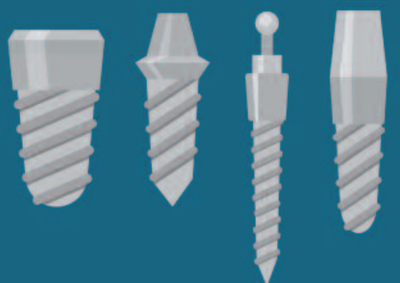
MONTEREY BAY

SMILELINE

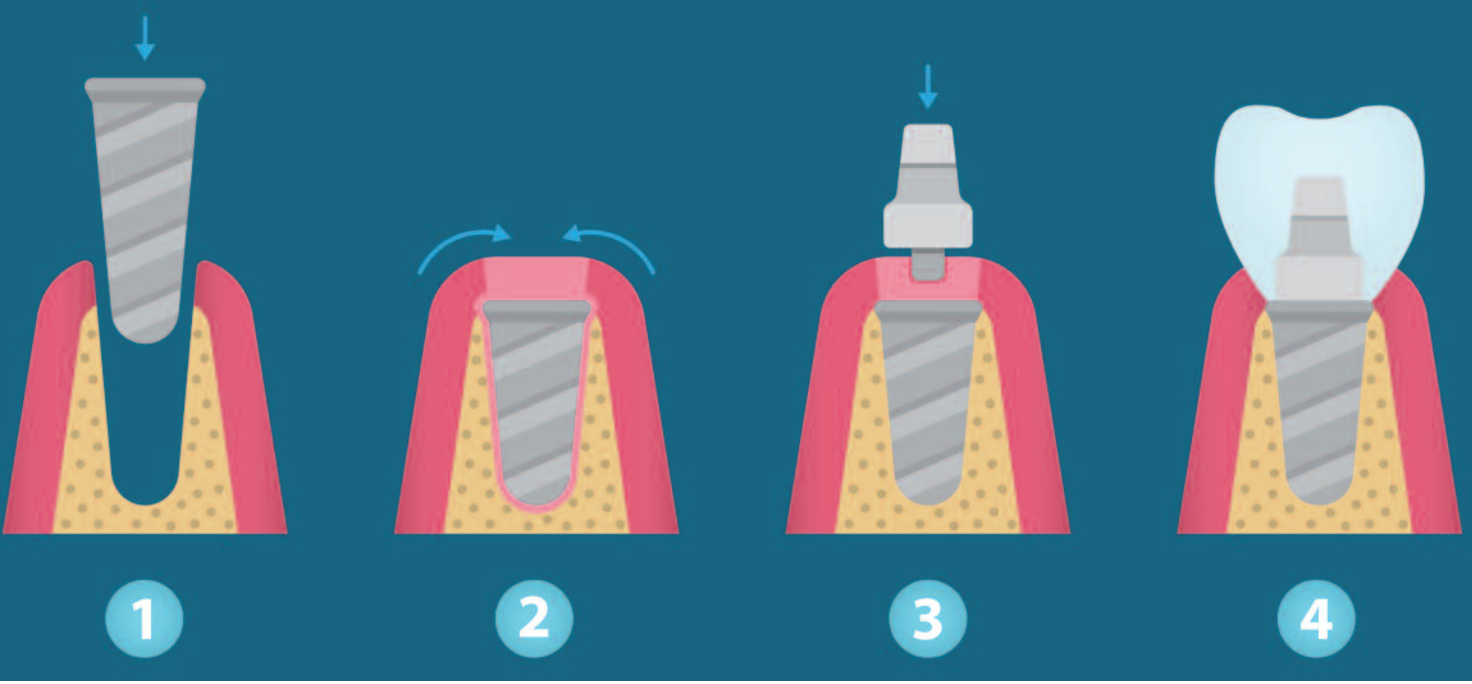
THE NEWSLETTER OF THE MONTEREY BAY DENTAL SOCIETY

WINTER 2019



- Implants Should Be a Standard
- Anterior Implants— A Restorativley Driven Workflow
- Mandibular Implant Assisted Overdenture Bar Design

FOCUS ON IMPLANTS AND PROSTHODONTICS



"People who are crazy enough to think they can change the world, are the ones who do."

—Rob Siltanen

SmileLine

The Newsletter of The Monterey Bay Dental Society

Published By
Monterey Bay Dental Society

8 Harris Court, #A2, Monterey, CA 93940
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www.mbdsdentist.com

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MONTEREY BAY
SMILELINE

A Message From Your Incoming MBDS President

Happy Holidays from your Dental Society!

Steve Ross, DDS

Our lives in so many ways are a reflection of the lives that touch ours. In my life, by far the biggest influence on who I am today is my parents. They gave me life, of course, and for that I'm grateful, but they gave me many advantages and head-starts that started me on the path of who I am today. I can hardly count the many times I have been sitting in a course where a good idea is presented, and the thought occurs to me, "oh!, this is just like what my Mom taught me." or "this is how my Dad does things."

Secondly, my wife. As I reflect on my path to being a dentist, there were many times where she was right by my side supporting me, and even kicking me out of bed in the morning when she knew I had something important to do on that path. If it weren't for her, I would likely be a hermit somewhere cut off from as many social interactions as I could manage left to my video games and movies.

And as a direct offshoot from her, our kids, though at times can be seen as a time drain by some, to those who know, they are a source of drive and inspiration. When you have kids it is kind of like that moment in the Grinch that Stole Christmas where his heart grows three sizes bigger. Your whole world changes. You have a lot to do to keep them alive and thriving, yes...but, your capacity to deal with all the world has to throw at you is increased dramatically.

Next, on the path to becoming a dentist are the countless teachers, mentors and friends that helped me on my way. Once you start on that path, the path is such a busy one that just keeping up with everything you have to do to stay on the path takes nearly all your time and efforts. But like the victory tunnel at the end of our kids soccer games, there is a solid row of support members on both sides of the path that make navigating the path possible.

Once I actually became a dentist, many of the hurdles were in the past, but other hurdles that I could not foresee were still to come.

Economic troubles made me aware how lucky we have it here in America. There are many forces out there in the world, and many of those work to our advantage to make this corner of the world a place of abundance where there is enough to go around and extra to spare. Our nation's leaders start a good deal of these advantages. Our armed forces enforce the ideals and policies that make these advantages work.

I believe there are countless ways where God in Heaven influences and guides much of what goes on in this world so our world IS a world of abundance. Think of the last time you, or anyone you know has gone hungry. Our world is not without its problems, but God is working through countless angels walking among us to help heal those problems.

Now, more directly, my business life was touched early on by Jennifer Wynn and Lew Richardson as well as Marla Tillery. Now that I have a place where I can practice dentistry, I wouldn't be able to get much done at all if it were not for my team. My wife calls some of them, "my work wife," probably because we spend sooooo much time together. But it is more than that, there is an understanding where I know what drives them, they know what I am thinking and together we can work fast and efficiently to get a patient out of pain, or give another patient their smile back.

Debi Diaz acting in the role as dental society executive director has provided countless instances of support. Other members of the dental society provide support as well, some directly, and some by way of competition drive me in general dental practice to strive to provide excellent care each and every day. The many businesses of the area each contribute to a robust local economy that gets hundreds of thousands of people out

of bed each day seeking to better their life in some way. And I know many of us groan when we think about our interactions with dental insurance companies, but, yes I am grateful for dental insurance companies too.

Dick Kent, dental society president in 2017, once said that he might make his project as president to help create a better dental insurance company. He cited the Stanislaus Dental Foundation as an example. It is a dental insurance company that is not for profit. In Stanislaus county, some board members of the local dental society also serve on the board for the local dental foundation. It reimburses dentists at a fairly high rate, and strives to keep its own overhead low by utilizing volunteer leadership.

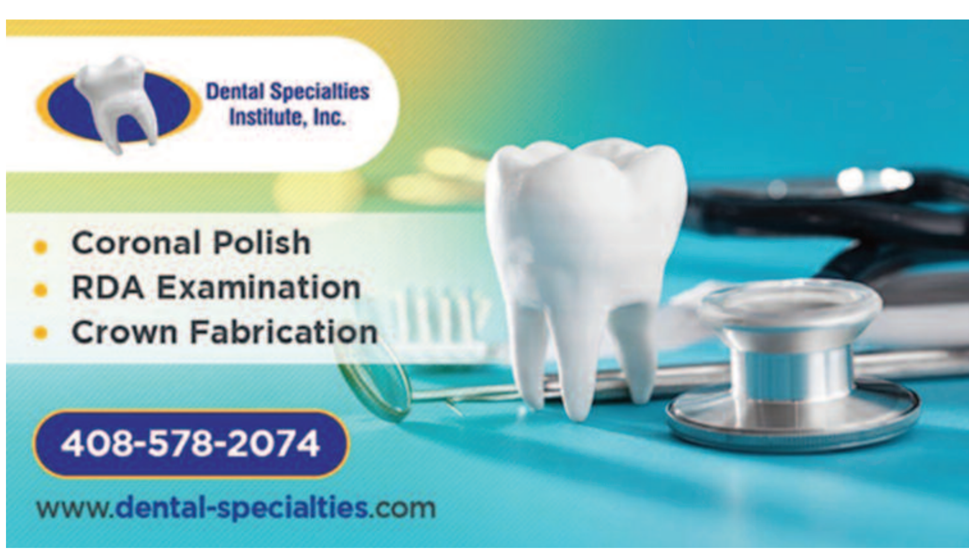
After looking into the matter, I discovered that Coastal Healthcare Administrators is under the same state umbrella on a local level in Monterey County as the Stanislaus Dental Foundation is for Stanislaus County. For those of you that are contracted with Coastal Healthcare Administrators, check your fees, I think you will find that they are among the best. However, it has an outdated provider list. Also, it lacks a competitive edge when being presented to local businesses. The dental society is anxiously awaiting a recommendation on what to do to make Dr. Kent's project more of a reality. I was appointed head of the task force to gather information and make recommendations. This is a call to any who might be interested in joining the task force.

I know little about insurance, and I know less about task forces, but I think it will be worth the effort if we can come up with something like what Stanislaus Dental Society has in their midst. And it may be as simple as revamping the current local plan.

I have heard that the best time to plant a fruit tree in your yard is 20 years ago, but the second best time is today. So, join me to plant a proverbial tree.

Steve Ross, DDS
MBDS President 2020

> "*Your smile is the prettiest thing you'll ever wear.*"



Editor's Column Fall/Winter 2019

Dr. Carl Sackett, DDS, Editor

Happy Holidays from the Monterey Bay Dental Society!

I hope this issue finds you and your families well, amidst the hustle and bustle of the season.

What a great year it was for the Dental Society. We continued to host various member events (Shred-A-Thon, I nstallation of Officers, etc.), and our CE offerings remain top notch. It is such a privilege and honor to be able to provide you all with these newsletter updates, and keep everyone in the loop with on-goings within our component.

The "specialty" theme of the Summer issue was well received, and I had an inkling to proceed along that same path for the subsequent issue. When I arrived at our Fall Board Meeting and Debi Diaz handed me a newsletter with that exact topic, I took it as a sign.

Hence, I am proud to announce that this edition of the SmileLine focuses on Implants and Prosthodontics. Once again, we were overwhelmed with positive responses to our petition for participation from our own member specialists, and I hope you enjoy their contributions.

I have to admit that I have always found Prosthodontics to be incredibly fascinating, and I likely suffer from a bit of "Implant-Envy." While Pediatric Dentistry is wonderful and has its own benefits, I can't deny that I have pipe dreams of placing my own titanium implant someday. While I may complete my career having never delivered a single Nobel Biocare, I can still admire them from afar, and appreciate their beauty and precision.

In researching content for this issue, it quickly became evident that there is a plethora of different Implant/Prosth organizations. To name just a few, they are the American Academy of Implant Dentistry, The Academy of Prosthodontics and The Academy of Osseointegration. As far as journals go, there is vast amount of resources to choose from as well, including The Journal of Oral and Maxillofacial Implants, The Journal of Implantology, and the Journal of Prosthetic Dentistry.

Indeed, the spectrum is extensive, and we were literally inundated with potential content for this issue. Needless to say, we had to pick and choose what to include, and we hope you enjoy the variety of articles. In addition, as Editor for the SmileLine, I get the unique opportunity to read newsletters from all the components throughout California. We'd like to extend thanks to the Executive Director of the Sacramento Dental Society, Cathy Levering, who was willing to share three Implant Articles from their most recent publication, "The Nugget".

Thank you again for your support of our dental society, and helping to keep our membership engaged. Wishing you all a blessed and safe holiday season, and a very Happy New Year as well.

Sincerely,

Carl Sackett, DDS
MBDS SmileLine Editor

Welcome To Our New Members for 2019

BIG SUR
Lura Orsino, DDS

DANA POINT
Tiana Dorneman, DDS

FREEDOM
Shannon Hayashibara, DDS

HOLLISTER
Leanna Ursales, DDS

MONTEREY
Natalie La Rochelle, DDS
Michelle Manimtim, DDS
Linda Martin, DDS
GlennTakenaga, DDS
Mayank Sharma, DDS

SALINAS
Daniel Cummins, DDS
Tala Gredinberg, DDS
Kathleen Mascardo
Sami Sreis, DDS
Romy Fe Valiente, DDS
Sung Sohn, DDS

SEASIDE
Tiana Dorneman, DDS
Michael Faktor, DDS
Kunjal Patel, DDS

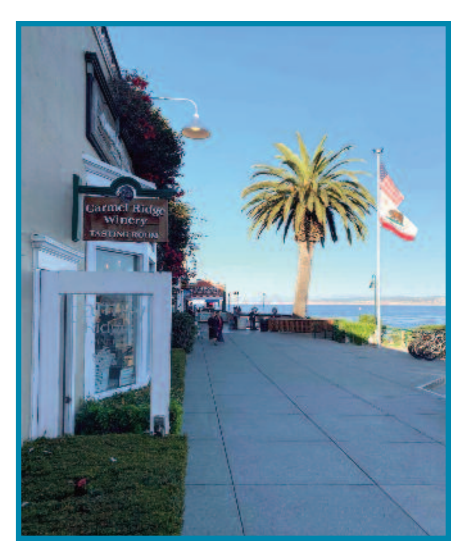
SANTA CRUZ
Kevin Reuter, DDS
Jessica Ray, DDS
Nathan Oster, DDS

SCOTTS VALLEY
Corrine Cline-Fortunato, DDS

We encourage old members to reach out and welcome our new members if they have not done so already. We are excited and happy to have them join us! For information about contacting our new members visit the member only section of the website for the full member directory that includes addresses and phone numbers.

New Dentist Social

On Thursday, September 19th, many new dentists joined us for a fun and social mixer for both new and tenured dentists on the Central Coast. Held at Carmel Ridge Winery in Monterey and sponsored by: Jason Greenland, Territory Manager for Wells Fargo Practice Finance, and Anna Tadevosyan, Wells Fargo Healthcare Business Development Officer. It was an opportunity for all to meet and mingle with industry experts as well as peers in the area. Wine tastings and appetizers were complimentary at the event. We gave away a free bottle of wine from Carmel Ridge Winery during the event night. All enjoyed the beautiful ocean front view at this amazing location on Cannery Row!



THANK YOU TO OUR OUTGOING 2019 BOARD OF DIRECTORS

Position	Name
President	*Lindley Zerbe, DDS*
President-Elect	*Steven Ross, DDS*
Vice President	*Matthew Wetzel, DDS*
Secretary	*Jennifer Lo, DDS*
Treasurer	*Richard Kent, DDS*
State Trustee	*Nannette Benedict, DDS*
Immediate Past President	*Eric Brown, DDS*
County Directors	*Devin Bernhardt, DDS, David Brock, DDS, Rajneesh Dail, DDS, Sarah Frahm, DDS, Geralyn Menold, DDS, Matthew Ronconi, DDS and Joseph Robb, DDS.*
Publications	*Carl Sackett, DDS*
Legislative Chair	*Daniel Pierre, DDS*
Dental Health Committee	*Lloyd Nattkemper, DDS*
Community & Public Relations	*Steve Ross, DDS*
Ethics Committee	*David Shin, DDS*
Peer Review Committee	*James Leamey, DDS*
New Dentist Committee	*Garrett Criswell, DDS*
Membership Committee	*Matthew Wetzel, DDS*
Continuing Education Committee	*Steve Ross, DDS*

WELCOME TO OUR 2020 INCOMING BOARD OF DIRECTORS

Position	Name
President	*Steven Ross, DDS*
President-Elect	*Matthew Wetzel, DDS*
Vice President	*Matthew Ronconi, DDS*
Secretary/Treasurer	*Jennifer Lo, DDS*
State Trustee	*Nannette Benedict, DDS*
Immediate Past President	*Lindley Zerbe, DDS*
County Directors	*Devin Bernhardt, DDS, David Brock, DDS, Rajneesh Dail, DDS, Sarah Frahm, DDS, Christopher Mule, DDS and Joseph Robb, DDS*
Publications	*Carl Sackett, DDS*
Legislative Chair	*Daniel Pierre, DDS*
Dental Health Committee	*Lloyd Nattkemper, DDS*
Community & Public Relations	*Matthew Wetzel, DDS*
Ethics Committee	*David Shin, DDS*
Peer Review Committee	*James Leamey, DDS*
New Dentist Committee	*Garrett Criswell, DDS*
Membership Committee	*Matthew Ronconi, DDS*
Continuing Education Committee	*Matthew Wetzel, DDSs*

Monterey Bay Dental Society Board of Directors — Past Presidents

1980-1981	*John Rhoads, DDS*
1981-1982	*Raymond Hansen, DDS*
1982-1983	*Stephan Ferman, DDS*
1983-1984	*Lewis Richardson, DDS*
1984-1985	*John Steel, DDS*
1985-1986	*Barry Staley, DDS*
1986-1987	*Joe Mitchell.DDS*
1987-1988	*Gerry Tarsitano, DDS*
1988-1989	*Tom Gorman, DDS*
1989-1990	*Christopher Keys, DDS*
1990-1991	*Kevin Landon, DDS*
1991-1992	*Leon Cooper, DDS*
1992-1993	*Mark Joiner, DDS*
1993-1994	*Gary Klugman, DDS*
1994-1995	*Geralyn Menold, DDS*
1995-1996	*Philip Bhaskar, DMD*
1996-1997	*Bruce Donald, DDS*
1997-1998	*Norman Jacobson, DDS*
1998-1999	*David Simonsen, DDS*
1999-2000	*David Stein, DDS*
2000-2001	*David Montgomery, DDS*
2001-2002	*Rick McBride, DDS*
2002-2003	*Mic Falkel, DDS*
2003-2004	*Bryan Mansour, DDS*
2004-2005	*Kevin Ippisch, DDS*
2005-2006	*Lloyd Nattkemper, DDS*
2006-2007	*Harry Stuart Osaki, DDS*
2007-2008	*William Francis, DDS*
2008-2009	*Chad Cassady, DDS*
2009-2010	*Marielena Murillo, DDS*
2010-2011	*Nannette Benedict, DDS*
2011-2012	*Corrine Cline-Fortunato, DDS*
2012-2013	*Daniel Pierre, DDS, MS*
2013-2014	*Tim Griffin, DDS*
2015	*Carl Sackett, DDS*
2016	*Ariana Ebrahimian, DDS*
2017	*Richard Kent, DDS*
2018	*Eric Brown, DDS*
2019	*Lindley, Zerbe, DDS*

> *"A man begins cutting his wisdom teeth the first time he bites off more than he can chew."*
>
> — Herb Caen

"Spotlight" Interview with David Brock, DDS

The Monterey Bay Dental Society Board of Directors is pleased to welcome Dr. David Brock as County Director. Dr. Brock is a prosthodontist in Monterey, who's scope of practice focuses on comprehensive restorative dentistry.

In keeping with our Winter SmileLine theme of "Advancements in Prosthodontics and Implants", we felt he would be a perfect candidate to spotlight as a new member to the BOD. Please enjoy our conversation with Dr. David Brock:

CS: Welcome to the Board of Directors! What made you want to join the BOD, and what do you hope to bring to the position?

DB: I have always been impressed with the activities and services provided by our Dental Society. The success that our members enjoy today is the direct result of all the hard work and dedication by our many volunteers, and our very own, Executive Director, Debi Diaz.

I hope to see more opportunities for dentists to volunteer their time to those living under difficult circumstances. I was sad to learn that Christina's Smile would not be returning to Salinas. I had been an active volunteer there, since 2000. I understand that new opportunities to serve are in the works, and, as a member of the Board, I hope to help bring these programs front and center.

CS: As you know, the theme of this Winter Edition is focusing on your very own specialty of Prosthodontics. Are there any exciting or interesting updates with the specialty that you'd like to share with the members?

DB: At a recent ACP meeting, most of the speaker topics were hyper-focused on digital solutions to the overall dental workflow, from diagnostics and planning, to the final placement of the restorations.

By scanning a patient's mouth, that information can be utilized on a multitude of platforms. For example, a patient's maxillary and mandibular scan can be inserted into a digital articulator, and from there, restorative treatment options can be designed and implemented: a single fixed restoration, a fixed partial denture, a removable partial denture, an occlusal device, and even complete dentures.

In the field of maxillofacial prosthodontics, CAD/CAM and printing are already utilized. The future technology that is getting a lot of attention is facial holograms. By wearing a headband or a pair of glasses with mini-projectors, a patient can replace their missing body part, such as a nose, and it looks real.

Another exciting development that's emerging is in the field of robot-guided surgery. The technology promises more accurate implant and restorative prep placement. One study demonstrated that without the help of the robotic arm, the angle of the implant was misplaced on average by 10 degrees. It's easy to imagine that with all this technology, robots will soon be taking over our profession; but, if that's possible, I doubt anyone reading this will witness it within their lifetime.

CS: There is an impression amongst dentists that Prosthodontists take on the most challenging and complex restorative cases. Is there any truth to this, and if so, what is the most complicated case you've ever done?

DB: Challenging and complex cases are not just for specialists. I have seen excellent patient outcomes provided by many dentists from all over our County. What makes cases difficult are the factors that are out of our control: patient finances, patient expectations, etc. Under most circumstances, the planning and execution of the restorative treatment is the straight-forward part. That being said, the craziest case I've ever done that really made me push a sweat was a sub-gingival #16 DB amalgam on a man who could not lay back more that 20 degrees.

CS: Thank you again for allowing us to highlight your involvement with the Board of Directors. We look forward to working alongside you in the near future.

DB: It is a pleasure to serve on the Board, and I look forward to working with everyone on the projects.

Upcoming MBDS Calendar of Events for 2020

Continuing Education 2020

Friday, February 28, 2020

Oan Otomo-Corgel, DDS, MPH, FACD, APDC

• AM Session: "Systemic Perio – 2020 Update. (Diabetes, Cardio, Preterm low birthweight, Rheumatoid Arthritis, Alzheimers disease).

• PM Session: Periodontal Regeneration: Soft Tissue Root Coverage, Soft tissue thickness, Bone grafting for periodontal regeneration, and new technologies.

Embassy Suites, Seaside, CA 93955

9 AM – 5 PM 7 CE Units (Core)

**Member Dentists $285—Non-CDA members $385—Auxiliary $135*

Friday, April 24 2020

Julia Goldman, Esq. & Theresa McCarter, RDH –
"California Dental Practice Act, Infection Control & OSHA"

Embassy Suites, Seaside, CA 93955

8 AM – 1:30 PM 4.5 CE Units –

(Satisfies Dental Board's License Renewal Mandate)

**Member Dentists $285—Non-CDA members $385—Auxiliary $135*

****Includes Breakfast- no lunch***

Friday, April 24, 2020 (Limited space, register early)

CPR for Health Professionals (Re-certification)

Embassy Suites, Seaside, CA 93955

2 pm – 6 pm 4 CE Units

(Immediately following the Infection Control/OSHA & CDPA course)

Course fee: $85.00

Friday, August 28, 2020

Michael R. Dorociak, DDS, MAGD
"The Best of Everything 2020"

Embassy Suites, Seaside, CA 93955

9 AM – 5 PM 7 CE Units (Core)

**Member Dentists $285—Non-CDA members $385—Auxiliary $135*

Friday, October 9, 2020

Charles Blair, DDS
"STAY OUT OF JAIL: Avoid coding errors and excel in insurance administration."

Embassy Suites, Seaside, CA 93955

9 AM – 5 PM 7 CE Units (Core)

**Member Dentists $285—Non-CDA members $385—Auxiliary $135*

Lunch is included with registration for all full day courses
Register Online at www.mbdsdentist.com

General Membership Dinner Meetings:

Thursday, January 23, 2020

Kevin Thurman, CPA/MST
"Lower Your Taxes and Increase Your Dental Practice Value"

Bayonet Black Horse, Seaside, CA. 93955 (No CE Units)

Thursday, March 26, 2020

Lisa Fitzpatrick, DrOT, CHT, CAES
"Ergonomics And Injury Prevention"

Santa Cruz venue TBD (2 CE Units – 20%)

Thursday, June 25, 2020

"Embezzlement: Can't Happen to Me! …Or Can It? Proven Business Systems for Increased Protection and Profit in Your Practice."

Bayonet Black Horse Golf Club
Co-sponsored by Patterson Dental
Seaside, CA. 93955 (2 CE Units – 20%)

Thursday, September 24, 2020

Legally Mine, USA
"Keys to Lawsuit Prevention and Dental License Protection."

Santa Cruz venue TBD (2 CE Units – 20%)

TBD, 2020 -6:30 PM – 11:00 PM

INSTALLATION OF OFFICERS

MBDS Board Of Director's Meetings 6:00 PM Dental Society Office 8 Harris Ct, A2, Monterey

(2nd Tuesday of every other month beginning in January)

Tuesday, January 14, 2020
Tuesday, March 10, 2020
Tuesday, May 12, 2020
Tuesday, July 14, 2020
Tuesday, September 8, 2020
Tuesday, November 10, 2020

2020 CDA House of Delegates – Anaheim, CA

Friday, November 13th – Saturday, November 14th (Los Angeles, CA) (tennative)

MBDS Board Room Available: Members can now utilize the board room at the dental society for a small fee to host study groups, meetings or staff events. For more information, contact the Dental Society at 831-658-0168

Implants Should Be A Standard

Dental implants are now a major part of dentistry and should be thought of as a standard. I won't go so far as to suggest that they are standard-of-care (the definition of which is a bit of a gray area sometimes), but from a practice management standpoint, I will suggest that dental implants should be a standard offering to any patients who are missing teeth. Taking it a step even further, I would suggest that dental implants are a key component of increasing practice production — the essential factor in the success of any dental practice.

As a quick review, osseointegrated implants had their birth in the early 1980s. By the 1990s, implant placement was becoming routine for oral surgeons, periodontists, and a very small segment of general dentists. Over time, dental implants have continually demonstrated high success rates, which motivated an increasing number of general dentists to refer patients for implant placement and to learn implant restorative dentistry. Today, dental implants for many practices are routine, and many dentists automatically recommend dental implants for missing teeth. The truth is that dental implants improve the quality of life for almost any patient and should now be thought of not only as a "standard" but also, in most cases, as the "ideal" treatment.

So why aren't more patients receiving implants? The primary reason is the cost and lack of insurance coverage. Many more dental implants would be placed if they were less expensive to the patient. This dynamic needs to be offset by excellent case presentation that motivates patients to seek a surgical consult or accept dental implant treatment. Improved case presentation is the key to increasing the number of implants placed and restored and could allow the field of dental implants to grow exponentially.

Here are three recommendations to increase dental implant case acceptance.

1. Make a commitment for both dentists and hygienists to recommend dental implants to every edentulous patient. The practice should begin to think of dental implants as a "standard" that is automatically offered to patients and, in most cases, it should be recommended as the "ideal" treatment. Don't think about cost as much as what is best for the patient. Very few patients would agree to have a less expensive hip replacement in order to save money.

Dr. Roger P. Levin

Roger P. Levin, DDS is the CEO and Founder of Levin Group, a leading practice management consulting firm that has worked with over 30,000 practices to increase production. A recognized expert on dental practice management and marketing, he has written 67 books and more than 4,000 articles and regularly presents seminars in the United States and around the world.

To contact Dr. Levin or to join the 40,000 dental professionals who receive his Practice Production Tip of the Day, visit www.levingroup.com, or email rlevin@levingroup.com.

Dental implants should become an automatic part of the practice culture. Everyone in the office (including the front desk) should understand them and be positive about the high quality they provide and the quality-of-life enhancement the patient will receive.

2. Identify three key benefits of dental implants, unique to each patient, and then repeat those benefits at least three times in the presentation. Adults learn in threes. Too many practices overemphasize the technical factors of implants rather than the benefits. You might choose to focus on comfort, convenience, retention, longevity, eating, smiling, the more natural feel, etc. Patients need to understand the benefits in order to make a decision, especially when they consider implants to be a complex or unfamiliar procedure.

3. Be sure that every patient knows, prior to hearing any fees, that there are several financial options including patient financing. As I've stated time and again in numerous seminars, "In the end it always comes down to money." This is normal and to be expected. If the practice simply announces a very high fee for implant dentistry, that's the last thing many patients hear. If you begin the fee discussion by letting patients know that there are several financial options available that will help them to afford treatment, they will be more open to accepting your recommendations.

Dental implants are a growth field but have the potential to grow exponentially faster. The key is to begin to think of dental implants as a standard and often the ideal treatment. As this confidence grows within the culture of a practice, you can then implement excellent techniques, such as those described above, to increase dental implant case acceptance. In the world of win-win, the patient wins, and the practice wins.

The invisible Dental Implant Patient

Dr. Roger P. Levin answers some questions that can help to expand an implant practice

Question: *How can I identify more potential implant patients for my practice?*

Answer: There probably aren't many people who haven't heard about dental implants or have a basic understanding of their benefits. This is vastly different than in 1985 when implants were relatively new, and a great deal of time was spent trying to prove to specialists and general dentists that dental implants were a viable service that would be successful. There was a great deal of debate as to the best type of implant, implant coating, and other biological factors. And while there still may be some deliberation over what type of implant is most successful, dental implants are now widely accepted.

Given that, your focus should now be on reaching the "invisible implant patient." This is the patient who, despite already knowing that dental implants are successful and can enhance the quality of life, never presents for a consult and may not even visit a dentist regularly. These patients may be from a lower, middle, or even upper socioeconomic background. And as insurance patients, they haven't been exposed to implants through their coverage and fear that the implants are too expensive or painful.

When thinking about your approach to this type of patient, it may help to consider this analogy. In the 1940s, orthodontic care was only for the rich, as an orthodontic case at that time rivaled the cost of a new car. When dental insurance began to cover orthodontics, it became more and more mainstream and is now considered a rite of passage for anyone desiring a great smile regardless of their income bracket.

Third molars in oral surgery are another good example of how a new dental service became a go-to dental treatment. Third molars were deemed to be unhealthy and prone to significant infection; however, they caused a much more complex and painful extraction for adult patients. As insurance coverage broadened to cover an increasing number of patients, the number of third molar cases expanded as well. Third molar removal is now considered a biological health necessity.

There is a slightly increasing amount of insurance coverage for dental implants; however, it is nowhere near the coverage of orthodontic care or third molar removal. This is why there are still so many invisible implant patients. So how do we begin to access the invisible implant patient in an interdisciplinary care environment?

• Give all edentulous patients an implant consultation. The cost of implants or knowledge of the patient's background should not be considered a factor. Every edentulous patient should be encouraged to undergo an implant consul-tation. This would include treatment design, cost, length, options, recovery, pain management, and fees. Having a consultation anytime a patient is missing teeth should be thought of as normal and automatic protocol whether the patient is currently interested in implants or not. Only with knowledge and education can a patient who is not currently interested in dental implants become more informed and decide to accept implant treatment today or possibly in the future.

• Explain the benefits of implants over other procedures. Invisible implant patients don't know enough to ask about implants and are often not presented with an implant option. These patients should know that dental implants are long-lasting and give patients a quality of life that they cannot get from any other dental treatment for missing teeth. Partial dentures are known to weaken the adjacent natural teeth that provide support for the dentures, and dentures overall do not look or feel natural, are prone to causing gum disease from trapped food, and must be consistently removed and cleaned.

• Promote convenience. People will pay to have their lives made easier. If you think your patients can't afford implants, simply ask yourself how many people you know who do not have cable, Internet, cell phone service, and a flat screen television. There are almost none. Most people find the money to pay for whatever they really want. They may prefer taking a cruise over getting implants, but you won't know until you present it to them. When discussing implant treatment with patients, it's best to focus on how implants will improve their quality of life through the convenience they offer. Explain that dental implants last for many years, stay in their mouth, are taken care of like natural teeth, and that most of the time they probably won't notice they have them. That's a level of convenience that many people are willing to pay for.

• Offer various payment options. Offer a 5% discount for paying in full by cash or check prior to treatment. Accept payment by credit cards, a short-term monthly payment plan, or patient financing. Companies like CareCredit® have different financing options, and one of our favorites is the 6-month interest-free option. The practice will give up approximately 6% of its fee (only 1% more than the discount we suggested that they pay upfront anyway), and patients get 6 months to pay if it's a case in the United States. Six months seems to be a fantastic time frame that patients like and it usually fits their budget. However, there are some patients who may need much longer-term payment plans and will choose loan options for payment. Whatever the option, patient financing can completely change their view of accepting dental implants.

• Educate all patients about dental implants whether they need them or not. Provide a complimentary first implant exam for any patient to learn more about dental implants. Many patients have aging parents or friends who complain about missing teeth. Patients who are educated about dental implants will educate others who may benefit from implant treatment.

• Provide consistent, long-term marketing to patients who have had implant consultations. Many invisible implant patients desire dental implants, but they put it off for some time in the future. However, they may never get around to it unless they receive some type of reminder. Practices should contact patients periodically by email or text to remind them about the benefits of implants.

• Infuse energy and enthusiasm in case presentation. As dental implants become more common, the case presentations tend to become more robotic. Having a treatment coordinator who can enthusiastically explain the benefits of dental implants can go a long way toward motivating the invisible implant patient to accept treatment.

Summary

All new dental services must go through a stage of gaining legitimacy both within the profession and with early adopter patients. As that service becomes more mainstream, it will take deliberate marketing strategies to excite, energize, and motivate potential patients. Use the strategies outlined here to reach and motivate the invisible implant patients and grow your implant production.

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Mandibular Implant Assisted Overdenture Bar Design

Mandibular implant assisted overdentures are frequently treatment planned for patients having difficulty using conventional lower dentures. Implant assisted overdentures aid in retention, stability and support. Primary support areas for the assisted design are achieved via the retromolar pads and buccal shelves and secondarily via the residual alveolar ridge and implant attachments.

Assuming appropriate patient selection criteria are met, either 2 or 4 implants can be placed in the interforaminal area of the mandible. The overdenture attachments can be done in two ways. The individual implants can be splinted together with a rigid interconnecting bar or kept as individual components. Many randomized clinical studies have shown the implant survival rates to be similar in both approaches. Prosthodontic maintenance and patient satisfaction varied, however, depending upon the type of attachment system used.

Depending on the number of implants placed, the interconnecting bar design should encompass principles of biomechanics. Assuming an anterior inter-implant distance of 17-18 mm, 2 Hader attachments with metal housings and 2 distal ERA attachments can be incorporated in the design. The nylon Hader clips will allow the overdenture to rotate around one axis of rotation as the patient masticates—versus multiple axes of rotation for individual implant attachments. This will serve to minimize wear of the attachments and thus help reduce frequency of replacement. The ERA resilient attachments will allow the denture to seat further upon function as well as prevent lifting from the denture-bearing mucosa. The resiliency of the ERA is greater than the resiliency of the mucoperiosteum, thus preventing load magnification on the distal-most implants.

The following design principles should be kept in mind. The interconnecting bar should fit passively on the implants. Due to unforeseen implant angulation issues, the external connection implants are preferred to best correct the angulation and achieve a passive fit. The bar should be parallel to the occlusal plane and perpendicular to a line drawn from 1⁄2 to 2/3 the distance on the retromolar pads. This will allow the overdenture to rotate without binding, prevent nonaxial loading of the implants and provide appropriate retention and stabilization forces. Adequate hygiene access spaces above the tissue should be allowed, minimum of 2-3 mm. A highly polished surface will minimize plaque adherence and prevent tissue inflammation and hypertrophy. Incorporation of a metal framework in the overdenture design at the sublingual area will minimize acrylic fractures and strengthen the prosthesis.

The properly designed implant assisted overdenture will improve masticatory comfort, patient satisfaction and minimize frequent adjustments and attachment-related issues.

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Dr. Dail is a UCLA-trained Prosthodontist with a private practice in Monterey. He is a member of the American College of Prosthodontics, as well as the International Society for Maxillofacial Rehabilitation.

Curtis E. Jansen, DDS

Maintenance Procedures for our patients with dental implants is often misunderstood. The differences in the supporting structure (hard and soft tissues) of the implant make them more susceptible to inflammation and bone loss when plaque accumulates as compared to the teeth. After final insertion of our patients implant retained and or supported restorations, patients need to be placed on a strict maintenance recall schedule. Both placement of implants and maintenance may require an interdisciplinary approach to ensure the best possible outcome. Once the implants have been placed in the edentulous region routine maintenance, recall evaluations and radiographs are necessary to insure the long life of these restorations, and this necessitates the patients team to be well versed with the implant maintenance procedures. These procedures are usually performed at selected intervals to assist the patient in maintaining oral implant health. With time, the emphasis for long-term success of implants has changed from a focus on the surgical phase of treatment to obtaining osseointegration and, now recently, towards the long-term maintenance health of the peri-implant hard and soft tissues. While the full scope of this discussion can not take place in these pages, two of the most important parts, and often overlooked areas, of the implant maintenance visit are below.

Occlusal Evaluation

The status of the patients articulation in regards to teeth and implants is crucial to evaluate on regular intervals. Teeth are very dynamic and implants are very static. Over the years in a mixed dentition (implants and teeth) patient occlusion changes. Many times the implants become over loaded and can complications can occur. The occlusal status of the implant and its prosthesis must be evaluated on a routine basis. Any signs of occlusal disharmonies, such as premature contacts or interferences, should be identified and corrected to prevent occlusal overload which can in turn cause a host of problems, including loosening of abutment screws, implant failure, and restoration failure.

Radiographic Evaluation

A mean crestal bone loss ≥1.5 mm during the first year after loading and ≥0.2 mm/year thereafter has been proposed as one of the major success criteria. Hence, long-term preservation of peri-implant crestal bone height is extremely crucial. Making of simi-annual, or annual "correctly made radiographs" is important. In general, the long-cone paralleling technique, supported by positioning devices, is used. Preventive maintenance appointments should be scheduled every 3 to 4 months and a periapical/vertical bitewing radiograph at 6 to 8 months should be compared with the baseline to assess crestal bone changes, which occur often during the first year of loading. These two previous radiographs should be compared with another vertical bitewing radiograph at 1 year. If no changes or unfavorable clinical signs are apparent, subsequent radiographic examinations may be scheduled every 3 years. However, if crestal changes are evident, radiographs must be taken and reviewed every 6 to 8 months until the bone is stable for two consecutive periods, besides occlusal examination and hygiene modification.

Clinical Practice Guidelines from the American College of Prosthodontists

Tooth-borne Dental Restorations

AMERICAN COLLEGE OF PROSTHODONTISTS

1 Professional Maintenance: (Removable and Fixed)

- Perform an extraoral and intraoral health and dental examination of existing teeth and components of the prostheses and the prosthesis itself. Identify and correct clinical problems that could result in future complications.
- Perform oral hygiene interventions (cleaning of all natural teeth and tooth-borne restorations) using professionally accepted mechanical and chemical methods.
- Use oral topical agents and oral hygiene aids as deemed clinically necessary.
- Fabricate an occlusal device to protect tooth-borne fixed restorations when indicated.

2 Patient Education and Maintenance:

- Patients with existing natural teeth and teeth with multiple and complex restorations should be given oral hygiene instructions to brush twice daily with oral topical agents such as toothpaste containing 5000 ppm fluoride and/or toothpaste with 0.3% triclosan.
  - Add supplemental short-term use of chlorhexidine gluconate when indicated.
- Recommend oral hygiene aids such as dental floss, water flossers, air flossers, interdental cleaners, and electric toothbrushes appropriate for the patient's needs.
- Patients with occlusal devices should be advised to wear them during sleep, and clean them before and after use with a soft brush and the prescribed cleaning agent.
- Patients with a removable prosthesis should be advised to remove the prosthesis during sleep, and store it in the prescribed cleaning solution.

3 Patient Recall

- Recall for dental professional examination every six months as a lifelong regimen.
  - Patients identified as high risk are advised to obtain a dental professional examination more often than every six months.

Bidra AS, Daubert DM, Garcia LT, *et al.* ACP Clinical Practice Guidelines: Recall and Maintenance of Patients with Tooth-Borne and Implant-Borne Dental Restorations. *J Prosthodont* 2016; 25:S2-S40

The American College of Prosthodontists thanks Colgate Oral Pharmaceuticals, a subsidiary of Colgate-Palmolive Company, for an unrestricted educational grant to develop these guidelines.

Colgate

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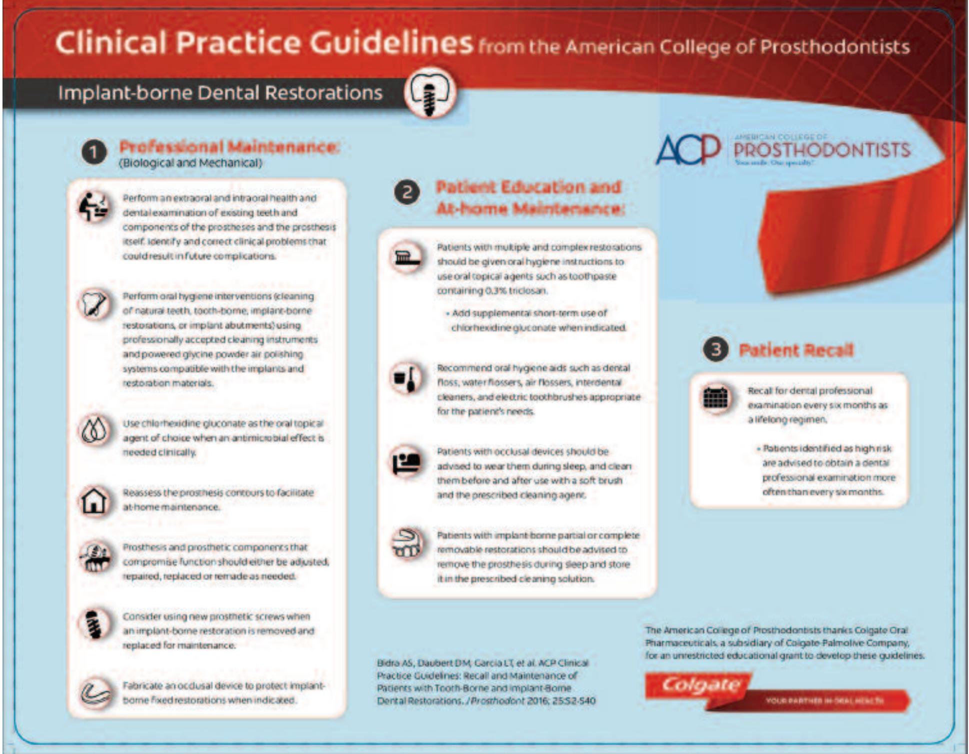

Some of the above was used from this article. For more on the subject and a fantastic review article on Implant Maintenance please down load the following.

Also provided are the American College of Prosthodontists Chair side guides for Clinical Practice Guidelines for tooth-borne (Removable and FIxed) and Implant-borne restorations. They can be downloaded @ http://prosthopedia.prosthodontics.org/assets/resources/documents/Final_ACP_Chairside_guide_July_2016.pdf

Implant Maintenance: A Clinical Update
Minkle Gulati,1 Vivek Govila,2 Vishal Anand,3 and Bhargavi Anand4 1Department of Periodontics, Surendra Dental College & Research Institute, Sri Ganganagar, Rajasthan 335 001, India 2Department of Periodontics, Babu Banarasi Das College of Dental Sciences, Babu Banarasi Das University, Lucknow, Uttar Pradesh 227015, India 3Department of Periodontics, Sarjug Dental College & Hospital, Darbhanga, Bihar 846003, India 4Department of Prosthodontics, Rama Dental College and Hospital and Research Centre, Kanpur, Uttar Pradesh 208025, India Received 10 March 2014; Accepted 13 May 2014; Published 9 July 2014 Academic Editor: Paul C. Dechow

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> *"Dentists are medical professionals who help you put your money where your mouth is."*
>
> **— Author Unknown**

2019 Installation of Officers At Pasadera

The Installation of Officers Dinner is always a fun event for the MBDS, and this year was no exception. Held at the beautiful Club at Pasadera on Friday, November 8th, it was well attended and enjoyed by all.

The outgoing Board of Directors were recognized, and Dr. Lindley Zerbe was acknowledged for his role as 2019 President. We look forward to having Dr. Steve Ross take over the position next year, and we also welcome some new faces to the incoming 2020 Board of Directors.

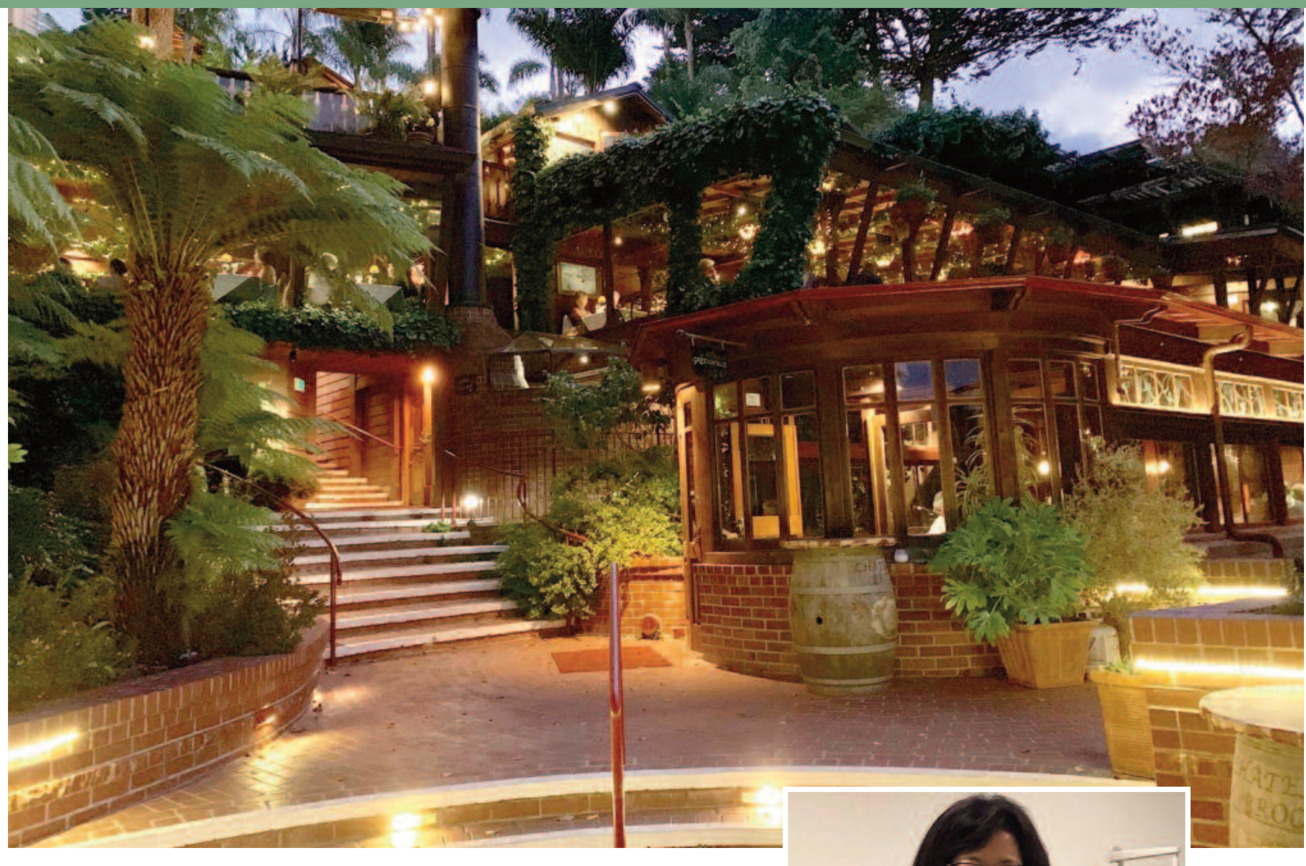
Congratulations to **Dr. George Yellich**, who was awarded the **MBDS Outstanding Dentist of the Year**. Dr. Yellich is an oral surgeon in Santa Cruz, and was instrumental in establishing the local philanthropic organization, Dentistry4Vets. Because of his efforts, countless local veterans have benefitted and had their oral (and overall) health greatly impacted. If you would like to become involved in Dentistry4Vets, Dr. Yellich is an incredible resource for further information and help.

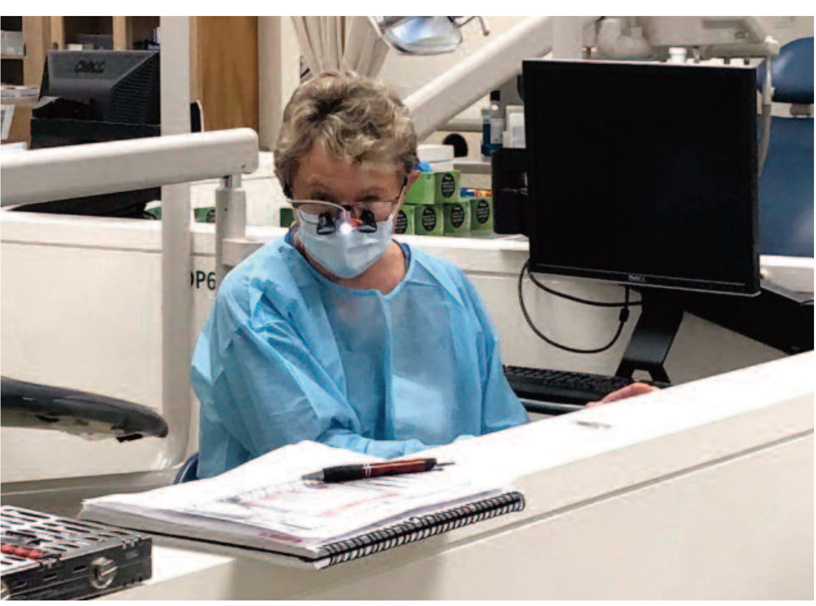
For musical entertainment, Dr. Jeff Meckler and his band "The Rhythm Rebels" performed for everyone. In all, it was a fun evening with great food, and even better company! Thank you to all who attended.

First Ever Hands-On CE Course

On August 23rd and 24th, the Monterey Bay Dental Society hosted its first ever Hands-On CE Course at Cabrillo College in Aptos. Our speaker was general dentist, Karl Koerner, and the topic was, “Oral Surgery for the General Dentist: Making it Easier, Faster and More Predictable.” The two-day event was well attended, with 41 present for the Friday all-day lecture, and seven participants for the Saturday course.

Special thanks goes out to Noel Kelsch, RDH, RDHAP, MS, Cabrillo Hygiene Director, whose tireless efforts helped to bring the course to fruition. In addition, CE Committee Chair, Dr. Steve Ross, was instrumental in putting on this first-of-its-kind course for our component.





Time to Hit the Gym – The MBDS is Getting Shredded Again…

On Thursday, Sept 26th, the Monterey Bay Dental Society hosted yet another "Shred-A-Thon" Event. The success of last year's inaugural event was overwhelming, and we were pleased to host once again.

The services of Same Day Shred (www.samedayshred.com) made a repeat appearance, and they were generous enough to provide their services free-of-charge. Tacos Don Beto cooked delicious food, and helped to ensure everyone was well fed.

During the event, 83 boxes were shredded, which included paper waste, Xrays, and E-Waste.

Many thanks to all who participated - The MBDS looks forward to hosting another Shred-A-Thon event in the near future.

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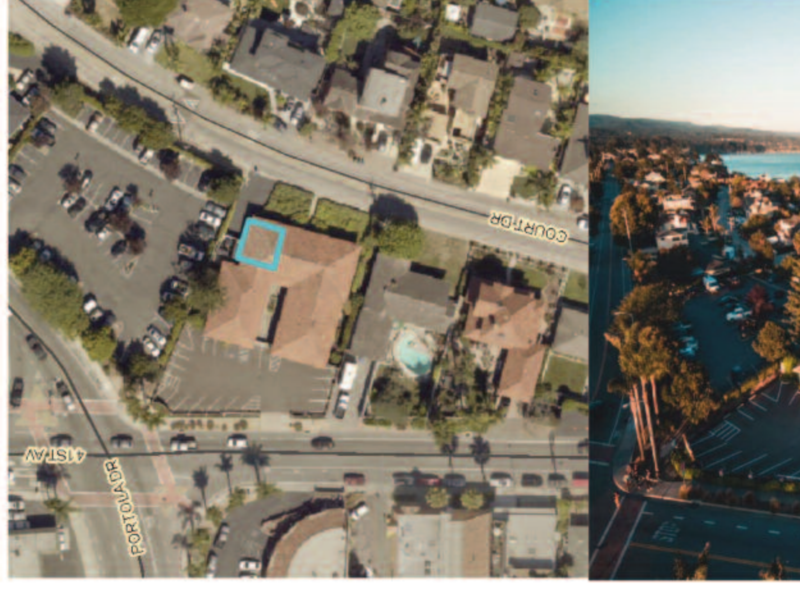

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Common Prosthetic Complications with Implants in Everyday Practice

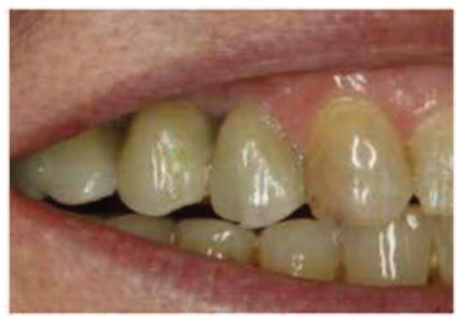

Figure 1 – The patient presents with fracture in the veneering porcelain.

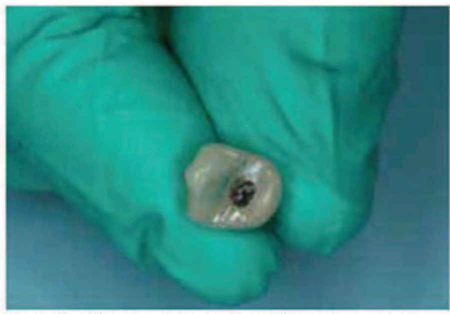

Figure 2 – Showing the buccal cantilever that was place into function.

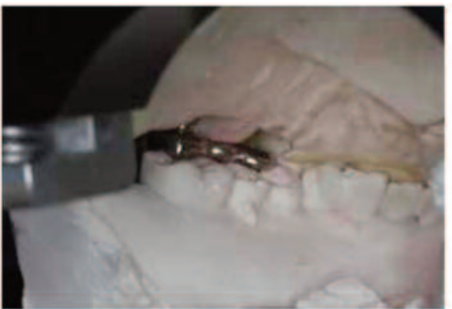

Figure 3 – The use of a metal restoration was the only solution for this minimal space case.

Figure 4 – The minimal space on the anterior implant abutment did not allow for the screw retained feature on both abutments.

Figure 5 – The separated "screwmentable" restoration after 1 year of use. Notice the short axial height of the abutment and the mesial cantilever .

Figure 6 – The repaired, re-cemented prosthesis.

By Kenneth E. Moore II, DDS

Dental implant therapies to replace missing teeth have become common place in private practices. As a profession we have grown and improved with implantology, yet this treatment is still particularly challenging for many reasons. The treatment success requires a collaborative effort between surgical, restorative, and laboratory team members as well as the patient's compliance and maintenance. While complications can occur at any phase of implant treatments, restorative complications tend to be visible and challenging for patients and practitioners alike.

In this article, a focused look will be on two common restorative complications for fixed implant units: fracturing of the veneering restorative porcelain and loss of interproximal contacts. Recommended strategies and solutions to address these difficulties are discussed.

Complication #1: Fracturing of the Restorative Materials

Fracture of the veneering restorative porcelain is a complication commonly seen by experienced practitioners. Fractures generally stem from the absence of a ligament between implant and bone. Both the shock absorption and proprioceptive qualities that protect natural teeth from overload are lost in an implant restoration. Strategies to mitigate potential complications of porcelain fracture involve attention to the positioning of the implant as well as controlling the thickness of the material. An adequate thickness of material is required to provide resistance against functional forces. Conversely, too much space or extensive cantilevered material will increase the risk of fracture (Figures 1 and 2). Proper placement of the implant allows for idealized design and support of the restoration. Restoratively driven treatment plans and guided surgery offer ways to reduce these errors. Effective communication and execution between surgical, restorative, and lab support teams are critical in reducing fractures.

Another strategy to address complications of porcelain fracture involves knowing the fundamentals and properties of dental materials. The modern ceramics such as zirconia and lithium disilicates have improved esthetics, but still require more thicknesses for strength when compared to metal restorations. If one is looking for absolute minimal thickness, solid or partially-veneered metal restorations are the best options (Figures 3 and 4). Dentists should tailor their choice of material to different situations and patient demands, rather than selecting one material exclusively across all cases.

Ultimately, overloading force on the restoration is responsible for the fracturing of their porcelain veneer.

Different occlusal schemes have been debated as strategies to address the effects of force. The current thought is to protect the implant restorations by spreading out the forces to natural teeth with group function or using a only natural tooth such as canine guided, mutually protected patterns. Having functioning contacts solely on the implant restorations have been shown to increase complications. The compliant use of occlusal guards may reduce the chipping from happening if the problem can be identified to occur at night.

The screw-retained versus cement-retained debate also plays a part in fractures as well. There is evidence to report that non-retrievable, cement-retained restorations have less fracture rates due to an uninterrupted layer of porcelain (Zarone et al. 2005). When minor fractures do occur the retrievable screw-retained restoration allow for thorough polish and reglazing to occur. The practitioner should weigh the risk factors presented and determine the design best for the individual case.

Recently solid zirconia has been used as a refuge from fractures due to the significant strength of the material. This should be done cautiously as the force is no longer absorbed in the restorative material and is instead passed through to the implant-restoration interface or the implant-osseous connection. Both areas are much more catastrophic and costly to repair should they fail. This has been highlighted with the relatively new "screw-mentable" restoration. The design utilizes either a stock or custom abutment and a high strength ceramic restoration cemented extra-orally with a hole to allow a screw-retained prosthesis. The weakest link in the system is the cement bond between the abutment and the crown. This junction can fail if the abutment is not properly treated or designed in the laboratory or the forces on the implant crown are not controlled (Figures 5 and 6). Given the relatively recent use of this design, there is little, if any data on this type of prosthetic complication. If the restoration cannot be rebonded, more involved solutions, such as reducing the occlusal table or changing the prosthesis design to a single solid material such as a cast gold restoration can be done.

Complication #2: Loss of Interproximal Contacts

Another relatively new challenge for fixed implant units is the loss of interproximal contacts between natural teeth and implant restorations. In the last ten years, a few groups have documented this issue when following implant restorations. Implants maintain a static position while natural teeth can change position. Incidence of this contact loss was reported as high as 66% in a 2016 article by Greenstein and colleagues but has been dialed back to 27% in the most recent 2019 retrospective analysis by French and colleagues.

The causes of interproximal contact loss are currently unknown, but potential hypotheses include contact contours, higher load forces on natural teeth as a result of practitioners leaving the implant occlusion "light," continual growth potentials, and interproximal attrition. There is not enough research on the topic to make any definitive statements on the subject; however, it does appear the mandibular posterior is the most affected area. Also the loss of contact is more likely on the mesial than the distal by a factor of 7:1 (French 2019). Some patients can maintain the area and all that is needed is close monitoring. Other experiences the

Kenneth E. Moore II, DDS

Dr. Moore completed his dental degree at the Arthur A. Dugoni School of Dentistry in San Francisco and completed his Graduate Prosthodontic Training at University of California, San Francisco. He currently maintains private practice in San Mateo, California.

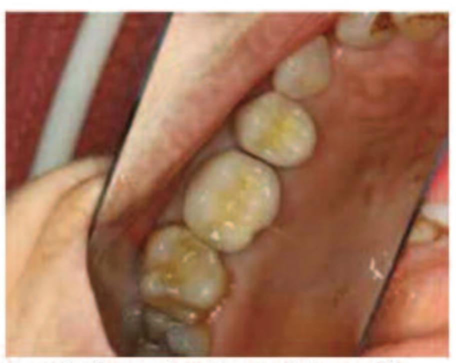
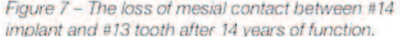
Figure 7 – The loss of mesial contact between #14 implant and #13 tooth after 14 years of function.

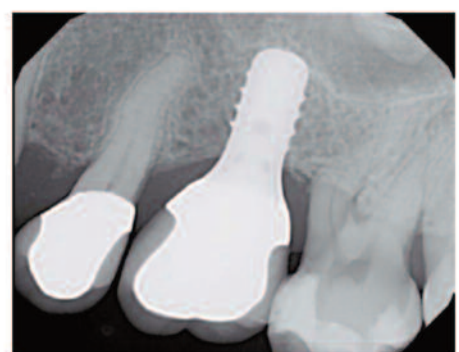
Figure 8 – Crestal bone height when loss of mesial contact was identified.

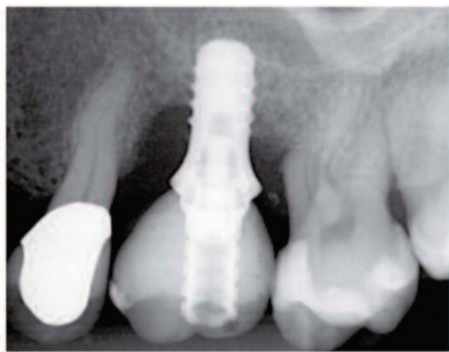
Figure 9 – Significant bone loss occurred by the time the provisional was placed.

negative implications of open contacts such as food impaction, increased caries, and periodontal breakdown. A patient in our office had open contact developed between a tooth and an implant restoration that had been in function for over 14 years. By the time the crown was temporized to retreat the case, significant bone-loss was seen radiographically (Figures 7 through 9).

Many strategies have been proposed to treat or prevent interproximal contact loss, including flat, broad contacts on the restorations, screw-retained designs to allow addition of low fusing porcelain to the restoration should the gap open, direct resin applied to the natural tooth, and the use of retainers. While the study of this problem is relatively new, more information and recommendations will continue to evolve as more of these cases are encountered in practice.

Conclusion

This article discussed two common fixed implant restoration complications and associated solutions or strategies: porcelain fracturing and interproximal contact loss. There are also several additional complications that can occur that are outside the scope of this article. In preparation for encountering these restorative complications, dental professionals must educate themselves to reduce their incidence, and gain experience and knowledge of the fundamentals to allow them to address the complications once they occur. Finally, documentation and open communication between practitioners will be critical to grow and develop new treatments for the future.

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> "*Treat your password like your toothbrush.*
> *Don't let anybody else use it,*
> *and get a new one*
> *every six months.*"
>
> — Clifford Stoll

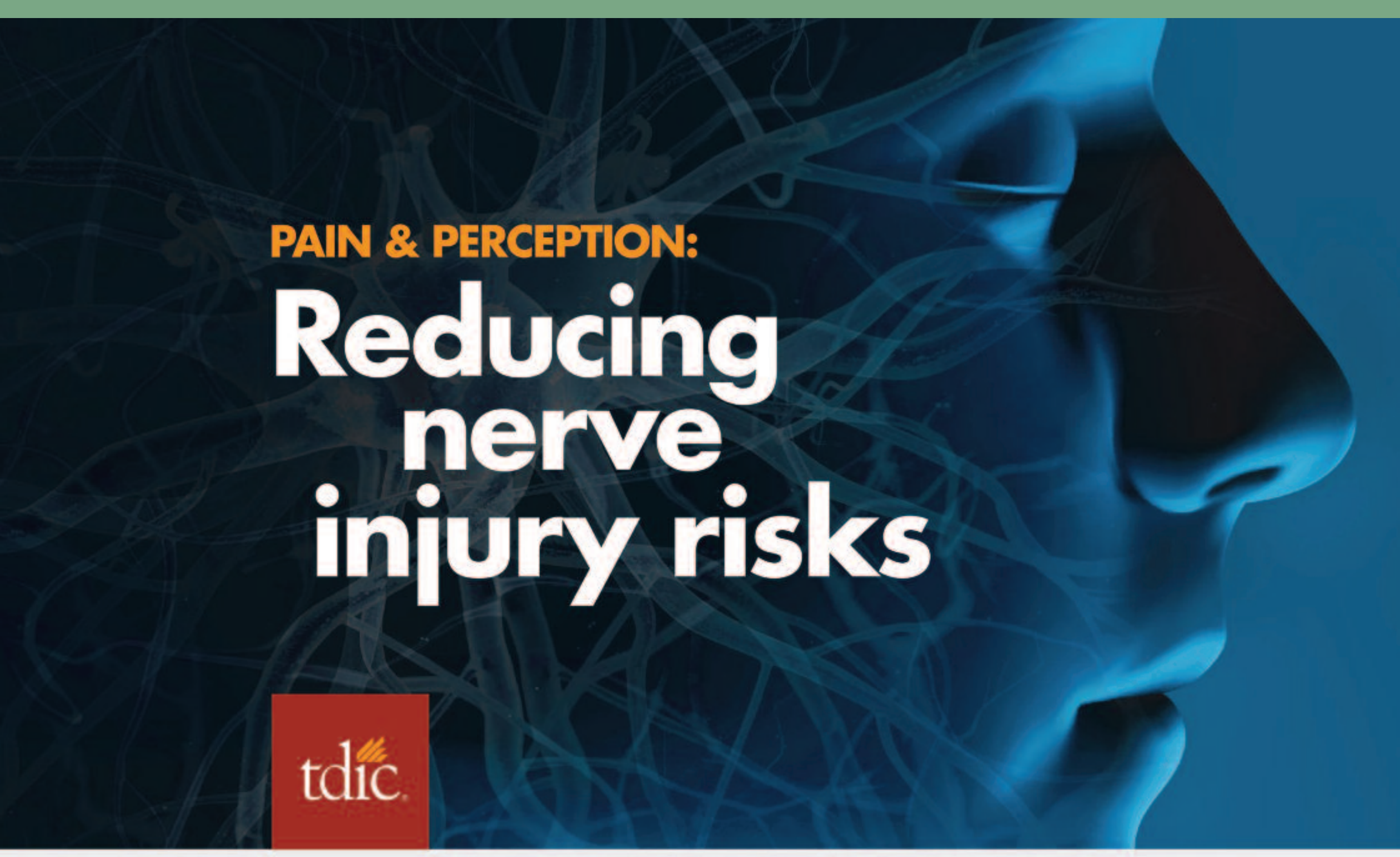
2019 House of Delegates

The 2019 CDA House of Delegates was held on November 15th and 16th at the Hyatt Regency in Sacramento. The MBDS is incredibly fortunate to have dentists on our Board of Directors who enthusiastically represent our component here on the Peninsula.
In addition to discussing various topics surrounding organized dentistry in California, delegates participate in fun events such as the President's Party as well. And our very own **Executive Director, Debi Diaz,** was able to enjoy the Executive Director's Component Exchange, and interact with other E.D.s throughout the state.

Thank you to **Drs. David Brock, Geralyn Menold, Dick Kent,** and **Steve Ross** for representing the MBDS in this capacity. CDA is able to flourish and benefit our membership because of you! We are also grateful to **Dr. Nannette Benedict** who serves as Trustee to the BOD as well.

All Board members are invited and encouraged to attend the HOD at some point during their tenure, as it provides a unique perspective into how these organizations function. The 2020 House of Delegates is scheduled for November 13-14th at the Los Angeles Airport Marriott.

CDA



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Anterior Implants - A Restorativley Driven Workflow

By Diana C. Fat, DDS

Implant dentistry is now, more than ever, prosthetically driven. The technology available today allows the restorative dentist to visualize the end result prior to starting, then work backwards from there, much like the "crown-down" approach. The intended final prosthesis drives the workflow from start to finish. By taking this approach, unwanted surprises at the end of the restorative process are minimized or eliminated. The key to successful implant restorations is to develop a systematic workflow that will provide a level of comfort in the process.

Diana C. Fat, DDS

Dr. Fat received her Prosthodontic degree from Louisiana State University School of Dentistry in 2004 and her DDS degree from the University of the Pacific School of Dentistry in 1999. She has a private practice in Midtown Sacramento.

Initial Exam Should Look into the Following Factors

Lip Dynamics/Smile line: high smile line may require bone and soft tissue augmentation to achieve a more exacting gingival margin making it more challenging

Tissue Biotype: thin, highly scalloped gingivae are prone to gingival recession

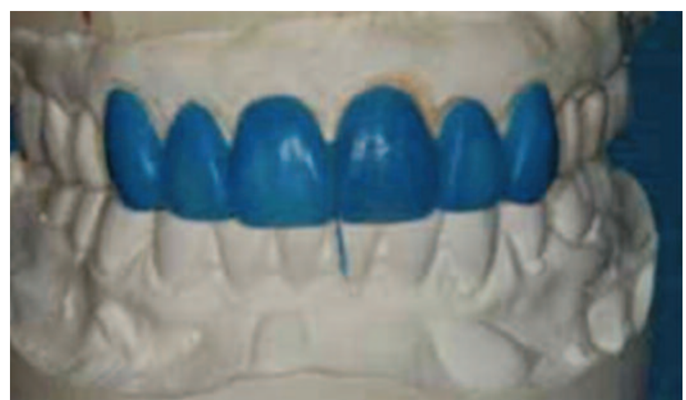
Interproximal bone height and papillae levels: ideal distance between crest of bone and contact should be 3–5mm

Adjacent Teeth Shape: square form has a wider cervical area and is more desired; triangular form has more divergence creating a narrower cervical area and more challenging

Shade: determines metal vs porcelain abutment and components; high value shades will many times require a zirconia abutment

Diagnostic Wax-up

Harmonious occlusal relationship is key. Use esthetic guidelines such as establishing the incisal edge position in reference to the face, incisal inclination, occlusal plane. Develop an occlusal scheme that reduces stress on the implant(s) to minimize screw loosening, porcelain fracture, etc. Communication with the lab is important to accurately transfer intraoral data to the laboratory by using occlusal records, facebow records and facial photographs; give the laboratory technician everything they request. This can be achieved digitally or by traditional analog techniques Have the lab fabricate a surgical guide with radiopaque markers which can then be used for the CBCT scan as a radiographic guide.



Diagnostic Wax-up to prepare surgical guide

CBCT with a Radiographic Guide

A radiographic guide, which is generated from the diagnostic wax up, provides an ideal position of final prosthesis which can the guide the implant position. Based on the findings one can assess the ideal path for surgical access in order to have the desired emergence profile. This will also allow for identifying any anatomical factors that may need to be considered or bone and soft tissue augmentation procedures that may be required for an ideal result. This will eventually facilitate and implant being placed ideally in all 3 dimensions: mesio-distal, apico-coronal and bucco-lingual.

Surgical Guide

The surgical guide is A MUST when placing maxillary anterior implants for ideal results. If a radiographic guide was not used then a surgical guide based on the wax up is critical to ensure proper implant positioning. The guide is not a guarantee of a successful outcome, but rather a safety measure and facilitator for the surgeon in navigating the implant drill based on the prosthetic end result.

Provisionalization and Soft Tissue Alteration

A Tooth or Implant-supported provisional is more desirable than removable. The provisional could be the blueprint to the final prosthesis. In many cases the patient's perception of the final outcome is closely connected to the provisionalization phase. It is Important to consider the patient's comfort during osseointegration, restoring function, achieving an esthetic result similar to the final desired outcome, protection of any graft site, and maintain durability/longevity. Gingival levels and papilla contours can be created with proper modification of the provisional during this phase. The restorative dentist has to be comfortable in altering the soft tissue to create a smooth emergence profile, other wise the lab technician will feel "hand cuffed."

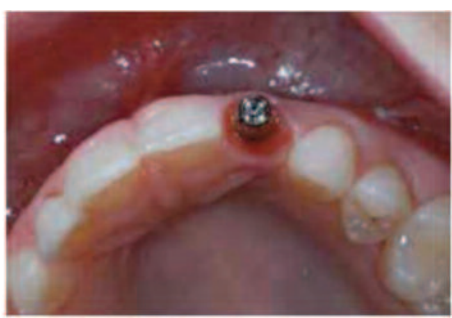
One of the most important factors is not to be fearful about putting a much needed pressure on tissue because when you have too much tissue that's how you're going to mold it to the correct shape. During this phase consider working with a soft tissue cast to adjust vertical levels first, then bevel with a blade or course football diamond bur, leaving at least 1.5mm thickness of remaining facial tissue; when transferring to mouth, mold tissue w/pressure.

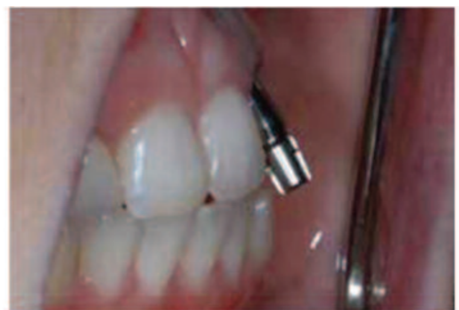
Abutment Selection/Emergence Profile

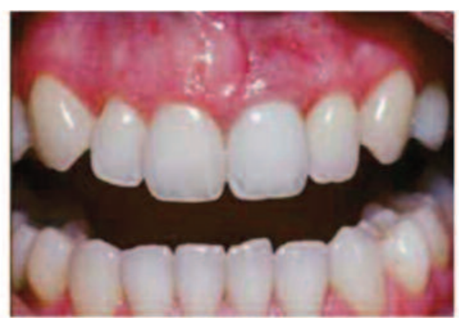
When it comes to abutment selection for the anterior implants a custom abutment is able to mimic the ideal tooth preparation giving complete control of transition from a 4mm implant diameter to a 7mm cervical crown diameter, and control of implant long axis angulation discrepancies if they exist. Another important factor to consider is the material and titanium gold hue, zirconia hybrid (titanium base w/ zirconia abutment); zirconia abutments may be preferable to titanium or gold-hue abutments for the anterior region and when all-ceramic restorations will be the final prosthesis; smaller diameter implants should preferably use a zirconia hybrid as opposed to an all ceramic internal connection/abutment because the latter lacks the strength; metal abutments offer strength when needed.

Margin Placement

This is ideally determined at the time of diagnostic wax-up stage which establishes the gingival architecture. An ideal implant should mimic tooth preparation and it is best to keep the margin 1.0–1.5mm below the facial gingival margin.


Facially inclined implant - occlusal view


Facially Inclined Implant


Ideally Restored Implant 9

Pink Porcelain

Surgical placement of an implant in a less than ideal position creates a dilemma for the clinician. Although surgical intervention may be warranted, the patient may not approve the treatment and request an alternative solution. Pink materials — used as composite with a provisional prosthesis and as porcelain with an abutment and final restoration — have the ability to mask a defect and create a symmetric and esthetic result, offering resolution for both the patient and clinician. The facial positioning of an implant may predispose the situation to facial bone resorption and subsequently lead to lack of bone facially which may result in lack of attached gingiva.

Pink porcelain is a simple option that optimizes esthetics and masks compromised surgical outcomes. Pink porcelain materials give the advantage of blending with soft tissue and also maintain esthetics over time.

In conclusion, when the above mentioned factors are taken into consideration, a smooth and desirable outcome for the patient can be achieved. The secret of getting ahead is getting started. The secret of getting started is breaking your complex, overwhelming tasks into small, manageable ones, then starting on the first one.

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Amalgam Separator Deadline Approaching Quickly

October 15, 2019
By David Burger

Under a federal rule adopted by the Environmental Protection Agency in 2017, many dental practices will need an installed amalgam separator by July 14, 2020. A few practices may be exempt, but some of those that are still need to submit a form to affirm their exemption from the rule.

"Although most dental offices currently use some type of basic filtration system to reduce the amount of mercury solids passing into the sewer system, dental offices are the single largest source of mercury at sewage treatment plants," the EPA notes on its website.

The EPA deadline provides a minimum standard to be met by dental offices on a national level. State and local regulations may have more stringent requirements with earlier deadlines or fewer exempt categories. State or local regulations cannot directly conflict with federal regulations, but they can be more restrictive.

Dr. Radack

General dentist Dr. Stephen Radack, based in Erie, Pennsylvania, was an early adopter.

"I do still occasionally place amalgam and of course remove it every day as a general dentist," Dr. Radack said. "You may not place amalgam, but almost all practitioners have to remove failing amalgam. I am just not sure what the hesitancy is to purchase the unit and get it installed. It was easy, you are in compliance and it is the right thing to do."

The ADA Center for Professional Success has resources available for member dentists looking for more information on the looming amalgam rule. The ADA.org/RecycleAmalgam web resource includes:

• A flowchart to help dentists determine what course of action to take.

• In-depth FAQs from the ADA and the EPA on how to comply with the rule.

• An on-demand webinar in which ADA and EPA representatives provide information and answer questions from participating professionals.

Dr. Radack purchased an amalgam separator from HealthFirst, the amalgam solution endorsed by ADA Member Advantage. HealthFirst's Amalgam Recovery Program offers ADA Members a cost-effective, worry-free compliance solution with exclusive, members-only pricing.

Description: Stephen Rathman
Dr. Radack "The price was very reasonable," Dr. Radack said. "I had a great conversation with my rep and he helped me select the right unit for the size of my office and then followed up once the unit arrived. It was very easy to install."

"Please do your research and give HealthFirst a call to see what they can do for you," Dr. Radack advised other dentists. "I know in Erie the water authority will be watching and waiting to make sure the dentists they serve are compliant."

ADA members buying through HealthFirst receive a special discount of up to 50% off list price for the Rebec amalgam waste separator. Enter "ADAMEMBER" at the discount code during checkout at healthfirst.com/ADA or speak to a HealthFirst compliance counselor at 1-800-331-1984.

Amalgam kit: ADA members buying through HealthFirst receive discounts for amalgam waste recovery products and services.

What's The Status Of Dentistry4Vets?

Curtis E. Jansen, DDS
D4V Board Member

Dentistry4Vets just celebrated it's ONE year anniversary! We are very excited with the progress achieved by our 503c non-profit. D4V's mission statement is "To provide High Quality Dentistry and Dental Implant Care for the deserving Veterans of Monterey, Santa Cruz, and San Benito Counties through volunteer efforts within our community."

Dentistry4Vets has named Dr. Hugo J. Ferlito as its Executive Director. Dr. Ferlito has been instrumental in making contacts within the dental community as well as arranging cooperative efforts with Cabrillo Dental Hygiene Department and Dientes.

Most importantly Dr. Ferlito has arranged for a clinic in Marina at the Montage Wellness Center. The D4V clinic, which will be opened in the first quarter of 2020, is made possible by the generosity of the CHOMP Foundation.

Once the facility is open, D4V will need volunteers, DDS's, RDH's, RDA's, DA's. and support individuals. The Veterans need our help, please consider going to the Dentistry4Vets website (Dentistry4Vets.org) and signing up to help. Your support will be needed in the new clinic, but you can help now in your office with your TEAM (together everyone achieves more). What a great News Years Resolution for you and your TEAM. For more information please contact Dr. Ferlito at Hferlito@dentistry4vets.org. All lab bills and hard costs will be reimbursed by D4V, D4V only asks for your time to be donated.

On Veterans day, D4D doctors saw fourteen patients. Screenings were performed, one Veteran had a single tooth implant restoration placed, another had preliminary impressions made for diagnostic procedures, four more veterans had their teeth cleaned. Another fully edentulous veteran, who had an awful lower restoration and an upper broken down RPD he was been wearing for the last 10 years, had 8 implants placed and upper and lower immediate fixed implant restorations done. He is truly a new Marine/Man!

Dentistry4Vets encourages you to find out more about the organization. D4V wishes you and yours a Happy Holiday Season and looks forward to seeing you get involved with our dentally underserved Veterans.

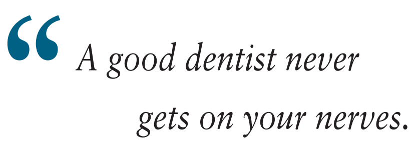
Marine Veteran John Tomkinsons' before image.

"Veterans Day 2019"

Marine Veteran John Tomkinson, with his long time friend Robin, immediately after his eight implants and restorations.

Participating D4V dentists so far—this list must grow!

Matthew Wetzel
Mic Falkel
Stewart Osaki
Phil Bhaskar
Lindley Zerbe
Malia Seltzer
Richard Kent
Jeanette Kern
Bill Kelley
Jochen Pechak
TJ Khalizadeb
Cabrillo Dental
Hygiene Department
Brian Lackey
Brian Carr
Arleen Lackey
Jon Dean
Jeffrey Meckler
George Yellich
Curtis Jansen
Dientes Dental Care
Salud de Valle Salinas
Ryan May
Ryan Lehr
Noel Kelsch, RDH
Bridgette Clark
Hugo J. Ferlito



A good dentist never gets on your nerves.

— Author Unknown

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Restoring Posterior Dental Implants: 10 Factors of Success

By Jefferson Clark, DDS, MS

Dental implants have forever changed dentistry for the good. They frequently enhance traditional and modern dental concepts. Successful implementation depends on following surgical and restorative principles. When some of these principles are overlooked it can lead to unnecessary failure of the implant fixture leading to unwanted stress and loss of productivity. In this article I would like to highlight what I believe are 10 key factors to consider when restoring posterior implants.

Factor 1

Determine the size and shape of your crown before implant placement

This can be a digital mock-up or a conventional wax up. This allows for good assessment of the area to be restored. One can then visualize the mesial distal, bucco-lingual and apico-coronal aspects of the proposed crown for the best restorative outcome and uncover potential problems. It will also direct the implant size and location to achieve the desired goal. The picture below shows this important factor being ignored.

Factor 2

Avoid the one size fits all mentality – Implant Diameter

Choose the appropriate implant for the site you are restoring. Implants are designed for various types of bone and situations. Select the ideal implant diameter. For posterior teeth this is typically the largest implant the bone can support. This will help with emergence profile while limiting implant flexure and fracture. My recommendation would be to avoid implant designs with narrow interfaces or press fit connections.

Factor 3

Use a surgical guide

Even the most experienced surgeons can improve outcomes and consistency by using a guide. A surgical guide helps reduce iatrogenic damage, guesswork, and chair time. Surgical guides may be partially (pilot) or fully guided. Surgical judgment is still required when drilling and placing the implant. For this, all you need is an impression of the arch and a Cone beam computed tomography (CBCT) scan. The impression can be a simple alginate impression or a digital one. Patients can be referred out to an imaging center for the scan. Most labs can help you design and fabricate the surgical guide. Communication between the surgeon and the restoring dentist is key.

Jefferson Clark, DDS, MS

Dr. Clark received his DDS degree with honors and completed a Certificate in Advanced Graduate Studies in Prosthodontics and a Master's degree in Prosthodontics from Loma Linda University School of Dentistry. He is a Diplomate of the American Board of Prosthodontics and currently operates a private practice dedicated to prosthodontics and implant dentistry in Roseville, CA.

Factor 4

Good impression technique - When possible consider open tray impressions

Open tray impression in the posterior can be challenging, however, this will help ensure your impression is the most accurate when using conventional impression material. Lute two or more adjacent implants together for greater stability when doing an open tray impression technique. This will result in a more passive final restoration. If closed tray copings are used, attach the analogs and place them in the impression yourself to make sure they are seated properly. If you use digital analogs or coded healing abutments, make sure they are seated properly so your scan accurately represents the implant location.

Factor 5

Take radiographs along the way

Although tactile sense with direct sight can be successful most times it is wise to take radiographs of any abutments, copings and/or final restorations. X-rays will allow for good visualization of the interface and will take the guesswork out. This ensures the implant location is registered and restored properly. In addition, it protects the internal implant threads before applying the final torque.

Factor 6

Avoid prefabricated and zirconia abutments

Prefabricated abutments may be adequate for some premolar restorations, but the larger molar restorations are best handled with custom abutments. Prefab abutments frequently debond or cause crown fracture over time due to excessive occlusal forces transmitted to its weak interface. A custom abutment can be designed to strengthen the interface and support the crown material while allowing for an appropriate emergence profile. When possible avoid zirconia abutments in the posterior as there is an increased chance of fracture, especially when the implant may not be ideally positioned.

Factor 7

Select screw retained restorations when possible

The pros outweigh the cons. You can avoid the issue of peri-implantitis caused by cement, is easily retrievable and allows for screw access in case of screw loosening. For higher esthetic demands the access hole can be hidden with opaque resins or ceramics. If cement retained is required, make sure a radiopaque (zinc containing) cement is used to help ensure the excess is completely removed.

Factor 8

Establish proper contacts with the adjacent teeth and a good Emergence profile

The more it looks like a tooth, the more likely hood it will function like a tooth. This includes establishing proper contacts and emergence profile which in turn will reduce food impaction and recurrent caries to adjacent teeth. The implant crown should function with proper occlusion while in harmony with the surrounding teeth. However, since implants lack periodontal ligaments the occluding contacts should be lighter and narrower than natural teeth.

Factor 9

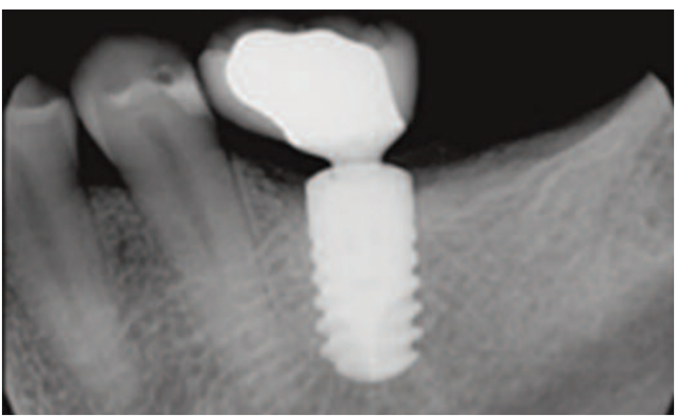
Select the ideal material for the crown

Today we have more material selection than ever before. We have full contour materials; zirconia, lithium disilicate, metals (gold or titanium), and even composite crowns. In addition, we can cut the materials back and add the appropriate ceramics for more customization. All of these are reliable options for implant restorations. The important thing to consider is that they are fabricated properly. They must have the proper abutment support, material thickness, and processing protocols followed. Consider that like materials perform well against each other since they will have similar properties. Heavy occlusal forces may require a full contour material and choose polished over glazed surfaces. Once the glaze wears off the underlying surface could be abrasive and cause excessive wear.

Factor 10

Make it maintainable for the long term

This starts with using the manufacturers' specifications for screw torque. Annual recare appointments should check occlusion since teeth move, monitor crestal bone loss, screw loosening and porcelain fracture. If the implant is ever removed, inspect the screw threads and replace it as needed. Recent studies have shown a high caries rate adjacent to implant restorations. Educating our patients on good hygiene techniques is key to reducing this trend and maintaining successful implant restorations.



As you start your next posterior implant restoration think about these 10 factors of success to help you have a good long-term successful implant restoration.

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Four Reasons To Stock Up On Equipment Sooner

When managing your day-to-day overhead, it can seem challenging to allocate spending to upgrade, enhance or expand your dental equipment. However, being strategic about when to purchase higher-dollar items can help you realize the most value. By filling your supply and equipment needs before the end of this year, you can categorize to your advantage before next year's tax time and get your practice running at peak efficiency.

Alleviate pain points

Perform an equipment performance audit by asking yourself and your team:

- How often are we having poor-performing equipment serviced or repaired? At what cost?
- What has been the cost of not being able to treat patients during equipment downtime?
- How much time have we lost due to ineffective tools or a lack of tools?
- Do any of our current tools compromise our patients' comfort?

Improve productivity

To evaluate your return on investment in new equipment, it takes the full view of what your practice needs to achieve peak production. Ask these questions:

- What steps can we take to increase confidence in our equipment and decrease stress?
- Where would digital equipment streamline processes and save money over time?
- Have we missed potential revenue streams by not investing in new technology?

Acknowledge that value doesn't always mean the lowest price. Securing durable equipment from authorized vendors means that it will likely have a longer lifetime. Trusted products that are well-designed and properly maintained generally have a lower cost per use.

Leverage depreciation

Professional equipment that has a "useful life" of one year or more may be tax-deductible. Dental equipment and technology are usually depreciated over a period of five years; furniture and fixtures (including dental cabinets) over seven years —reducing taxable income each year. A dental practice can deduct up to $1 million in equipment purchases during 2019 as long as the total purchase of equipment during 2019 does not exceed $2.5 million.

Accelerate deductions

The Tax Cuts and Jobs Act of 2017 provides an opportunity to maximize savings and tap into tax deductions sooner. Section 179 of the IRS tax code allows businesses to now deduct the full price of qualifying equipment and/or off-the-shelf software purchased during the tax year. That means that if you buy dental equipment and put it into service in 2019, you can deduct 100% of the purchase price from your reported 2019 gross income.

To manage your tax brackets and leverage deduction benefits, you could choose to use the Section 179 accelerated deduction for part of an equipment's purchase price and depreciate the remainder over five years.

However, it's important to know that you cannot use Section 179 deductions to lower your income below zero and create a loss. This can prove to be a "trap" for dentists using S Corporations who do not have sufficient owner's equity (basis) to realize the benefits of expensing equipment.

Through the year 2026, Section 168(k) also allows business owners to take an additional first-year depreciation deduction in the placed-in-service year of qualified property. There are no dollar limits, and you can create losses if you desire. But, S Corporations do have the same basis limitations related to losses.

There are, of course, complexities and limitations to claiming deductions. And different practices and different dentists' spending habits will yield different results. A dentistry-specific CPA can provide in-depth expertise on the many important tax considerations associated with purchasing large equipment or renovating your office.

Stock up for success in 2020

When it is time to buy, know that there are resources to help members of organized dentistry secure the best deals. Through The Dentists Supply Company, association members benefit from negotiated discounts and free shipping on an expansive online catalog from authorized vendors.

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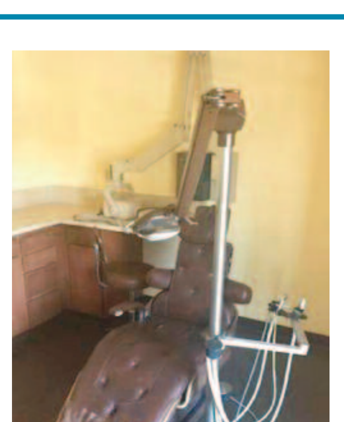

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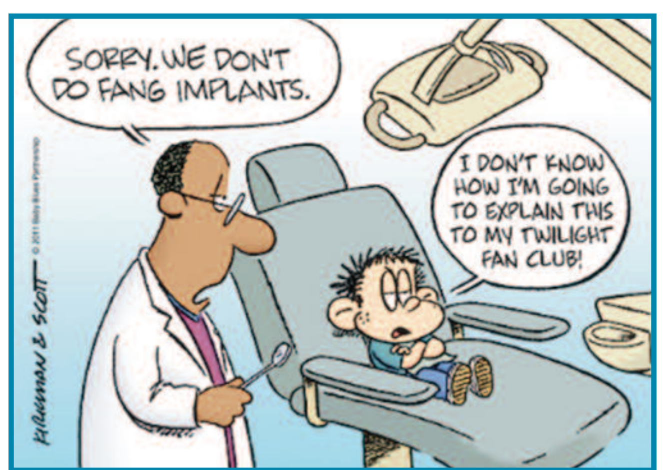

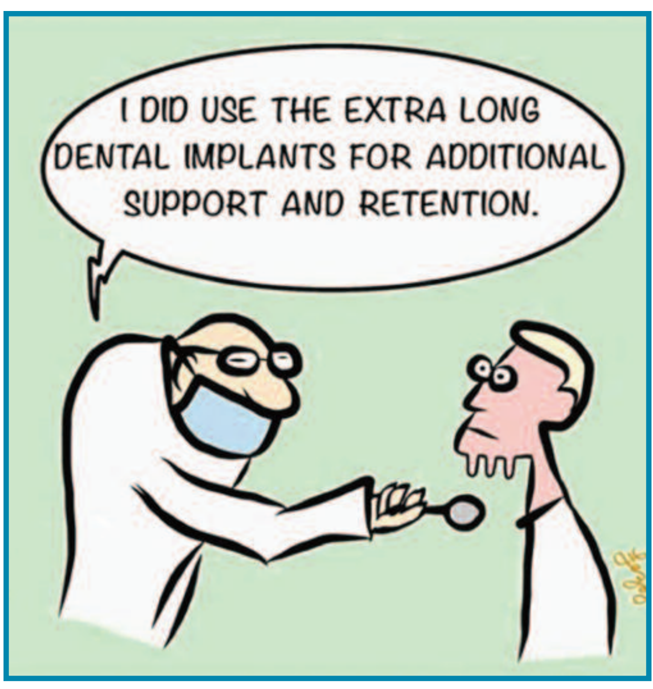

Steve Austin, DDS

The Monterey Bay Dental Society would like to acknowledge the passing of longtime member, Dr. Steve Austin. A graduate of UOP Dental School, Dr. Austin joined the MBDS in 1983 (he was a member with the San Joaquin Dental Society for three years prior). He practiced in Carmel Valley, and was a stable figure there before retiring in 2015.

A Celebration of Life was held at Saint Dunstan's Episcopal Church on December 14th. We extend our deepest condolences to his family and loved ones.

Jeff Daughenbaugh, DDS

Longtime MBDS member, Dr. Jeffrey Daughenbaugh, recently passed away at Salinas Valley Memorial Hospital after a lengthy illness. A graduate of UOP Dental School, Dr. Daughenbaugh practiced Endodontics in Salinas for many years, before passing his practice along to Xudong (Don) Yang. Our thoughts and prayers go out to his wife, Cheryl, and the rest of his family as well.

“*The best and cheapest dentistry is when the right thing is done extremely well the first time and it lasts for a long time.*”

— Author Unknown

“*You'll find that life is still worthwhile, if you just smile.*”

— Charlie Chaplin

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Temporary Crown Fabrication
Ultrasonic Scaling Certification
X-ray Certification (M)
X-ray Technique Refresher

Our focus is on our Students

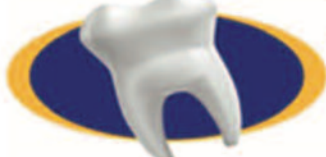
Dental Specialties Institute, Inc. is an approved provider of these programs by the Dental Board of California

(M) -Mandatory Courses for the RDA application: Dental Practice Act, 8 hour Infection control, Coronal Polish, X-ray Certificate, Pit and Fissure Sealant is required upon the first renewal period of RDA license. The supervising licensed dentist will be responsible for ensuring that each Unlicensed dental assistant, who is in continuous employ for 120 or more, has successfully completed board approved courses in Dental Practice Act, basic life support and an eight hour course in infection control within one year.

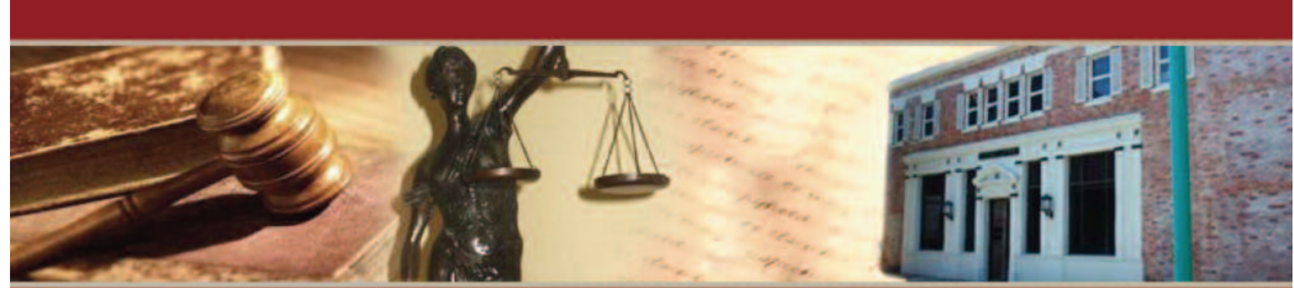
Phone: (408) 578-2074 Fax: (408) 578-4036

DENTAL BOARD OF CALIFORNIA

E-mail: info@dental-specialties.com
www.dental-specialties.com



Dental Specialties Institute, Inc.



THE GOLDMAN LAW FIRM

Business Employment Malpractice Defense

The Goldman Law Firm provides aggressive cost-effective and result-oriented representation to our clients. GLF focuses its practice in the representation of dentists in all of the practice areas which a dentist will typically encounter during his/her practice career.

Business Law and Litigation: GLF attorneys have comprehensive experience with the sale and acquisition of dental practices, associate agreements and partnership/corporation formation. We also handle business related lawsuits between dentists. Our knowledge with business litigation spans such issues as practice value matters, loss of goodwill, unfair competition via patient solicitation, actions against former associates, partnership dissolutions and breaches of either practice sale or associate agreements. GLF has the experience in this field second to none!

Employee Relations: GLF recognizes the need for expert advice in labor and employment contracts and disputes in today's high-risk professional environment. One of the most significant concerns facing a dentist is how to minimize the risk of an employee-based lawsuit. GLF proactively provides dentist/owner protection with effective staff employment agreements, policy manuals with mandatory dispute notice provisions, and binding arbitration of disputes. GLF defends dentists in matters ranging from Labor Commissioner actions, whistle blower claims, gender based claims, PAGA actions and traditional wrongful termination of claims.

Malpractice Defense: GLF has one of the most successful track records in winning jury trials and arbitrations in malpractice cases involving restorative, endodontic, periodontic, orthodontic, nerve injury, osteomyelitis and complicated infection issue cases. GLF welcomes doctors to contact them regarding potential claims or to obtain a second opinion on a malpractice defense position.

Having the right lawyer can make the difference between winning or losing and between a really good deal or a really bad deal! For those reasons, consider The Goldman Law Firm for your legal needs.

GOLDMAN LAW FIRM
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Parting Shot

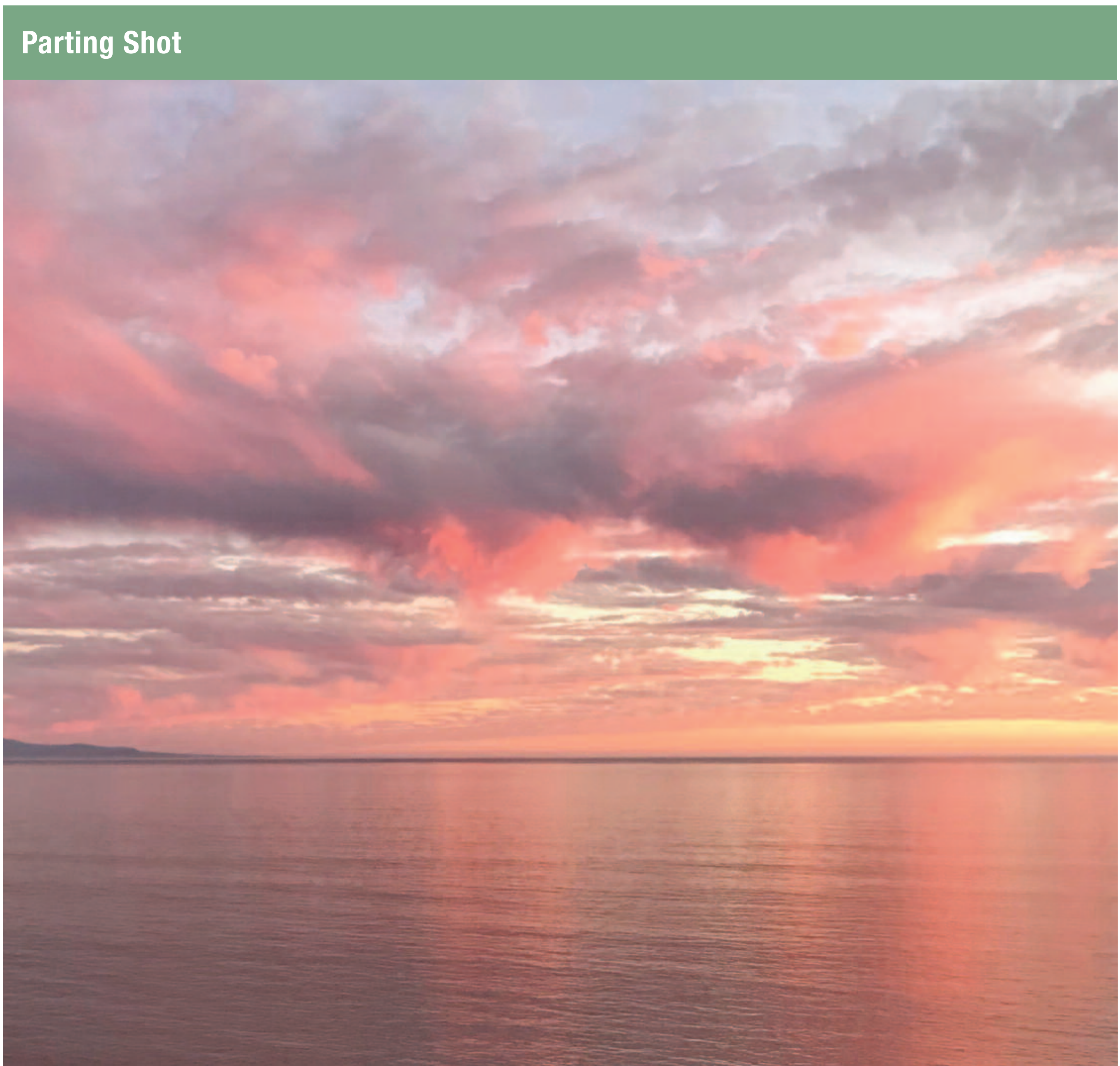

PHOTO BY: HEIDI HEATH GARWOOD Spectacular pink sunset on October 6, 2019. Taken from Aptos looking over to tip of Cypress Point.

"By the way, I'm wearing the smile you gave me."