleep specialists or physicians if sleep apnea or other sleep disorders are suspected. The only way to diagnose sleep apnea is with a sleep study, interpreted by a sleep physician. Treatment options for sleep apnea may include continuous positive airway pressure (CPAP) therapy, oral appliance therapy, surgery, and lifestyle modifications. Oral appliances, custom-made by dentists, reposition the jaw and tongue to maintain an open airway during sleep. These interventions significantly improve sleep quality and reduce the risk of associated health complications.

The AADSM and the field of sleep dentistry offer valuable resources and interventions to address sleep-related breathing disorders. By actively participating in the screening, referral, and treatment process, dentists can positively impact their patients' quality of life. The collaborative efforts between dental professionals, sleep specialists, and physicians play a crucial role in ensuring comprehensive care and better overall health outcomes for individuals suffering from sleep disorders. If you are interested in learning more about being an essential part of this team, please check out www.aadsm.org for more information. ◊

Screening for Orofacial Myofunctional Dysfunctions

IN THE GENERAL DENTISTRY PRACTICE

BY PAT BRINKMAN-FALTER

Pat Brinkman-Falter, BSDH, MS, COM, FADHA practiced clinical dental hygiene for 35 years and has owned her practice of orofacial myofunctional therapy for 15 years. She lectures on tethered oral tissues, oral development affecting airway, TMD and the tenets of myofunctional therapy. She developed the chairside screening protocol or SPOTS and is an examiner for the International Association of Orofacial Myology.

One of the current trends in dentistry is acknowledging the importance of airway and its resulting impact on craniofacial and dental development as well as sleep apnea. We are often faced with how to recognize dysfunctional patterning and when to intervene in our total patient care in the brief time we see the patient for their regular exams. This is not a new phenomenon in dentistry. The "Father of Orthodontics", Edward Angle made many observations in the early 20th century relating to mouth breathing, the tongue resting on the floor of the mouth and primarily Class 2 dental malocclusions (Angle, 1907). Dr. Angle made other astute recognitions of myofunctional disordered patterning contending that the rest posture of the lips and tongue, tongue thrust swallowing and nasally breathing are important indicators in maintaining orthodontic stability. In 1918, Alfred Rogers, DDS was the first to state that an imbalance of the orofacial muscles resulted in malocclusion. He subsequently created orofacial exercises aimed at developing the tonicity and proper function. (Rogers, 1918) (Rogers, Muscle Training and its relation to orthodontia, 1918). With the studies of many influential orthodontists through the years, the program of "myofunctional therapy" was introduced to the university setting in the 1970s (Mills, 2011) and is now taught widely throughout the world with several areas of specialized studies in the last few years. Primarily dental hygienists and speech pathologists specialize in this field adding the additional training to their licensure.

MOUTH BREATHING

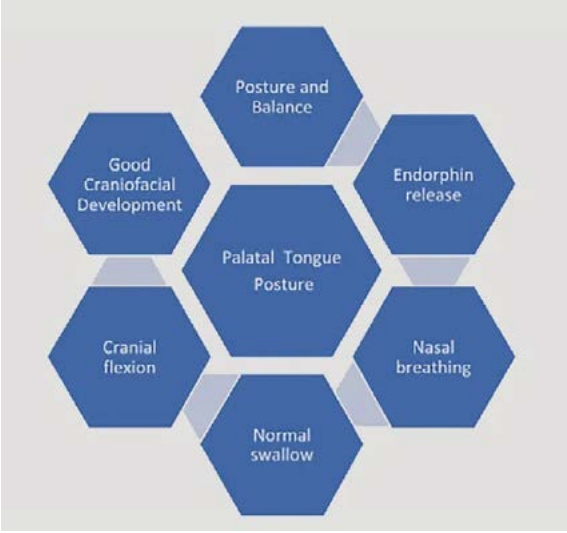
Mouth breathing is at the root of localized gingivitis in the anterior regions of the mouth. Open mouth posture will also create an elongated face hallmarked by a narrow maxilla, excessive premaxilla, and steep mandibular plane. Dr. E. P. Harvold demonstrated the relationship between mouth breathing, dental malocclusion, and jaw morphogenesis with primates. Harvold's findings showed that due to the pressures of the facial muscles not being opposed by the tongue the maxilla becomes underdeveloped in all three dimensions creating a crowded, often class 2 occlusion, and a long soft palate (Harvold EP, 1981). The soft palate grows forward with normal development and when typical growth is not attained it further obstructs the oropharyngeal airway. A long soft palate obstructs the view of the oropharynx and is one of our first clues to poor maxillary development and reduced airway (Shigeta, 2010). With the narrowing of the maxilla the nasal nares also constrict due to incomplete maxillary lateral development further compromising nasal breathing (Gungor, 2009) (Sato, 2018) (Atlee, 2016). The primary things to look for in our pediatric population are mouth vs. nasal breathing, mentalis strain, tonsil hypertrophy, ankyloglossia, dental wear and a V-shpaed arch (Breathe, 2019).

THE TONGUE

Additionally, the tongue must move forward out of the oropharynx to adequately breathe. Low and forward tongue posture can create an open bite or intrude teeth to accommodate the overflow of the muscle. Without proper oxygenation through the nose, the air is not properly warmed or moisturized and consequences such as reduced oxygenation to the muscles and brain arise (Tsubamoto-Sano, 2019). Studies show that newborn mouths are about 30% of the adult size. By the time they are two they are 60% and at age 5 they are 80-85% of full development. In comparison, the mandible is 60-70% adult size at age one (Albert, 2019). Assessing early growth at preventative visits is essential for the growing child. Optimal growth is positively influenced by placing the tongue on the palate with the lips closed and nasally breathing. The use of nasal saline sprays to open the nose and chewing hard detersive foods to stimulate bone growth will help our children start to grow as our grandparents did.

POSTURE

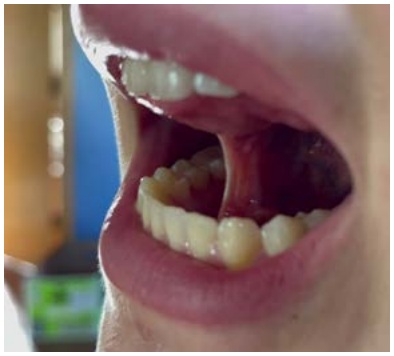
Body and head posture will also influence our craniofacial development and is another clue to airway deficiencies (Sidlauskiene, et al., 2015) (Zafar, 2018). Part of every dental new patient exam should also include a photo of the face at rest and a lateral view of their posture. Normally the ear, shoulder and hips follow a straight line to the ankles. Variations will have the head in front of the shoulders indicating the desire to open the airway. This is known as forward head posture (FHP). As the head comes further and further forward the mandible retracts and can cause Class 2 malocclusion tendencies. Tongue bracing between the arches lends stability to this posture and tooth intrusion and TMJ issues often arise down the road (Saito, 2009). These patients will usually stand more on their toes instead of their heels, known as toe standing, and lowers their resting tongue posture (Valentim, Furlan, Perilo, & Motta, 2016). If they lean over too far, they will fall over. At some point they will arch their backs to rebalance the body and lift their chins to open the airway. Taking a lateral view posture picture will easily demonstrate any adaptations and compensations.



Low tongue posture is when the tongue is on the floor of the mouth instead of lightly suctioned on the palate and has many consequences. A palatal resting posture helps grow the maxillofacial system and if it is not on the palate, it can restrict the oropharyngeal airway as well (Yu, 2019). The pressure of the resting tongue can be compared to the pressure of braces; it will move teeth slowly but surely. Low and forward tongue positions will affect speech and swallowing as well as successful denture wearing. Speech errors such as lisping and seeing the tongue on the lower teeth while talking are our first clues.

The tongue on the palate serves many purposes for homeostasis of the human being (Bordoni, 2018) (Saccinanno, 2020). With the tongue pressing against the median palatine suture line the body's balance is enhanced and the endorphins serotonin and dopamine are released for homeostasis of the body (Van Norman, 1999). As we swallow, the median palatine suture is expanded, aiding the cranial movement of the sphenoid, and occiput. This helps to pump the cerebral spinal fluid (CSF) from the cranium to the sacrum. Diaphragmatic respiration is also involved in returning the CSF to the brain (Saccinanno, 2020) (Osteopathy, 2020) (Atlee, 2016).

Discerning why the tongue is resting low is important to total patient care. Early habits such as digit sucking, prolonged pacifier use, or sippy cup use promote low tongue posture. Posture adaptations can also be from a tongue tie which restricts movement of the stylohyoid and palatoglossus muscles. These muscles serve the important function of elevation and retraction in swallowing and speech (Luxgrant, 2020). A tight lingual frenulum can also be involved in a low and forward head posture affecting the SCM, traps and surrounding muscles. Many people with tongue ties can have clear speech but may suffer from other issues such as slow or picky eating, choking, or gagging on foods, snoring or bruxism.



(a "posterior" tongue tie with lingual palatal suction)

TONGUE TIE SCREENING

Dr. James Murphy has a quick way to find lingual ties. Place your little finger at the base of the tongue on one side and sweep across to the other side. If you can feel resistance or a "fence" then most likely there is a problem (bfmed, 2010). Elevation of the posterior tongue is important for easy palatal rest posture, correct anchoring for speech and sealing the posterior palate for a normal swallow. This can be assessed by having the patient suction their entire tongue to their palate and open wide. The suctioned opening should look like an umbrella and be equal or greater than 60% of full opening (Yoon, 2017). This may also be done manually, by placing your index fingers under the tongue at

the base and lifting. This vertical dimension will show a "posterior tie" that is not attached at the tip of the tongue nor to the inferior alveolar ridge. An estimated "normal" vertical elevation for the tongue from the floor of the mouth is 1cm (a finger width) for newborns, 2cm for children and 3 cm for older children and adults. These maneuvers are easily done during the oral cancer check (https://youtu.be/hw5kB82og58).

TONGUE THRUST

Tongue thrust therapy is one of the original terms for myofunctional therapy. Many issues arise from mouth breathing, low togue posture, tongue tie and parafunctional habits leading to the adaptation of this reverse swallow. A tongue thrust is the adaptation that is used for nourishment because of alterations in functional development. A normal swallow involves the posterior tongue rising and sealing the hard palate, then the soft palate starting the peristaltic wave (Kelly, 2017). The lifting of the posterior tongue to seal the soft palate creates a negative pressure and lets the epiglottis completely cover the trachea and the esophagus open without force for a safe swallow. Tongue thrusting involves the tongue touching the teeth for stability then sucking down food and liquid with positive air pressure to force it down. This creates sounds like a gulp or may result in coughing or choking due to the epiglottis closing incompletely. This is known as silent aspiration in the speech community. Many times, the lips and mentalis will purse to aid in this swallowing pattern.

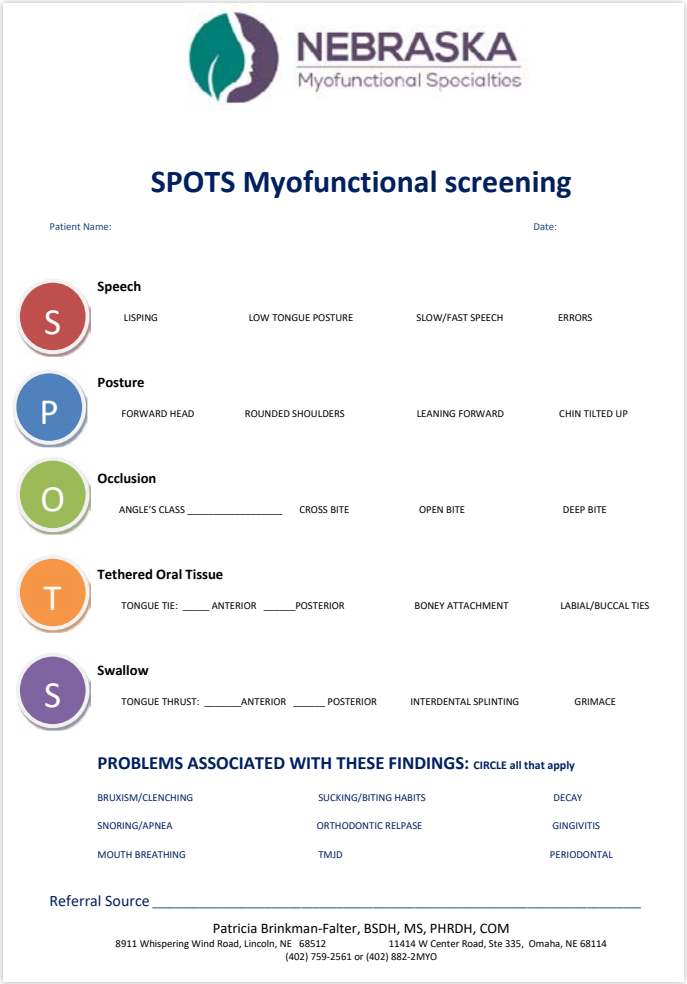
To easily check for a tongue thrust swallow, have the patient swallow while you are checking their occlusion. Be sure that their lips are open, and your finger is on one side of the cheek and the mirror on the other. If they cannot perform the task easily, without facial movement, closing their lips or having their tongue come between their posterior or anterior teeth, they have a tongue thrust. Explaining to the patient and parents that the deviant swallow will not correct itself and discussing the other issues present will aid in the referral and acceptance process.

MYOFUNCTIONAL THERAPY

Orofacial Myofunctional therapists are primarily involved with good resting oral and facial posture and nasal breathing resulting in optimal craniofacial development. While the theoretical principles of orofacial myofunctional disorders are derived from dental science, their treatment is a combination of dental, speech and physical therapy practices. Myofunctional therapy inhibits muscle dysfunction problems and normalizes rest postures, breathing patterns and swallowing with neuromuscular repatterning. These all-influence dental occlusion, facial shape, mastication, deglutition and tongue lip and jaw resting postures (Liu, 2023). Therapy can be used to aid in orthodontic correction and relapse, obstructive sleep apnea, TMD, noxious parafunctional behavior, and improve craniofacial morphology (Brinkman-Falter, 2020) (Yue Liu, 2023 Mar 31).

An easy screening tool to quickly identify an orofacial myofunctional disorder (OMD) encompasses five noticeable signs that we see at the dental visit. These five areas are speech, posture, occlusion, tethered oral tissues and swallow (SPOTS). The document lets the provider circle the symptoms in each area for the referral and scanned into the patient chart. It can also be used for patient education and sent home with the patient for their reference. There are additional factors listed at the bottom of the SPOTS screening tool that are complicating factors in the patient's treatment and will help your myofunctional therapist in their assessment.

Myofunctional therapy is an important part of dental care for our patients with OMDs and is a stabilizer in the treatment of many orofacial dysfunctional conditions. It is part of the multidisciplined care we seek to provide our patients with comprehensive services. With myofunctional therapy our patients can begin to sleep, eat, and breathe better. https://youtu.be/Cg4_dcKVMq4 ◊



NEBRASKA
Myofunctional Specialties

SPOTS Myofunctional screening

Patient Name: Date:

S **Speech**
LISPING | LOW TONGUE POSTURE | SLOW/FAST SPEECH | ERRORS

P **Posture**
FORWARD HEAD | ROUNDED SHOULDERS | LEANING FORWARD | CHIN TILTED UP

O **Occlusion**
ANGLE'S CLASS _____ | CROSS BITE | OPEN BITE | DEEP BITE

T **Tethered Oral Tissue**
TONGUE TIE: ____ANTERIOR _____POSTERIOR | BONEY ATTACHMENT | LABIAL/BUCCAL TIES

S **Swallow**
TONGUE THRUST: _____ANTERIOR _____ POSTERIOR | INTERDENTAL SPLINTING | GRIMACE

PROBLEMS ASSOCIATED WITH THESE FINDINGS: CIRCLE all that apply

BRUXISM/CLENCHING	SUCKING/BITING HABITS	DECAY
SNORING/APNEA	ORTHODONTIC RELPASE	GINGIVITIS
MOUTH BREATHING	TMJD	PERIODONTAL

Referral Source _____

Patricia Brinkman-Falter, BSDH, MS, PHRDH, COM
8911 Whispering Wind Road, Lincoln, NE 68512 11414 W Center Road, Ste 335, Omaha, NE 68114
(402) 759-2561 or (402) 882-2MYO

Oral Surgery Program

BY DR. NICK PARQUE

Dr. Parque grew up in Northeastern California in the small town of Susanville. After high school, he then moved to Spokane, Washington, where he attended Gonzaga University. Dr. Parque completed his dental school training at the University of Detroit Mercy in Detroit in Michigan and had a special interest in surgical training completing the Periodontics Clerkship and Advanced Oral Surgery Clinical Elective programs. Following the completion of his dental training, Dr. Parque completed a General Practice Residency Program at Swedish Medical Center with special focus on advanced oral surgical procedures, sedation dentistry, and management of medically complex patients. During his residency training he also obtained Advanced Cardiac Life Support certification as well as his Intravenous Moderate Conscious Sedation Permit in the state of Washington. Since the completion of his residency training, Dr. Parque has served as an attending dentist within the Swedish residency program and has trained five cohorts of resident dentists on advanced oral surgical procedures. He has a passion for teaching and helping others learn to deliver excellent surgical care.

The Washington Academy of General Dentistry (Washington AGD) has continuously strived to be a leader in providing high-quality continuing education while also making a significant impact on the community. With a strong commitment to serving the Pacific Northwest, our organization has gone above and beyond to bring innovative course offerings to dentists in the region. Over the past decade, the footprint of the Washington AGD has expanded, enabling us to offer a multitude of clinical courses that have a positive effect on dental care in the community.

In 2021, the Washington AGD took on a new challenge: creating a program that would allow general dentists from all over the country to participate in hands-on, patient-facing oral surgery training. This endeavor was driven by the recognition that post-graduate oral surgery training, outside of traditional university or hospital centers, was scarce and difficult to find for dentists eager to expand their skills in this area. Nationally, there are few courses available, as hosting such a program presents numerous logistical challenges.

Despite these obstacles, the Washington AGD successfully hosted its sixth iteration of the three-day course, "Surgical Extractions for the General Dentist." This course has evolved significantly since its inception, with each offering improving upon the last. Dentists from across the country have eagerly attended, recognizing the immense value of gaining hands-on experience and expertise in oral surgery.

The course design is broken into two parts: day one being didactic and bench top training, with the following two days being entirely dedicated to patient care. The focus of the first day is to highlight key medical considerations for oral surgery, principles of surgical extractions, how to deliver proper informed consent, and post-operative management. This day is also used to highlight techniques through suturing mat and pig's jaw exercises.

Aside from offering a high quality education experience, the AGD aims to use this course as a means to provide a positive impact in the community by treating underserved populations. All patients treated at the "Surgical Extractions for the General Dentist" course are provided care at no cost. A large portion of the patients seen in this course are referred from clinics in the community who do not have a reliable referral source for oral surgery needs as there are very few providers in the region who offer these services covered by State dental insurance. As a result, the participants of the course can provide much needed care to eliminate pain and infection for those in need.

The Washington AGD's commitment to aiding the community and offering free treatment to patients is a testament to our dedication to improving oral health for all. Through these efforts, we have provided high-quality oral surgery training and have made a profound impact on the lives of individuals who would otherwise face significant barriers to dental care. The ripple effect of this work extends far beyond the confines of the classroom, ultimately creating a healthier and more inclusive dental landscape for communities across the country. ◊

Don't be the Hammer

BY DR. LEROY HORTON

Dr. LeRoy Horton completed his Bachelor's degree in Biology from Pacific Lutheran University in 2003 then attained his DDS degree from the University of Washington School of Dentistry in 2007. Having always been fascinated with dental implants, Dr. Horton pursued advanced training over the years attaining fellowships and completing Master's courses. Eventually he earned his board certification in Implantology as a Diplomate of the International Congress of Oral Implantology. After practicing for 14 years he sold his offices and decided start a new chapter in academia and research. He currently is a 3rd year graduate periodontics resident at Oregon Health Sciences University where he is pursuing a periodontal certificate and a Master's degree in periodontal science. Over the last third of his career he serves our profession as a nationally recognized AGD instructor #389294.

The old adage of "to a hammer everything looks like a nail" is very true in our profession. When I first got into Implantology, my eagerness to find opportunities to practice this developing skill set of mine colored my treatment planning. I didn't realize how much until I became much more experienced, and no longer as driven by this enthusiastic ambition to become an implant doctor. We tend to avoid such honesty in our conversations, even the ones we have with ourselves. I like to think that I am a refined clinician now, but I am sure I will always have room for growth and improvement. Dental implants is a passion of mine, but the more I interact with other doctors entering the field the more I see these older versions of myself. That helps shape my approach to continuing dental education. According to a study by Lanning et al., roughly half of general dentist have place implants to one degree or another, and recent graduates are likely to have placed more than their predecessors[1]. This is likely due to the advancement of technology and its accessibility, prevalence of implant education in dental school/residency/continuing education, and a competitive dental field where expanded skill sets is often the only way to economically survive.

Where I hope to fit in is not to simply teach dentists the A-Z of dental implants nor to just place them in edentulous areas. I want to advance the skill set of my colleagues, so that they can better serve each individual patient as their particular needs dictate. For some of these patients implants will be a great option while for others traditional restorative services would be preferable. As experts in the field of oral health, we have to stay more committed to the data than our enthusiasm. For example, in one of my continuing education articles I wrote for Dental Town Magazine, I explore common risk factors such as periodontal disease, smoking, and diabetes[2]. Common in our patients, but also commonly forgotten by providers when they consult me on cases. The conversation starts with the edentulous or soon to be edentulous site, rather than a top down description of the patient and their overall health.

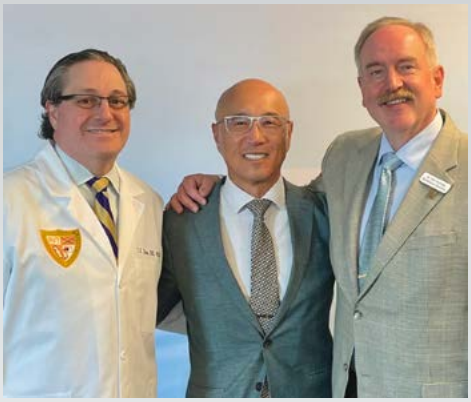
In my courses, we will absolutely dive into how to become an implantologist. We will however focus on how to look at the whole patient when considering implant therapy. Bruce Lee in the movie Enter the Dragon speaks about the "art of fighting without fighting". I see Implantology in the same vein. A true master can place an implant, but also knows when not to. I look forward to sharing my knowledge with you all in my upcoming lectures as part of the WAGD master track. ◊

1. Lanning SK, Best AM, Hunt RJ. Periodontal services rendered by general practitioners. J Periodontol. 2007;78(5):823-832.

2. https://www.dentaltown.com/magazine/article/8651/dental-ce-in-it-for-the-long-haul

Crown Preparation 101: From Analog to Digital

UWSOD AGD STUDENT CHAPTER COURSE



Washington State is home to one of the most active AGD chapters, the Washington Academy of General Dentistry (WashingtonAGD). Through the WashingtonAGD's guidance, mentorship, and financial support, the University of Washington AGD Student Chapter (UWSOD AGD SC) has created some innovative opportunities for students to experience all the AGD has to offer.

Under the leadership of Dr. James Newman and President Jason Lu the UWSOD AGD SC has created numerous CE opportunities for its student members. This includes up to 3 CE and 1 social event per quarter. The University of Washington School of Dentistry Graduate Prosthodontics program and its Director, Dr. Van Ramos, provide a prosthodontic lecture by one of the UWSOD Graduate Prosthodontics Residents every quarter. This is a "win-win" for the student chapter and the Graduate Prosthodontic program. The chapter selects another speaker to present on a relevant topic. Another CE event the chapter attempts to host every quarter is a live, hands-on event. Attendance continues to grow and now the UWSOD AGD SC CE opportunities are being extended to dentists in the community often being hosted at the WashingtonAGD Global Learning Center (https://washingtonagd.org/).

The UWSOD AGD SC in 2019 launched the now annual course "Crown Preparation 101: From Analog to Digital" mentored by Dr. Timmy Hess. On May 20th, 2023, with support from Komet USA, NSK, Ivoclar, Planmeca, Diashine, Pascal, and Washington Dental Insurance Agency, 27 students were led through the "38 Steps" of a crown preparation. Drs. Karl Hoffman and John Yae demonstrated and supervised the procedures throughout the day. This CE experience being a guided hands-on course, attempts to create a logical workflow from seating the patient through buildup, preparation, impression/scan, provisional, and finally releasing the patient. Students begin the day thinking a crown preparation course is about burs and typodont teeth and leave realizing there is much more when there is a patient in the equation.

The UWSOD AGD SC plans to take this course "on-the-road" to other dental schools and meetings. Future UWSOD AGD StudentTrack course offerings will include Dr. David Clark teaching composite restorations based on the Bioclear Technique. More digital dentistry is coming and the UWSOD AGD SC members continue to have access to the WashingtonAGD Fellowship and MasterTrack course at the WashingtonAGD Global Learning Center at greatly reduced tuitions.

The future is looking good for AGD student led CE. ◊

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WITH SPECIAL GUEST:
Timothy F. Kosinski, DDS

dm DenMat


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SATURDAY, JANUARY 20TH, 2024
8:00 AM-5:00 PM
WASHINGTON ACADEMY of GENERAL DENTISTRY
PACE
ACADEMY of GENERAL DENTISTRY
PROGRAM APPROVAL FOR CONTINUING EDUCATION
CLINICAL TRAINER:
DR. CARLA COHN
Komet
SCAN and PAY
PATTERSON DENTAL
ivoclar
NSK Create it


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ACADEMY of GENERAL DENTISTRY
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WASHINGTON ACADEMY of GENERAL DENTISTRY
SALVIN Dental Specialties
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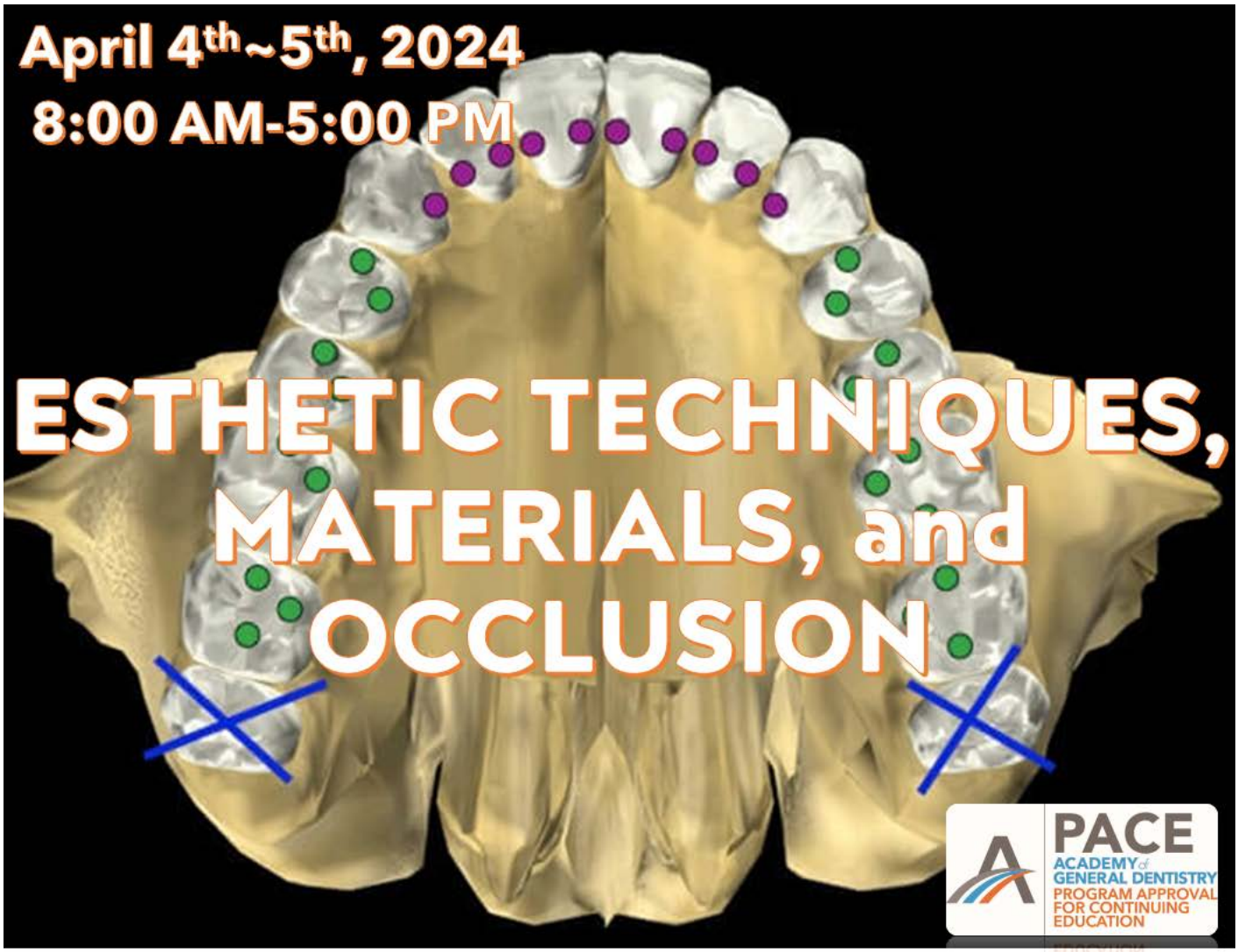
ivoclar



CLINICAL TRAINER:
DR. LEE ANN BRADY

SCAN and PAY

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Starting: September 27, 2024
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Dr. Prasith Kim-Aun
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Dr. Steven Karmy
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PLANMECA
SALVIN Dental Specialties

The Benefits of Obtaining Fellowship and Mastership

BY DR. THERON A. MANSON FAGD

Dr. Theron Manson was raised in British Columbia but now calls Seattle his home. He received his Doctor of Dental Surgery from the University of Washington. He and his wife Connie have two boys, and enjoy skiing, hiking, and traveling together.

When he isn't at work, Dr. Theron Manson also enjoys coaching his sons' athletic activities.

To stay abreast of the latest patient care techniques, Dr. Theron Manson completes as many as 200 hours of continuing education per year.

He has many areas of interest including sleep dentistry (for individuals with sleep apnea), Invisalign braces, and other orthodontic therapies.

The article presents an in-depth discussion on the benefits of obtaining Fellowship and Mastership in general dentistry from the Academy of General Dentistry (AGD). These prestigious awards serve as a testament to one's unwavering commitment to continuous learning and keeping up with the latest developments in the field.

Through AGD Fellowship and Mastership, dental practitioners can broaden their clinical knowledge and enhance the quality of care they provide to patients. AGD Mastership holders can also earn the Lifelong Learning and Service Recognition (LLSR) award, which acknowledges their dedication to ongoing education and active participation in organized dentistry and community outreach programs.

Only a small percentage of dentists worldwide have received the AGD Fellowship and Mastership accolades, with Mastership holders earning an average of $30,000 more per year than their peers. The AGD's Knowyourdentist.org website offers valuable information to patients on the importance of these awards and helps them locate an AGD dentist.

To be eligible for the Fellowship award, a dentist must complete a minimum of 500 continuing dental education hours, pass a rigorous exam, and maintain continuous AGD membership for three years. Mastership recipients must first receive the Fellowship award and then fulfill an additional 600 approved CE hours in specific dental disciplines.

Overall, AGD Fellowship and Mastership represent a level of commitment to excellence that exceeds the standard education and licensing requirements. The awards are celebrated annually at the AGD Convocation Ceremony and can be promoted to patients through an extensive range of resources and tools provided by the AGD. ◊

ACADEMY of GENERAL DENTISTRY®

2024 AGD Membership Application

Join online at agd.org, or call us at 888.243.3368 or 312.440.4300.

PROMOTIONAL CODE:

REFERRAL INFORMATION

If you were referred to the AGD by a current member, please note his or her information below:

Member's name

City, state/province, or U.S. Federal Services branch

MEMBER INFORMATION

First name | MI | Last name | Designation (e.g. DDS, DMD, BDS) | Primary Email address

Do you currently hold a valid U.S./Canadian dental license? ☐ No ☐ Yes: License number | State/province | Date renewed (mm/yyyy)

Type of membership: (Check one.) ☐ Active general dentist ☐ Associate (dental specialist) ☐ Resident ☐ Dental student ☐ Affiliate

If you are not in general practice, please indicate your specialty: _____

Current dental practice environment: (Check one.) ☐ Solo ☐ Associateship ☐ Group practice ☐ Hospital ☐ Resident ☐ Corporate

☐ Other _____ ☐ Full-Time Faculty _____ (Please indicate institution) ☐ Federal Services _____ (Please indicate branch)

CONTACT INFORMATION

Preferred billing/mailing address: ☐ Business ☐ Home

Your AGD constituent is determined by your business address, unless one is not available.

Business address | City | State/province | ZIP/postal code

Name of business (If applicable) | Phone | Fax

Home address | City | State/province | ZIP/postal code

Phone | Cell phone | Alternate email | Date of Birth ☐☐ ☐☐ ☐☐☐☐

EDUCATIONAL INFORMATION

Are you a graduate of an accredited* U.S./Canadian dental school? ☐ Yes ☐ No ☐ Currently enrolled

Dental school | State/province | Country | Date of graduation (mm/yyyy) ☐☐ ☐☐☐☐

Are you a graduate of (or resident in) an accredited** U.S. or Canadian postdoctoral program?
☐ Yes ☐ No ☐ Currently enrolled Type: ☐ AEGD ☐ GPR ☐ Other

**Official accreditation is given by CODA in the U.S. and CDAC for all Canadian provinces. **Accredited dental residencies qualify for the resident membership rate. Official proof of enrollment must be provided to AGD.*

Postdoctoral institution | State/province | Country | Start date (mm/dd/yyyy) | End date (mm/dd/yyyy)

OPTIONAL INFORMATION

Gender: ☐ Male ☐ Female ☐ Prefer not to disclose ☐ Not listed

Ethnicity: ☐ American Indian ☐ Asian ☐ African-American ☐ Hispanic ☐ Caucasian ☐ Other

DUES INFORMATION

Please check membership type applying for to determine Headquarter dues::

	U.S./ International	Canada/Puerto Rico (in U.S. dollars)
☐ Active General Dentist	$463	$438
☐ Associate	463	438
☐ Affiliate	232	219
☐ Resident	21	21
☐ 2023 Graduate	93	88
☐ 2022 Graduate	185	175
☐ 2021 Graduate	278	263
☐ 2020 Graduate	370	350
☐ Dental Student	21	21

1. AGD Dues: $_____

Upgrade to Premium Plus Membership* (Add $158 USD) $_____

2. AGD Constituent Dues: $_____

3. AGD Component Dues: $_____

Please refer to back side for constituent and component dues.

Total Amount Enclosed: $_____

Dues rates effective through September 30, 2024

I hereby certify that all of the above information is correct, and that by signing this application, I agree to all terms of membership including completion of 75 hours of continuing education every three years for active general dentist and associate members.

Signature | Date

Note: Check payment is required with hard copy applications. To pay with credit card, please apply online at agd.org/membership. If you have any questions, please contact our Membership Services Center at 888.243.3368.

Please sign this application and submit payment to:
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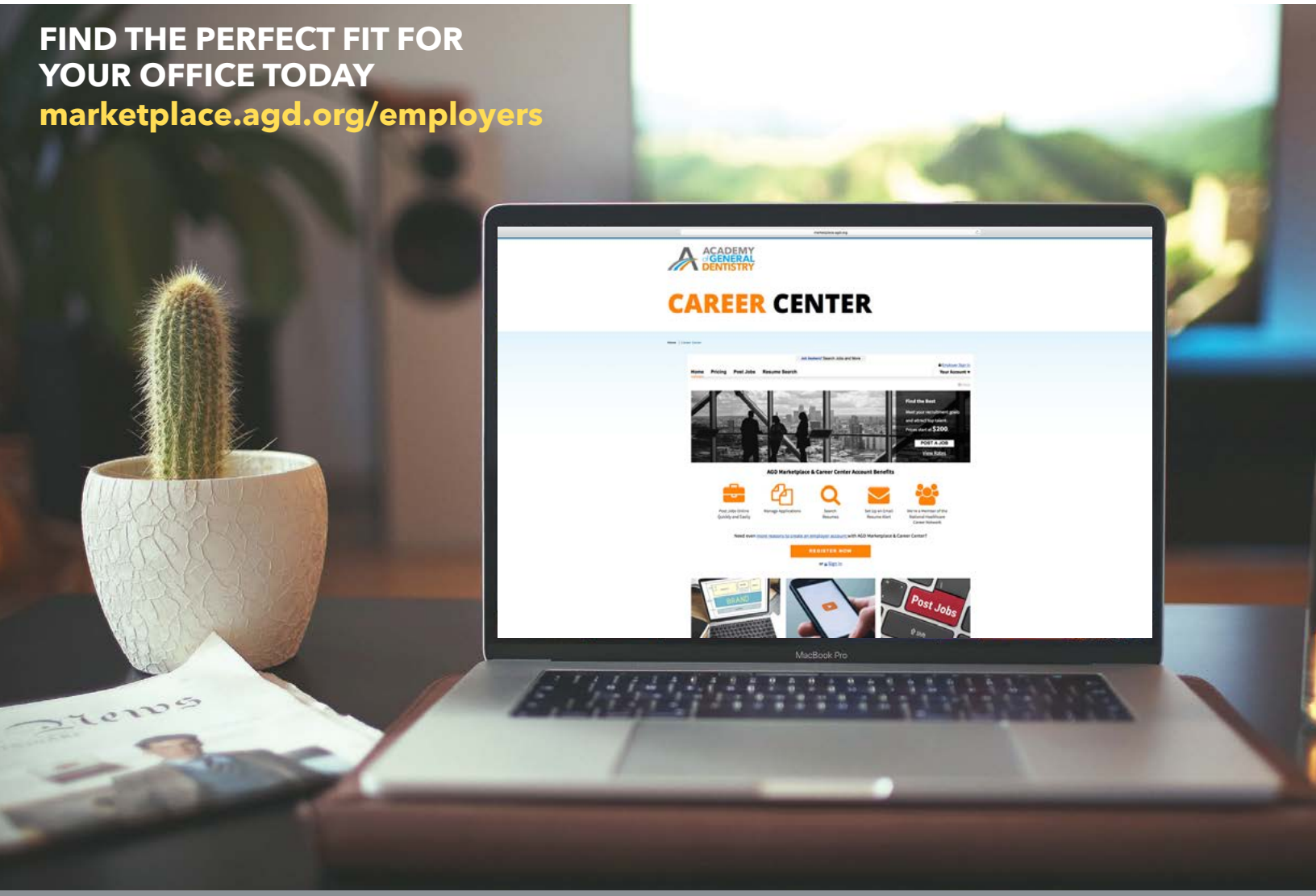

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