GP NEWS

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Dentistry at the Supreme Court

Harriet Seldin, DMD, *San Diego*

This article is reprinted from the January, 2015 issue of Acolade, the newsletter of the American College of Dentists, Southern California Section. After its publication on February 25th, the U.S. Supreme Court ruled against the North Carolina State Board of Dental Examiners.

Sometime this spring we expect the U.S. Supreme Court to issue an opinion in North Carolina State Board of Dental Examiners v. Federal Trade Commission. This is one in a series of Supreme Court decisions that dictate many parameters of the dental profession. At one time, there was a definition of a "profession" as "self-governing." But that is increasingly not the case. The cases noted here are illustrative of this change in dental practice over the years, and not necessarily meant to convey value judgments.

The FTC ruled that the North Carolina State Board of Dental Examiners violated anti-trust law in not allowing non-dentists to provide teeth whitening services. The North Carolina Board sued, losing at several levels. Most recently, the U.S. Court of Appeals for the Fourth Circuit upheld the FTC ruling. The ADA and other health organizations as well as over twenty state governments and several associations of state regulatory boards filed Friend of the Court briefs supporting the North Carolina State Board of Dental Examiners. This case, if decided against the Board, could undermine the authority of regulatory licensing boards around the country. Dental Boards might need to have a majority of consumers to avoid challenge.

In the North Carolina case, there is a combination of factors that weaken the position of that State's Dental Board. The composition of the Board is one factor and another is how they are selected. In North Carolina, there is just one public member on the Dental Board. He is appointed by the governor. There are six dentists and one dental hygienist on their Board. Dentists are elected by licensed dentists and the dental hygienist is elected by licensed dental hygienists. Thus, the FTC's argument that it is professionals restraining trade on behalf of their fellow professionals. The dental board is independent of the state government in North Carolina. In California, by contrast, although the current Board has a narrow majority of dentists, there are non-dentists, including several public members on the Dental Board of California (DBC). The DBC is within the State Department of Consumer Affairs. And all Dental Board members are appointed either by legislative leaders or the governor. These appointments are made directly by the state's executive or legislative branches—not elected by dentists. The North Carolina Board and its supporters argue that the Board is an agency of the state, established by state legislation, and thus a part of the state government. In addition, the aspect of dental practice being considered is tooth whitening. Whitening agents are regulated by the FDA as a cosmetic consumer product. Whitening agents are generally not regulated as pharmaceutical or medical device products.

Back in the 1990s, the diagnosis of HIV was new. There were no effective treatments and infection control techniques were evolving. A dental school classmate of mine, Randy Bragdon, was sued by an HIV-positive patient in his Maine practice. He hadn't refused to treat her, but he wanted to treat her in the hospital where he had privileges. He planned to charge her for hospital expenses. The case made its way to the U.S. Supreme Court, with ramifications far beyond dentistry. The patient claimed that she was being discriminated against because she was disabled.

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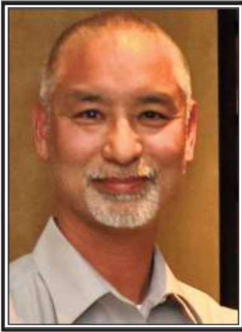

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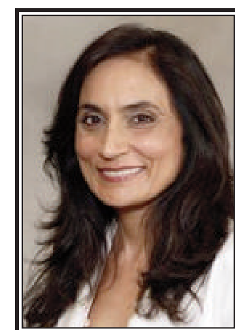

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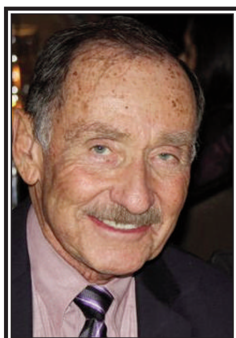

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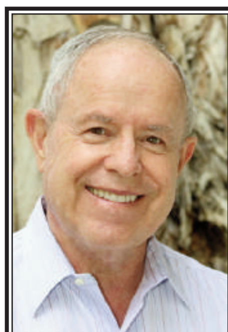

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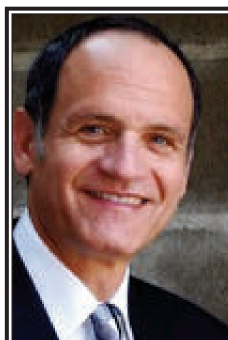

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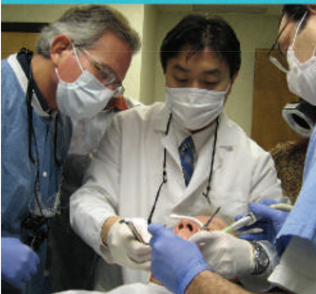

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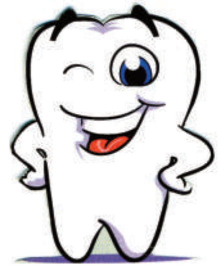

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Look for this logo when you sign up for continuing education courses

COURT *(continued from page 1)*

She was HIV-positive, but did not have AIDS. The patient's position was that it was unsafe for her to have children due to her HIV status, and hence was disabled. The outcome of this case was not only that dentists are required to treat HIV-positive patients the same as any other patients, but also that reproduction is considered a "major life activity," covered by the Americans for Disabilities Act. Based on this 1998 Supreme Court decision, dentists could not refuse to treat HIV-positive patients nor charge them differently than other patients.

In 1999, the U.S. Supreme Court looked at the California Dental Association's Code of Ethics. The Court recognized the FTC's power to regulate the conduct of non-profit professional associations. Separately, way back in 1977 in Bates v. State Bar of Arizona, the U.S. Supreme Court upheld the right of lawyers to advertise their services. This opened the door to all professionals advertising, including dentists. But CDA and the local component dental societies held false and misleading advertising to be a violation of the Associations' Codes of Conduct. Thus, dental association members could potentially have their membership revoked for advertising in violation of the Code of Conduct. This was a long and complicated case, but the bottom line is that it is very difficult for dental associations to impose advertising standards on member dentists.

The parameters of the profession of dentistry have been set in part by actions of the U.S. Supreme Court. Whether we can advertise, what patients we must treat, and criteria for membership in dental associations has in part been set by past court actions. We now wait to learn whether the role of state dental boards in regulating the profession will change as well. These four U.S. Supreme Court cases, from the 1970s to the present have set the law for dentists as individual practitioners (Bates v. State Bar of Arizona and then Bragdon v. Abbott), dental professional associations (California Dental Association v. FTC), and lastly, state dental regulatory boards (North Carolina State Board of Dental Examiners v. FTC). ■

DR. H. SELDIN

Dr. Seldin, CAGD Public Information Officer, is a past member of the Dental Board of California. She also serves as the Editor for Acolade and is in private practice in San Diego.

★★★★THE PRESIDENT'S CORNER★★★★★★★★★★★★★★★★

S. PENUMETCHA, DDS, MAGD
Elk Grove

As the year unfolds, we all have many things to look forward to. I am very eager and can't wait for the AGD Annual Meeting to happen in our very own San Francisco. The weather is going to be perfect and the venue has been long overdue. Plan now to attend from June 18th thru June 21st. Registration is open.

The CE and the exhibition are attractive, but the most exciting part for me is the convocation on June 20th. A selected few general dentists each year receive their awards of recognition, namely the Fellowship and Mastership awards in AGD. Why does it mean so much to me? Because dentistry is tough, and amidst all the challenges of being a dentist and running our practices, it takes a very few determined dentists to finally achieve this status. To pass the Fellowship exam, complete the countless 500 CE hours to achieve Fellowship (FAGD) and then another 600 CE hours to achieve Mastership(MAGD) is a battle worth fighting. And then there is the Lifelong Service and Recognition award (LLSR), which is an award to honor those very few who venture into lifelong learning, and continue to accumulate hundreds of hours beyond Mastership.

The California MasterTrack program helps dentists complete the requirements to attain Mastership. It is a four-year program. The class of 2010 has thirty-two dentists achieving the Mastership award; forty-one dentists will attain Fellowship status.

Volunteers making "Smiles for Kids Day" a success!

It is wonderful that they can receive their awards at the convocation ceremony amidst friends, family and team members. There won't be long flights and layovers and many days to miss from home. Congratulations to the MasterTrack graduates! *If you are interested in joining the MasterTrack program, call Lynn Peterson, our executive director, for more details at* 1-877-408-0738.

I will be a delegate and will be unable to attend much CE, but advocacy is just as important as CE when it comes to the practice of dentistry. So, I will be representing general dentists at the House of Delegates that will be held during the Annual meeting. It's where all the action happens, where you learn the new language of propositions, resolutions and the huge difference between "should "and "must" in the language of the Bills. We all get a chance to make our profession better for us and for our patients. It truly makes a huge impact on our future.

Update on our year so far:

Since being inducted as President in January, I have represented [general dentists] in as many ways as I could. "Smiles for Kids" was on February 7th. My office was one of twenty-four offices to participate by donating our services. We took care of several children and in the process, have adopted a few of them for continued treatment that we couldn't finish on that one day. It is very rewarding to do this. I suggest we all do this every year.

March was "CDA Cares." My team and I participated in delivering smiles in the Pediatric Division. We met many AGD leader-volunteers. It made me reflect—if all general dentists could participate in such wonderful community events organized by the CDA and the ones by the AGD, would we be able to solve the "Access To Care" without inventing a new tier of providers? Every patient needs the best dental care at the highest standard possible. Why should any Californian deserve less?

Dentistry is hard enough for dentists. There has never been a dull day in my office. The more we know, the more we see. When we graduate as dentists, we are pretty confident in treating patients. Then we start seeing some treatment fail, we experience less predictable outcomes. That is when we embark on a mission to improve and be better at what we do.

I joined the AGD to help me learn to solve the mysteries of dentistry. And I am still continuing to learn every day. The AGD quenches my

(continued on page 24)

THE LANGUAGE [CODE] FOR

Implant Dentistry Case Acceptance

Robert E. Garfield, DDS, *Los Angeles*

DR. BOB GARFIELD

Doctors:

You need not worry about finding new patients to treat with dental implants. Your filing cabinet and recall system are filled with formerly treated suitable candidates. Hygienist checks are an ideal place to start the presentation. *Make it short and sweet.*

1. The words you use and the sequencing of information to the patient are critical. Use lay terminology and keep it short, simple and encouraging at this first brief encounter.
2. Examination, treatment planning and documentation appointments are the next step.
3. You are responsible for any pre-existing abnormal condition that later causes a problem, unless you have informed the patient about it in the RBAs and SOAP and they have acknowledged this by signing an informed consent/refusal document, providing that postponing any necessary treatment is not below the standard of care.
4. Sending patients a 1-2-page summary of the RBAs and SOAPs is powerful, and will encourage them to accept your treatment recommendations. The letter is written in the "first person," however,

Comprehensive or minimal, case presentations and treatment planning should consist of approximately three or more short visits. This investment of your time, at nominal to no fee, will usually produce a good return. At the first visit the patient should only be told what can be done, but must never be given any details, especially cost estimates and the need for bone augmentation. After hearing only positive comments from you as to the treatment possibilities, at this point the patient will probably decide to proceed, regardless of cost, despite not knowing any more information. This is an interesting phenomenon.

For a patient who is about to lose a tooth, or wears a removable partial denture:

"Mrs. Smith, I can just put a new tooth/teeth right in there for you. This is how we replace teeth now. No more grinding-down the other teeth or having to wear removable appliances. We simply put teeth with metal roots right back into your jaw. They will never decay, and your bone will stop shrinking. You will be able to get rid of that bulky appliance." "How much will it cost, doctor?" "I don't know right now Mrs. Smith. I need more information. It's just like when you take your car in to find out what's making that funny sound. If you asked the mechanic "how much" he couldn't tell you either. He has to do an investigation since there are so many variables that can make a funny noise. I will need to do a complete exam first, so I will need to see you a few more times for models and different radiographs. After that we will know all the details and costs."

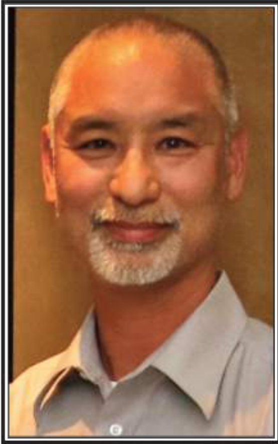
No surprises!

"By the way, Mrs. Smith, at the next visit I want you to carefully listen to what I say and possibly take notes. This is necessary because before any work is started, you I will ask you to read and sign a document covering what is to be done, and you will need to understand everything, so feel free to ask me any questions, even if you have to telephone me. I intend to put everything in writing for you and give you ample time to evaluate and decide on the treatment options." *Be quick and to the point, then stop.* ■

Make sure that your office staff members know and understand this information.

Questions? *Dr. Garfield can be reached at:* **drrobertgarfield@aol.com**

Michael Lew, DMD, MAGD, *Trustee, Academy of General Dentistry*



DR. MIKE LEW
Novato

What question are YOU asking to have answered?

"We can best answer tomorrow's problems by asking better questions today."

During my patient examinations, I often begin by asking questions — asking what he really wants out of the appointment. Is it simply to get his teeth cleaned, or is it to save his teeth? Would it be simply to avoid dental pain? Or was he getting the examination just to see how I can improve his smile? Answering his questions helps me establish my treatment plan for him. I did not say it determines how I would "sell" him my treatment plan. His answer really does establish what my goals of treatment are for him and who I could be as his dentist.

When taking many of my dental courses, I have found the experience the most engaging if I came into the class with questions. What has changed? Is my current technique still adequate? How can I be faster without compromising quality? When I come to my lectures with this attitude, they become more interesting than listening for new information. I am not alone. Dental lecturers often delight in lecturing to CAGD classes, whether for MasterTrack or for component study clubs, or our participation courses. AGD members often seem more driven to have questions.

At the national level, the AGD is continually asking itself similar questions: What has changed? Are our activities for our members adequate? How can we do it better? Our San Francisco Dental Meeting Committee under Dr. Tim Verceles asks how can they can make our upcoming convention both relevant to the attendees and a fun vacation. Dr. Sun Costigan shares our Membership Committee answers the question: What can the AGD do to become more relevant to the general dentist? Dr. Chetham Chetty will be answering the same question on the AGD Strategic Planning Committee. And Dr. Eric Wong chairs the PACE Committee in keeping the standard of dental continuing education for the general dentist. Many other California AGD leaders of our organization are answering these same questions.

Now, my friend and colleague — I have questions for you.

Who are you as an AGD member? Why are you a member of the AGD? What can we do to enhance your membership? How can the AGD benefit your future, your personal professional life? When will you attend your component's next study club meeting? Or, how can we bring the study club experience to you?

I believe that we as general dentists need to be asking ourselves these questions; not only from our AGD leadership, but for ourselves and our practice lives. WHAT do we really want out of dentistry?

The landscape of dentistry is changing. Today's dentistry offers many opportunities as well as challenges. We can best answer tomorrow's problems by asking better questions today. ■

Dr. Michael Lew is the Trustee representing California to the national AGD. He can be reached with your questions and comments at MLewMAGD83@gmail.com

COMBINING TWO APPLICATION TECHNIQUES FOR A

Composite Restoration

Howard Chi, DMD, MA, MAGD, *Stockton*

DR. HOWARD CHI

Today's composites have chameleon affects and an array of hue, chroma and value to choose from to help you achieve a highly esthetic restoration. And by combining both the incremental and the stratified technique, an anatomical and color-correct restoration can be accomplished. This article will discuss the steps necessary when one is applying both techniques together.

With the incremental technique, you can control shrinkage and depth of cure, enhance adapatation and over-contouring of the restoration resulting in a predictable outcome. While with the stratified technique, the desired esthetic outcome can be obtained with depth of color built into the restoration. You can apply these two techniques to any composite system to achieve the desired outcome.

A shade should be chosen for the restoration prior to placement of a dental dam. Next, an occlusal analysis should be to performed to determine the patient's centric stops and to note if there are any working or non-working interferences *(Figures 1 and 2).* Any lateral interferences should be removed and none should be created with the new restoration. The tooth is prepared for a composite restoration with rounded internal line angles, and a beveled cavosurface to expose the maximum amount of enamel rods for bond strength.

The preparation is etched utilizing a total etch technique using a 35% phosphoric acid etchant. First, an etchant layer is placed around the enamel layer at the cavosurface for 5 seconds prior to the remaining portion of the preparation being filled with etchant for another 10 seconds. A total of 15 seconds is utilized for the amount of etching time. This is rinsed with a copious amount of water, then blot dried with a cotton pellet.

A thin layer of bonding agent is applied to the preparation with an agitating technique and air thinned until no rippling is seen on the bonging agent. Once the rippling is gone, the bonding agent is ready for curing. The preparation is light cured for 10 seconds.

In the incremental technique, each layer is placed in a wedge formation no more than 2 mm thick. After the initial layer is placed, each subsequent layers are added, but not touching more than 2 surfaces, for example the pulpal floor and an axial wall. By placing small amount of composites, a low C factor can be achieved. The advantage to having a low C factor is to allow as much free surface area to flow, thus reducing the amount of shrinkage in the composite while it is being polymerized.

The stratified technique allows the practitioner to achieve a restoration that has a depth of color to match the original tooth. This is accomplished by placing darker chroma composite in the deeper portion of the preparation *(Figure 3)*, then with each additional layer, a lighter color shade is used *(Figure 4),* as to emulate the construction of natural tooth structure. For example, the enamel layer for a tooth is an A2 shade. To find the shade that you will need in the deeper layers, go 2 to 3 shades darker. Thus, A4 shade is used for the deeper dentin shade. The next subsequent layers are placed one

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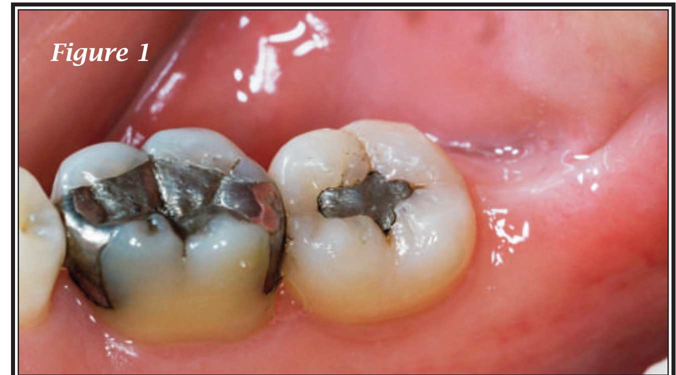


Figure 1: Pre-operative condition

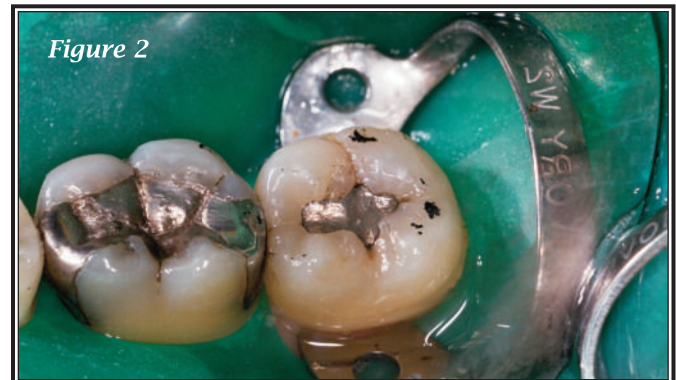


Figure 2: Note pre-operative centric occlusion

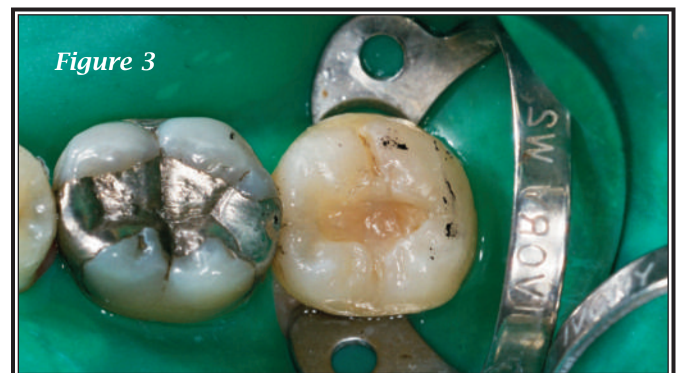


Figure 3: A3 dentin composite layer

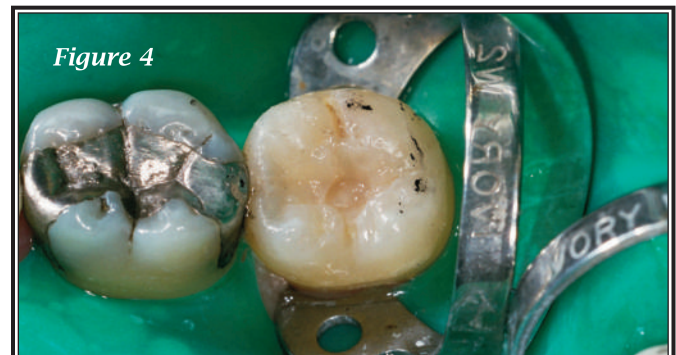


Figure 4: A2 enamel composite layer

shade lighter than the previous shade. Each layer is light cured for 10 seconds.

A microhybrid composite is used to filled the preparation with the exception of the final layer which will be a microfilled composite. A4 dentin composite is the first layer placed into the preparation and light cured for 10 seconds. The next layer is an A3 dentin composite added and light cured for 10 seconds. The second-to-last layer is the A2 enamel shade of the composite. The preparation is filled until the composite material is 1 mm short of the cavosurface

The high polishibility of a microfilled composite is used for the final layer of composite to be placed and light cured for 40 seconds. When placing the final layer it should be placed only on one side of the cavosurface, this will decrease the amount of cross marginal stress on the composite, which can lead to microcracks and leakage at the margins. The inherent strength of the restoration comes from the microhybrid composite placed below the microfilled composite. To minimized the amount of contouring with a handpiece, the composite layers should be placed in such a way as to emulate the anatomical structure of the tooth.

Fine diamond burs are to be used for finishing the composite restoration while fluted burs are contraindicated *(Figure 5).* Research has found that fluted burs produce microfractures in composites, while fine diamond burs produce a smoother finish.

After contouring is completed, the rubber dam is removed and the occlusion checked *(Figure 6).* The goal is to reproduce the patient's centric stops, made prior to replacing the restoration with no lateral interferences.

For the polishing stage of the restoration, composite polishing cups and points are used from coarse to fine. After each use of the polishing point, debris is rinsed off the tooth before the next polishing point is used. The final step in polishing uses a silicon carbide particle brush for the final polished surface.

To ensure a sealed margin that will last longer and less prone to staining over time, a surface glazing step is the final stage after polishing. A layer of etchant is placed on the margin of the restoration for 10 seconds *(Figure 7).* It is rinsed with a copious amount of water and air-dried. An unfilled resin is added to the restoration using a microbrush for better control and air thinned until there is no rippling and light cured for 40 seconds.

By combining both techniques one can achieve a restoration with predictable outcome and a highly esthetic result *(Figure 8).* With the incremental technique, a predictable outcome is achieved by controlling shrinkage, enhance adaptation, depth of cure and control of overcontouring the restoration. While with the stratified technique, the desired esthetic outcome can be reached with depth of color in the restoration. ■

Dr. Howard Chi is the President-Elect for the California Academy of General Dentistry and is in private practice in the City of Stockton.

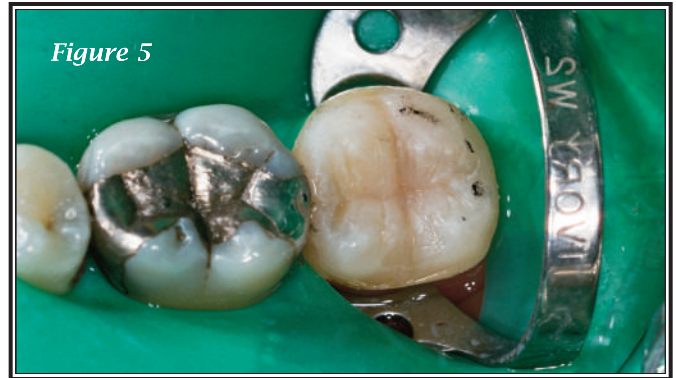


Figure 5: Contoured restoration after using a diamond finishing bur

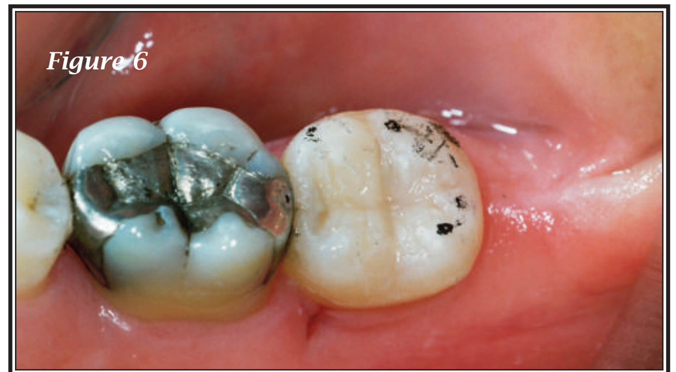


Figure 6: Occlusion checked after placement of restoration

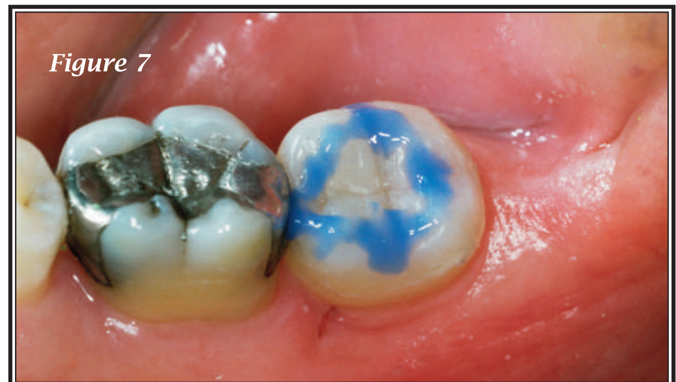


Figure 7: Etching margins prior to glazing

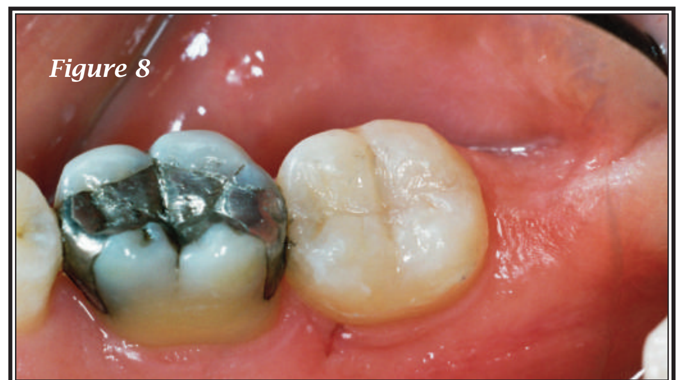


Figure 8: Final restoration

Chitra Shikaram, DDS, *President, Campbell*

DR. SHIKARAM

The NCAGD hosted a first of its kind a social event to recruit new members in February. The event took place at Scott's Seafood Restaurant in Walnut Creek. All in all, it was very successful. Three attendees joined the AGD that day.

We began with time for mingling and getting to know everyone. A representative from the Thomas Wrigg Doll & Co. CPA firm gave a brief presentation discussing the importance of proper accounting and tax filing. While attendees enjoyed a free lunch that started with a salad, followed by a chicken entree and ice cream for dessert, other presentations followed. AGD MasterTrack members Mina Levi and Paul Schafer presented a few of their MasterTrack cases. All attendees were enthused to learn valuable pearls of clinical dentistry from their peers. The NCAGD is planning to host more events such as this one in the future, since it was so overwhelmingly well received.

The Northern California AGD has a vision of promoting small study groups. Such groups will not only address the needs of the members and help add value to their membership, but also set us apart from other dental organizations. This is one excellent way to grow and retain membership!

Our plan is to host study clubs and membership recruitment events around the Bay Area. First in the series was an NCAGD Membership Recruitment Social in February at Scott's Seafood in Walnut Creek—an event that was extremely successful.

The NCAGD will track members who join the AGD through the small study group model as a way to measure recruitment.

"Pearls and Bullets for the General Practitioner" will be the theme of the small study groups.

The first in the series was held last year in Petaluma, by Dr. Ezra H Kantor, a well-respected prosthodontist from Marin who presented on the topic **"Practical Review of Implant-Retained Overdentures."** These were complementary no-cost events.

We launched our new website in August of 2014. The website now showcases the vision and mission that the board envisioned in terms of content and functionality. Our domain **www.NCAGD.com** is linked to the CAGD, AGD and AGD Foundation websites and informs members of developments in the dental community at the local, state and national levels. ■

Upcoming CE events include:

May 9th:
Important Physiologic Principles in Dentistry—"What Dental School Forgot to Teach You" in San Francisco by Dr. William Dickerson, the founder of LVI Global. This is the first time ever that Dr. Dickerson has spoken outside of LVI.

September 26th *(tentative date):*
Endo-Implant Course sponsored by DENTSPLY in San Jose.

Dr. Frank Ballard

Dr. Rosemarie Goldstein

Carson Henderson, CPA, from Thomas Wrigg Doll & Co. presenting to the group

Dr. Mina Levi won the raffle prize…a gift basket from Scott's Seafood

Dr. Rose Magno

Dr. Jennifer Cho

Dr. Gene Allen Herrera

For questions and information, contact:
Dr. Chitra Shikaram *at* **sclnk@hotmail.com**
or **president@nacgd.com**
or via my cell at 408-603-3938

DR. SMITA KHANDWALA

Smita Khandwala, DDS, FAGD, *President, Sacramento*

Clinical Implant Prosthodontics and Surgery

by **Dr. John DiPonziano**

This will be a full-day course on **July 19th** (9:00 *till* 5:00)

The course will be held at
SUDWERK RESTAURANT & BREWERY
2001 Second Street, Davis

All new graduates are encouraged to become members of the AGD; ***then take this course for free.***

Learning Goals:

- Learn to restore implant from A to Z. This in-depth course will review the various implant restorative components and their indication.
- Treatment planning and prosthetic design for single crowns, multiple units, stud and bar over-denture and fixed detachable hybrid prosthesis will be discussed.
- A review clinical tips, tricks, and trouble shooting of common implant prosthetic problems and complications.
- The surgical portion will cover predictable techniques for guided bone generation and proper implant positioning for esthetics and function.

In March we had wonderful, informative and social CE dinner meeting where our own SSAGD members, Dr. Howard Chi, Dr. Eric Wong and Dr. Ashkhan Alizadeh shared their knowledge and experience. The attendance was great and the program was well-received.

A PARADIGM SHIFT IN GENERAL DENTISTRY

Cerec Dentistry

Stephen E. Lockwood, DMD, MAGD
CAGD Regional Director, La Jolla

Many of us have heard about CAD/CAM (Computer-Aided Design/Computer-Aided Milling) restorations, or have heard that our dental labs can now fabricate our crowns using this technology. In 2005, twenty years since my GPR completion, I had the opportunity to try CAD/CAM dentistry on one of my patients. I had help from my local dental supplier who was distributing the new technology.

As with other technology and product/procedure advancements , I have asked myself three basic questions:

1. Is the technology more comfortable for the patient?
2. Is the technology faster for me or my office?
3. Does the technology produce a reasonable ROI (return of investment)?

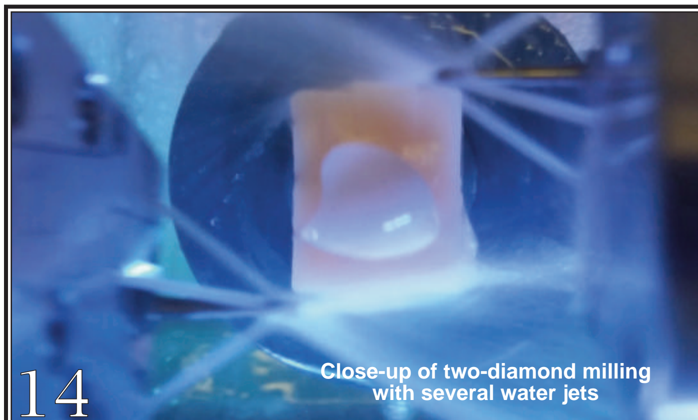
After all, you don't get such items at Costco or Home Depot, and the return policy is not so friendly.

When I first tried in-office CAD/CAM in 2005 I learned that my dental labs could still produce as good or better porcelain restoration than the CAD/CAM. In the last few years, however, my concerns about moving to CAD/CAM have been largely addressed. I have been excited about digital impression taking and having the digital impressions sent via e-mail to my dental lab. This was especially helpful with accuracy of marginal and contact precision. My reasons for continuing use of gold for maxillary 2nd molars and often mandibular 2nd molars were undercut, as I saw the accuracy, precision, and strength of monolithic milled zirconium and e-max porcelain crowns on second molars. The cost difference was an encouraging factor as well. The traditional impression and model work of these cases often resulted in 2nd molar crowns made out of occlusion. Even when labs were given instructions not to use plastic hinged "articulators," my cases were still out of occlusion. Every lab I have worked with has invariably called my office informing me there is not enough occlusal clearance with the opposing tooth. I would just tell the lab to reduce the opposing, knowing that I would not even have to adjust the opposing tooth. Sometimes, the crown was actually still out of occlusion.

The CAD/CAM technology has made major improvements since 2005. These include the enhanced digital video camera that is very small and capable of scanning the distal of 2nd molars without having to intubate the patient. The lack of need for the messy and asphyxiating disclosing powder was also welcome. So now I can take an accurate impression that is relatively more comfortable for the patient, while efficient and accurate for me. I can easily send a digital file to the lab after making a temporary crown and have the crown back in less than the standard two weeks. Previously, with the first return of the patient after the preparation, I had to hope that the lab had followed my Rx and I had accurate margins, shade, and contacts. Now, with minimal to no adjustments, I can use either a cohesive or adhesive luting agent that will secure the crown for more than five years. Along with the opportunities of technology, we are all aware of the challenges associated with performing good clinical dentistry. We all strive for excellence, but if we are honest with ourselves, we admit that we are vulnerable to the technicians who fabricate our dental work. Dentists like to control their environment and clinical outcomes because it is their responsibility. So how can we really achieve the predictability required by our treatment?

The paradigm shift in restorative dentistry is that dentists are learning to use technology in a fashion that brings control into our hands in a reasonable time-frame that is both comfortable and convenient for our patients. My practice is now benefitting from this. So instead of sending my digital image to the lab, I sit my patient up in the chair while my

(continued on the following page)



Close-up of two-diamond milling with several water jets

Telio CAD (Ivoclar) Temporary Bridge

CAD/CAM *(from the previous page)*

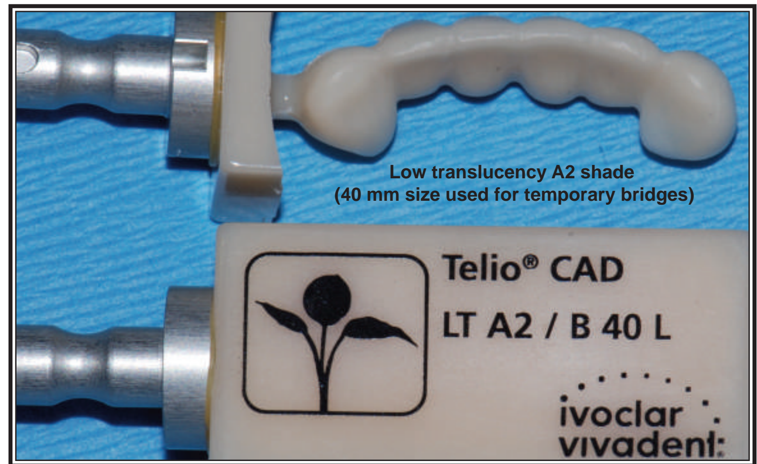
assistant directs the computer software to "stitch" the video images to workable digital models. Next, I walk around to the computer terminal and define my margin and path of insertion. Then I ask the computer to provide me with a "starting crown design" based on the boundaries of the digital model. From here I can re-design the crown's contours and contacts before I send the information to the Cerec milling unit in my own lab area where my assistant has inserted the size and porcelain-specific shaded block. Within 14 minutes the crown is milled. Then I try in the milled crown to verify IP contacts. The margins are impressively predictable and I do not check the occlusion at this time. Next I take the milled crown and place a glaze coating and any staining (characterization). The firing or glaze oven is 15 minutes plus another 4 minutes for cooling outside the oven. The finished crown is prepared for proper adhesive or cohesive luting. After excess material is removed, I do check the occlusion and find minimal to no adjustments are necessary. Most importantly, my patient has a final crown in about two hours and does not have to come back for a traditional second appointment.

In fact, I have been making very few temporary crowns lately. I did send a 3-unit Zirconium bridge and a group of individual porcelain crowns to my dental lab until my skill sets increase with Cerec. In the single-unit case above I have summarized the steps of controlling shade, margination, occlusal/interproximal contacts, and contours. This is simplest with smaller direct resin restorations, but more challenging with full-covered porcelain restorations. Still, the opportunity to gain better clinical control is undeniable. Controlling occlusion, anterior guidance, and artistic characterization all can now remain under the dentist's direct control. In my first two months of using the new Cerec Opticam (video camera), software, milling unit, and Ivoclar firing oven, I have begun a journey toward predictably delivering highly functional and esthetic restorations. I now deliver crowns that are as good or better than my labs produce.

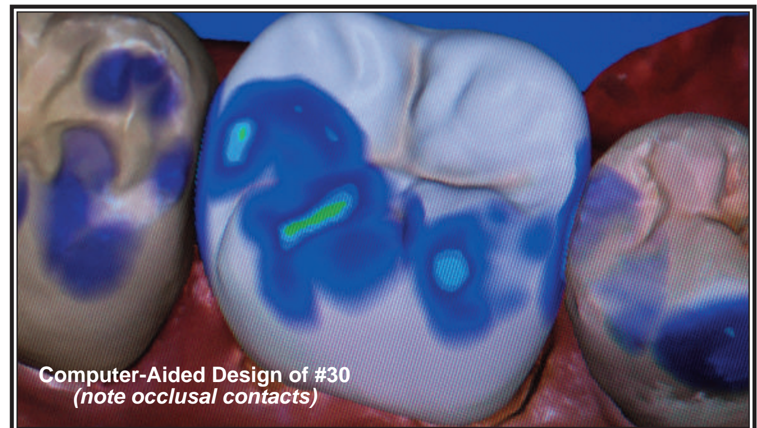
Financially, I can also calculate the savings gained by making my own crowns. I can estimate the reduction in chair time and overhead from a single appointment. This savings is similar to a single RCT visit. I gain tax benefits from equipment purchase as well. My ability to fully utilize this new technology is the unknown factor that will determine my best ROI. My experience demonstrates that the learning curve is not out of reach for those who have a passion for excellent dentistry and a passion for people. I am especially impressed with Sirona's Cerec 90-day training program to help both young and seasoned dentists adopt the changes necessitated by the new technology. This raises another question about purchasing of new technology: Does the company provide training and customer service?

CAD/CAM restorative dentistry is now an important aspect of "technodontia." It seems almost like cheating to view canals of teeth in a 3D image, with no more "guess work" needed. This has become my endodontic standard of care for viewing anatomy, diagnosing endodontic pathology, locating canals and determining their length. The 3D digital imaging for CAD/CAM production of surgical implant guides, clear orthodontic aligners, and eventually removable partial dentures is around the corner awaiting your discovery.

Don't miss out on this rewarding opportunity.



Low translucency A2 shade
(40 mm size used for temporary bridges)


Computer-Aided Design of #30
(note occlusal contacts)

Final restoration with no adjustments to contacts *(note clinical accuracy of CAD)*

An explanation about the different occlusal colors represent increasing intensity of contact areas that range from blue, to turquoise, to light green, to yellow, and red. Matching the intensity of adjacent tooth contacts is part of the design protocol. Also, appropriate contacts of functional cusps/fossa are achievable. Awareness of opposing tooth or implant crown is taken into design consideration. Here, tooth #30 opposes a maxillary porcelain crown.

This was an actual case that was recently treated by Dr. Lockwood using the CAD/CAM technology.

Note: The AGD is committed to the pursuit of excellence in general dentistry. Throughout my thirty years in dentistry, I have learned about new technologies and their clinical application through my involvement and participation in the AGD. Look to your Academy to provide updates on these important developments.

Dr. Lockwood is also an Associate Fellow in the AAID, the ADA, the CDA, and the San Diego County Dental Society and is in private practice in La Jolla.

Artin Manoukian, DDS, *President, Glendale*

DR. ARTIN MANOUKIAN

"Who do you think advocates solely for the GPs? It's not the ADA, and it's not the CDA... well, it's the AGD..."

Some of you already know what I am about to say. It merits saying again, but saying it especially to our non-member colleagues when we have the opportunity to do so.

I want to tell you why I believe every general dentist should be a member of the Academy of General Dentistry, especially if you intend to practice for another ten or twenty years. Aside from all the usual things like group insurance, CE courses, Fellowship and Mastership, etc., there is something even more important called **ADVOCACY.** As a G.P. your California dental license permits you to perform any and all procedures included in The Dental Practice Act, and that includes specialty work. There are other organizations and groups in our profession that disagree with this and want to change the law so that GPs cannot perform their particular specialty work. All of these attempts to legislate limits on your California dental license have failed over the years because the AGD has lobbied the state legislatures, explaining to them why these are not in the best interests of most dental patients. Some of these efforts have included Invisalign, oral surgery and implant dentistry, perio treatment and molar endodontics. ***Yes GPs, the AGD has your back.***

The specialty groups have their own organizations that advocate for their own interests. Who do you think advocates solely for the GPs? It's not the ADA, and it's not the CDA, since they have to represent ALL dentists regardless of specialty. Well, it's the AGD, the second largest dental organization in North America. And the more members we have the more effective we are. I believe that if these issues were known by all GPs our membership would grow rapidly to possibly 85% of all general dentists under the age of 65. Unfortunately, we have to improve our message in order to reach many more GPs.

Now, it costs about $450 per year to belong to the AGD, and about $2,100 to belong to the ADA/CDA. I am not advising you against joining the ADA or the CDA, since they do a lot of very good and important things for our profession as a whole, but for a young GP dentist starting out in practice I believe that he/she will get more "bang for their buck" by becoming an AGD member first, then joining ADA later when you become more financially stable and can join many other good organizations that you find an interest in.

AGD members and non-members should go to online to **www.agd.org** and spend some time reading about what we offer solely for GPs.

If you choose to join online you are welcome to use my name for *"Who referred you?"* ■

Thank you!

Artin Manoukian, DDS
President, SCAGD

THE SOUTHERN CALIFORNIA ACADEMY OF GENERAL DENTISTRY PRESENTS

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FOR ALL DENTISTS

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Patient evaluation, treatment planning, occlusion, radiographs and scans, the management of soft and hard tissue, placing implants, restoring implants, patient management and much more. A forty-page generic instructional syllabus worth $500 will be included with your tuition.

Friday Saturday , August 21-22, 2015

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€ **Kenneth Hebel**, **DDS**, **BSc**, **MS**

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Drrobertgarfield@aol.com

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Ayres Suites, 22677 Oakcrest Circle, Yorba Linda, California 92887 ™™š š™Š

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DR. GUY ACHESON

Watchdog REPORT

Guy Acheson, DDS, MAGD, *Rancho Cordova*

California IS Cutting Edge

HYGIENE CONTINUES TO PRESS FOR INDEPENDENT PRACTICE AND AN INDEPENDENT BOARD

The Dental Hygiene Committee of California (DHCC) continues to press for full independence. Instead of a full frontal attack they are working around the edges to obtain a greater level of autonomy. If approved, the changes would actually create an expansion of the scope of practice which is the one area where the Dental Board of California (DBC) has oversight. These changes would significantly cloud the clarity of this oversight.

AB502 (Chau) was introduced and is sponsored by the DHCC. It is specifying four changes to current law. First, it would allow an independent hygiene practice established by a Registered Dental Hygienist in Alternative Practice (RDHAP) to continue to operate the practice if the practice location loses its certification as being a Dental Health Shortage Area. Second, it would remove the requirement for a patient of an RDHAP to obtain a dental examination by a dentist or physician and an order to provide hygiene services before providing care beyond eighteen months from the start of providing hygiene services. Third, it would allow RDHAP practices to incorporate as a dental service provider and allow dental assistants to become shareholders in the corporation. Current law only allows a dentist to own a dental service corporation. It also allows the RDHAP-owned business to hire dentists as employees of the corporation. Lastly, it would require dental insurance providers to pay RDHAPs directly for the services that they provide.

THE DENTAL PHOENIX ARISES . . . DBC SUNSET REVIEW

2015 includes the Sunset Review process for the DBC. The law that created the DBC has an automatic termination date of January, 2016. There will be a series of hearings before the Assembly and Senate Business and Professions committees to draft new legislation to continue the DBC for another three to five years. The process allows the legislature to ask questions about how the Board is functioning and solicit feedback and suggestions for changes. The process usually provides an opportunity to correct problems in existing law that prevent the DBC from doing their job or to change their scope. It also provides opportunities to change the makeup of the DBC. We (CAGD) and the California Dental Association are hoping that this process will include the amending of Business and Professions Code 726 to nullify the section that makes it an act of sexual misconduct to have any sexual contact with a provider's spouse *(or significant other)* if they are also a patient of the practitioner. Physicians have this exemption. We are asking for the same. I hope you all have sent letters on this topic to the chairs of the Assembly and Senate Business and Professions committees using the CapWiz system. **If not, DO IT NOW.** And get all your dentist friends to do it.

Letters do make a difference in getting a legislator's attention *(see page 26 for more information).*

Use this link to send letters in your name automatically:

http://cqrcengage.com/agd/app/write-a-letter?1&engagementId=77263

IT'S ALL ABOUT MONEY, HONEY . . . AND DENTISTS ARE THE HONEY

Then there is the budget of the DBC. The DBC just had an increase in fees for licensure and re-licensure. Turns out that the increases were not enough. The DBC is running in the red.

An audit was just completed on the DBC budget. A presentation was made by the head of the independent audit company. He emphasized that the DBC was operating in the red and will need to SIGNIFICANTLY INCREASE ITS REVENUE. In California, the licensing boards must be self-funded. No general funds are used to pay for Board expenses. In the old days, the DBC ran the dental licensing examinations for dentists and made a profit at that activity. Now, the licensing

(continued on the following page)

examination is done by the Western Regional Board (WREB). When the DBC ended running their own examinations, they had over twenty million ($20,000,000) in reserve funds from profits. They burned through the last of that money about two years ago. The income generated by licensing fees does pay for the core DBC staff and services. It is the enforcement division that is costing much more than it recovers in fines and penalties.

The head of the enforcement division gave her usual summary of the department's activity and then reinforced the auditor's assessment that enforcement costs are not covered by the revenues generated from fines and penalties. She stated that they need to expand enforcement so that they can increase revenues. *This worries me.* Enforcement is one of the core functions of the DBC in supporting its mission of protecting the public. But, looking at increasing enforcement to increase revenues is scary stuff. It brings to the forefront the way many municipalities look toward traffic citations and parking fees as a way to make up for budget shortages. Red light cameras, rolling right turns, and speed traps usually results in a hostile environment being created by over zealous enforcement. The need for income should not drive enforcement activity.

THE MOLDOVANIANS ARE COMING, THE MOLDOVANIANS ARE COMING!

California IS cutting edge in breaking down traditional barriers and forging new ground. Case in point, California is the only state that has a process to allow graduates of foreign dental schools to apply directly for a California license. California law allows the DBC to certify that a foreign dental school's educational program is equivalent to a United States educational program which allows their graduates to apply for a California license without completing the two-year foreign graduate program. The first foreign dental school to obtain this approval was University de la Salle in Mexico. The DBC is now addressing an application from the Universitatea De Stat De Medicina Si Farmacie Din Republica Moldova to be an approved dental school.

For schools in the United States and Canada, the DBC has granted approval to any school that is deemed fully compliant by the Committee on Dental Accreditation (CODA) which is part of the American Dental Association. The problem lies in the California law that authorizes foreign dental schools to apply for DBC approval because it stipulates approval criteria that were the CODA standards way back in the 1990s. The CODA criteria have changed in significant ways since then. CODA will not agree to inspect and certify a foreign dental school using what are now outdated standards. Thus, the DBC must do it themselves. It takes a tremendous amount of time and resources to complete that process.

From my perspective the DBC has created this problem because they had an opportunity to correct these issues after going through the approval process of the Mexican dental school, University de la Salle. All the same uncomfortable questions are being discussed again like a bad dream that returns periodically. Because the DBC members are continuously changing there is very little corporate memory. I would hope that the DBC considers doing an after-the-fact evaluation of all significant projects; a corporate post-mortem. They can then develop a list of actions such as changes in regulations, statutes, or processes that could be taken to make future projects of a similar nature better. I wonder where the next foreign dental school application will come from: India? China? Nigeria? Brazil? ■

About the Author:

Dr. Acheson is in private practice in Rancho Cordova. He is a Past President of the California AGD.

He makes an effort to attend every Dental Board of California meeting as well as all meetings of the State Senate or Assembly when topics on the table are deemed important to California's citizenry and to its population of dentists.

He can be reached at

drguyacheson@gmail.com

The AGD is the organization for the general practitioner.

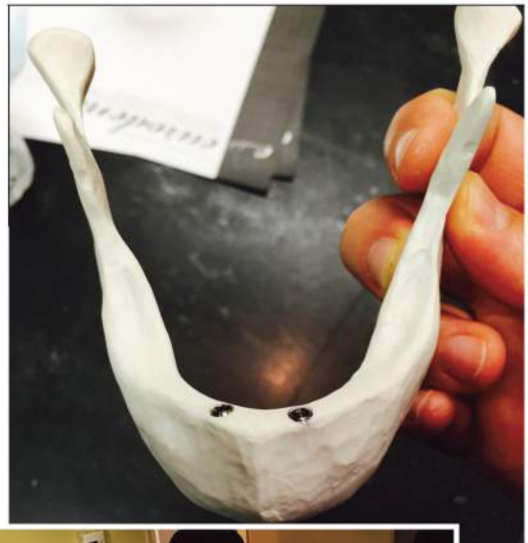
The website is

www.agd.org

University of Southern California

Eric Rabey, *Herman Ostrow School of Dentistry of USC*

ERIC RABEY



It has been an exciting trimester for the USC AGD Fellowtrack. Lately, the FellowTrack has been focusing on dental implants for the general practitioner. To kick off the theme, we had Dr. Nouri speak to our FellowTrack students about many topics surrounding implant placement. He explained the benefits and lab costs for SiCat —the computer-oriented technology that allows for accurate guided surgery. Dr. Nouri also informed us about the possibilities of Cerec milling in the dental office, what the benefits and potential risks are when buying a Cerec machine, and how to properly implement it into a practice. His lecture also covered case selection for ZMax implant abutments and cone beam CT for the general dentist. Following this lecture we offered two implant workshops.

The first workshop took place at a dental lab in Glendora Hills where Dr. Saeid Razi spoke to the Fellowtrack students of Southern California about a wide range of topics. The main focus of the workshop was implant placement for the general practitioner where we learned about evidence based dentistry, case selection, paresthesia, blocks vs. infiltrations for implant placement, bone type, different implant systems, and the science behind implant surface treatment. The lecture also involved a discussion about the different materials used for implant abutments and crowns placed on teeth and what the benefits and downfalls are of each. We also had an opportunity to learn more about how one successfully communicates with a dental lab.

A following workshop has been planned for late May. It will involve the placement of an implant and allograft into real cadaver bone.

Topics that the USC AGD FellowTrack plans to cover in the future will include everything from the science behind esthetic veneers to the applications of dental materials in the dental office. This is why the AGD Fellowtrack is so exciting. It gives students the opportunity to learn more about the topics they find interesting and relevant. The information surrounding dentistry is endless. Those of us who recognize that dentistry requires a lifelong dedication to education and improvement rather than four years have been given a forum to share our ideas and interests. ■

Fight On!

FellowTrack South

University *of* California *at* Los Angeles

ALLYSON TAYLOR

Allyson Taylor, *President Elect, UCLA FellowTrack*

The UCLA AGD student chapter had a busy and fun winter quarter full of community service and learning events. We hosted a half-day volunteer event at the LA Food Bank. Twenty UCLA dental students traveled to Vernon to one of the Food Bank's food sorting warehouses. We assembled packages for thousands of low-income seniors, women with infants, and children in Los Angeles County.

The food packages consisted of items like canned fruit, canned vegetables, rice, cereal and other non-perishable items. While sorting items along the assembly line, students got to know each other and other volunteers. The participants loved the event because it provided a fun, active way to help those in need. The UCLA AGD student group was one of several present at the event.

The UCLA AGD has also been active in providing lectures this quarter. We hosted a lecture on "What To Expect During Your First Year Out of Dental School." Dr. Colby Smith, Director of Advanced General Dentistry at the UCLA Venice Dental Center, shared his advice and personal experiences in answering questions. *Examples:* "How can we prepare for future employment while we are still in school?" *and,* "What types of options do we have for work as a general dentist upon graduation?" Dr. Smith also gave advice on managing practice and personal finances, what day-to-day life is like as an AEGD resident, and what to look for in an associateship. Students appreciated his straightforward approach in discussing important practical issues that may not be covered extensively in the formal dental school curriculum.

Our second "Lunch and Learn" of the winter quarter featured Dr. Todd R. Schoenbaum on "Introduction To Implantology." He covered the basics of implant science, allowing the student audience to get a glimpse of what the next few years could hold for them. Third- and fourth-year students in attendance were exposed to a review of material they had recently covered and are currently implementing in the clinic. Dr. Schoenbaum talked about the advantages and disadvantages of various implant connection types, strategies for success in implant crown cementation, and how the screw access marking technique can make the future retrieval of cemented crowns easier and more predictable.

In another implant-focused event in March, several UCLA AGD members, along with students from the other Southern California dental schools, attended a full-day implant workshop at the Eurodent Dental Lab in Granada Hills. The program included a lecture, a tour of the lab, and an implant workshop where students placed an implant in an imitation jaw.

Overall, the winter quarter has been a successful one for the UCLA AGD, and our frequent events have promoted the organization across the school. We have received positive feedback from students who attended both the Food Bank event and the lecture sessions, and plan to host more events like these in the upcoming months. ■

Western University of Health Sciences, College of Dental Medicine

SUNJOO PARK
FellowTrack Representative

MY EXPERIENCE WITH Implant Placement

With advancement in technology, implant therapy has become increasingly accessible for general practitioners. The procedure for implant placement is now much easier, safer, and less time consuming compared to when the technology was first introduced in dentistry. Even so, it is not something dental students get to perform on a routine basis while in school if not done by a specialist exclusively. Although there were a handful of lectures dedicated to implant placement and restoration that explore the procedure in great detail with visual presentations, I did not see myself placing implants upon graduation without further training.

I have always wanted to explore outside the so-called "bread and butter" of general dentistry. Being able to provide a variety of advanced general dentistry procedures is an important quality I see in a competent clinician of the twenty-first century. Implant placement is certainly one of them. Until recently, I did not have a clear idea of how to reach this goal. The continuing education course on implant placement with Dr. Razi definitely provided me with a much clearer road map. This one-day course is designed for the AGD FellowTrack program. It allows students to earn CE credits while in school and explore various topics within general dentistry.

Dr. Razi started his lecture with a thorough discussion on the historical background of implants. I admire how orthopedic screws were first used to replace teeth and evolved to become today's implant. Design features and the rationale of the Dentis Cleanlant implant system were explained in detail. This allowed me to appreciate the physical mechanisms of each design feature and compare one implant system to another. Dr. Razi also provided a good review of the important factors to consider in order to ensure the safe and successful delivery of implants within the scope of the general practitioner. Students were given a thorough tour of the Eurodent Laboratory. That helped us understand how prosthodontic cases including implant crowns are handled.

Lastly, clear and straightforward instructions for an actual implant placement were given. The highlight of the experience was the hands-on implant placement into artificial mandibles. Hearing a hundred times is not as good as seeing once, or even better, doing it yourself. This experience allowed me to incorporate and synthesize all the knowledge provided by the course and previous implant lectures. I will certainly need further training on the subject, but there is no doubt that this course definitely instilled confidence in students who wish to pursue implant dentistry in the future. ■

"Hearing a hundred times is not as good as seeing once..."

FellowTrack North

University *of* California *at* San Francisco

Danielle Niren, *AGD President, UCSF FellowTrack*

DANIELLE NIREN

The CAGD FellowTrack Program and the Northern California AGD hosted two "Lunch and Learns" this year: Oral Surgery Complications by Dr. Choi and a Smile Design Class hosted by Dr. Hoffman.

Dental students across all four years from the UCSF were in attendance for these successful and informative workshops.

The Lunch and Learn: **Oral Surgery Complications** with Dr. Choi was held in November at the University of California San Francisco.

Dr. Choi presented various case scenarios that involved complex surgical procedures. One such example is a case that he presented, in which a patient needed a root canal on a tooth near the inferior alveolar nerve. Dr. Choi proceeded to present how the tooth was later extracted and the third molar was extruded to take its place by using orthodontics.

Students were exposed to many case scenarios of surgical procedures that were completed by a general dentist.

The Lunch and Learn: **Smile Design Class** was hosted by Dr. Hoffman was held in January at the University of California San Francisco.

Dr. Hoffman presented case scenarios of esthetic concerns that he has seen in his private practice. Students were given the opportunity to engage and ask questions about the most important aspects of esthetic dentistry.

Additionally, in the coming month the CAGD Fellow Track Program and the Northern California AGD will be continuing our "Lunch and Learn" series on Thursday, April 30th with a presentation by Dr. Ward Noble.

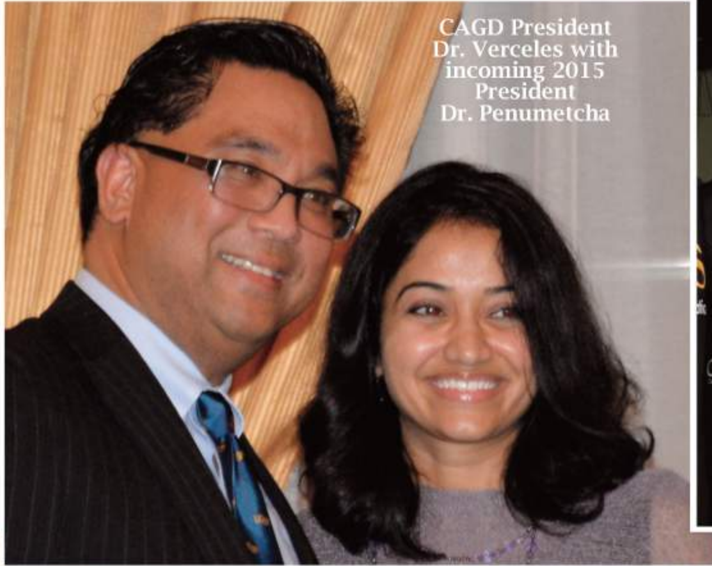
Dr. Noble's lecture titled **"Interdisciplinary Management of Complex Restorative Care"** will focus on case-based presentations, considerations of VDO, new ceramic materials, and the use of implants.

These valuable lectures have helped students to better understand the scope of general dentistry, and allow students to ask questions that are not as easily addressed in the curriculum. ■

AGD 2015 SAN FRANCISCO
a golden opportunity
June 18 to 21, 2015 Moscone West Convention Center www.agd2015.org

PRESIDENT'S MESSAGE

(continued from page 7)



CAGD President Dr. Verceles with incoming 2015 President Dr. Penumetcha

AGD leaders at a "CDA Cares" event held in Sacramento

thirst for knowledge while encouraging me to attain Fellowship and Mastership status. These awards just keep pushing one to be better. Being a Master in the AGD doesn't mean that we are good. It means that we have learned to be humble and that we are open to learning each and every day.

Become a member of the AGD if you aren't already and see the difference for yourself. *The AGD is addicting.* It makes you feel more secure knowing there are lobbyists working on your behalf, protecting your rights every day.

You only need to become a member to show your support. **It's the ONLY organization that serves ONLY general dentists** and their right to practice dentistry within their scope.

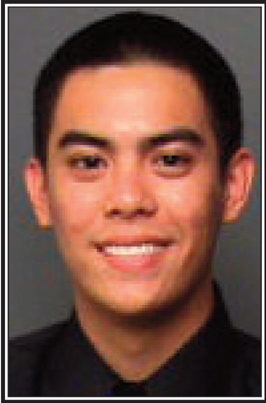
I am proud to be an AGD member and you should be too.

See you in San Francisco! ■

Sireesha Penumetcha, DDS, MAGD
President, California AGD
dr_sireesha@yahoo.com

Loma Linda University

Eugene Oriola
CAGD FellowTrack Program, LLU



EUGENE ORIOLA
Loma Linda University

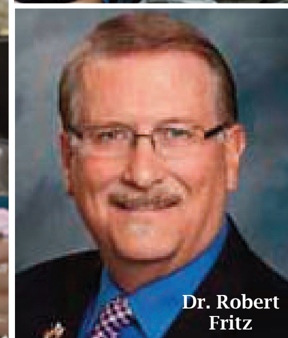
After several years of inactivity, AGD is once again an official organization at Loma Linda University School of Dentistry! In the past, the organization ran out of steam and ran out of students interested in leading it. This resulted in generations of students who did not even hear about AGD at LLUSD.

Brandon Soelberg approached me in the winter of 2014 about joining a specialty education organization. He asked me to be the "General Dentistry" representative and to speak with Dr. Goldasich about merging that with the AGD. Being great friends, we agreed and I was dragged into the whirlwind of the student body restructuring that was going on.

While the restructuring committee was not specifically against the AGD, the new sweeping changes they were making made it incredibly difficult to start the FellowTrack. I found roadblock after roadblock in attempting to start the club, whether it was waiting for meetings to convene to vote on my proposition, to making corrections to the AGD FellowTrack's constitution to fit with the new student body's rules. As someone who is not used to politics, I was frustrated.

It was not until Dr. Robert Fritz reached out to me expressing his concern about not having an AGD FellowTrack at the school that we got any traction. When I was able to get faculty on my side pushing for the AGD to be at LLUSD, the restructuring committee became much more receptive to making the AGD FellowTrack an official organization. Once it was pushed through however, we ran into trouble tracking down the donation in order to start activities. It took almost two months of back and forth before we were able to track down the check, and get it deposited into the account. Despite all the challenges, the AGD FellowTrack is now re-established at the LLUSD. Now that the dust is settling, Dr. Fritz and I will do everything in our power to make sure that it thrives in the future.

Our first "Lunch and Learn" was on April 16, 2015 *(more in the next issue of the GP News)*. ■



Dr. Robert Fritz

STAND UP, SPEAK UP

Send a Letter...!

Guy Acheson, DDS, MAGD, *Rancho Cordova*

You have read my multiple articles on Business & Professions Code 726 which makes any sexual contact with your spouse or significant other against the law if they are also your patient. Letters by constituents help obtain the legislator's attention and show interest and concern *(below is a sample letter in the boxed area).*

You can send the following letter with just a few clicks on your computer. Four letters will be sent out—the chairs of both the Assembly and Senate Business & Professions committees, as well as your representative and senator.

Follow this link: **http://cqrcengage.com/agd/app/write-a-letter?1&engagementId=77263**

The Academy of General Dentistry is making this service available to all California dentists. You do not have to be an AGD member to use the service. ■

Assemblyperson Susan Bonilla
Chair, Assembly Business & Professions Committee
Senator Jerry Hill
Chair, Senate Business & Professions Committee
Your representative
Your senator

Dear *(your representative),*

The California Academy of General Dentistry (CAGD) would like the Assembly Business, Professions and Consumer Protection Committee to consider including a proposed amendment to B&P 726 as part of the Dental Board of California (DBC) sunset review.

The CAGD has been following the DBC review of sexual misconduct regulations that was requested by the Senate Business, Professions and Economic Development Committee. That review highlighted the two primary laws addressing sexual misconduct by licensed dental providers; B&P 726 and B&P 1680. The two laws have what the CAGD believes to be two very different standards for defining what sexual misconduct is for a dentist in relation to the patients they treat.

B&P 1680 states: "The committing of any act or acts of sexual abuse, misconduct or relations with a patient that are substantially related to the practice of dentistry" is unprofessional conduct. However, B&P 726 says that "The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this division." Furthermore, the Enrolled Bill Report for the legislation that created B&P726 (SB743 Boatwright) stated: "This bill would clarify the definition of sexual contact to mean those acts done outside the scope of the medical examination and treatment, or for the purposes of sexual gratification." Our concern is that B&P 726 includes sexual contact that a licensed dental provider would have in their private home with their spouse or person in an equivalent domestic relationship, if the spouse or person in an equivalent domestic relationship were also a patient of the provider. That interpretation is only reinforced by the fact that B&P 726 includes an exemption for physicians and surgeons who provide treatment to their spouses or persons in an equivalent domestic relationship.

The CAGD asks the Assembly Business, Professions and Consumer Protection Committee to seek an amendment to B&P726 to include licensed dental healthcare providers in the exemption provided to physicians and surgeons regarding any sexual contact with spouses or domestic partners who are patients of those physicians and surgeons. The sunset review process for the Dental Board of California seems to be a logical time to implement this action. The CAGD does not understand why dentists and other licensed dental providers should be held to a more restrictive standard than physicians and surgeons.

Sincerely, *(your name)*

2015 GENERAL MEMBERSHIP APPLICATION

For more information, call us toll-free at
888.AGD.DENT (888.243.3368)
or join on line at **www.agd.org**

Referral Information:
If you were referred to the AGD by a current member, please note information below:

MEMBER'S NAME

CITY, STATE/PROVINCE OR FEDERAL SERVICE BRANCH

Member Information

FIRST NAME | MIDDLE INITIAL | LAST NAME | DESIGNATION *(e.g. DDS, DMD, BDS)* | INFORMAL NAME *(if applicable)*

Type of Membership *(check one):*

❑ Active General Dentist ❑ Active General Dentist *(but, a recent graduate in last four years)*
❑ Associate ❑ Resident ❑ Dental Student ❑ Affiliate

Date of Birth *(month/day/year)*
Required for access to the AGD website

Do you currently hold a valid U.S./Canadian dental licnese? ❑ Yes ❑ No
LICENSE NUMBER | STATE/PROVINCE | DATE RECEIVED *(month, year)*

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

Current practice environment *(check one):* ❑ Solo ❑ Associateship ❑ Group Practice ❑ Hospital ❑ Resident

❑ Faculty *(institution):* ❑ Federal Services *(branch):*

If you are a member of the Canadian Forces Dental Service, please indicate your preferred constituent: ❑ U.S. Military Counterpart ❑ Local Canadian Constituent

Contact Information

Your AGD constituent is determined by your address *(Northern California, Sacramento-Sierra, Southern California or San Diego)*

PREFERRED METHOD OF CONTACT: ❑ E-Mail ❑ Mail ❑ Phone
PREFERRED BILLING/MAILING ADDRESS: ❑ Business ❑ Home

BUSINESS ADDRESS | CITY | STATE/PROVINCE | ZIP/POSTAL CODE

NAME OF BUSINESS *(if applicable)* | PHONE | FAX

HOME ADDRESS | CITY | STATE/PROVINCE | ZIP/POSTAL CODE

PHONE | PRIMARY E-MAIL | WEBSITE ADDRESS

Education Information

ARE YOU A GRADUATE OF AN ACCREDITED* U.S./CANADIAN DENTAL SCHOOL? ❑ YES ❑ NO ❑ Currently Enrolled

DENTAL SCHOOL | GRADUATION DATE *(month and year)*

Are you a graduate of an accredited U.S. or Canadian post-doctoral program? ❑ YES ❑ NO ❑ Currently Enrolled TYPE: ❑ AEGD ❑ GPR ❑ Other

Post-Doctoral Institution | STATE/PROVINCE | Begin Date *(month and year)* to End Date *(month and year)*

Optional Information

GENDER: ❑ Male ❑ Female Are you interested in becoming a: ❑ MENTOR ❑ A MENTEE

ETHNICITY: ❑ American Indian ❑ Asian ❑ African-American ❑ Hispanic ❑ Caucasian ❑ Other

HOW DID YOU HEAR ABOUT US? ❑ AGD Member *(please indicate information in the Referral Information box, top right)* ❑ AGD Website ❑ AGD Constituent ❑ Newsletter ❑ Advertisement ❑ Mailing ❑ Dental Meeting ❑ Other

Dues Information

AGD HDQTR. DUES

Active G.P.	$380
Associate	380
Affiliate	190
Resident Program	76
2014 Graduate	76
2013 Graduate	152
2012 Graduate	228
2011 Graduate	304
Student	17

CALIFORNIA AGD DUES

Regular (GP/Assoc.)	$170
First Year Graduate	16

AGD Hdqtr. Dues: $

plus

California AGD Dues: $

equals

TOTAL AMOUNT ENCLOSED $

Payment Information

❑ Check *(enclosed)* ❑ VISA ❑ MasterCard ❑ American Express ❑ Diners Club ❑ Discover

Note: Payments for Canadian members can only be accepted via VISA, MasterCard or check

Expiration | PRINT THE NAME AS IT APPEARS ON YOUR CARD

I hereby certify that all the information I have provided on this application is correct and, by remitting dues to the AGD, I agree to all terms of membership.

Signature | Date

Return this application with your payment to:
AGD, 560 West Lake Street, Seventh Floor, Chicago, Illinois 60611-6600
Credit card payments, fax to: 312.335.3443

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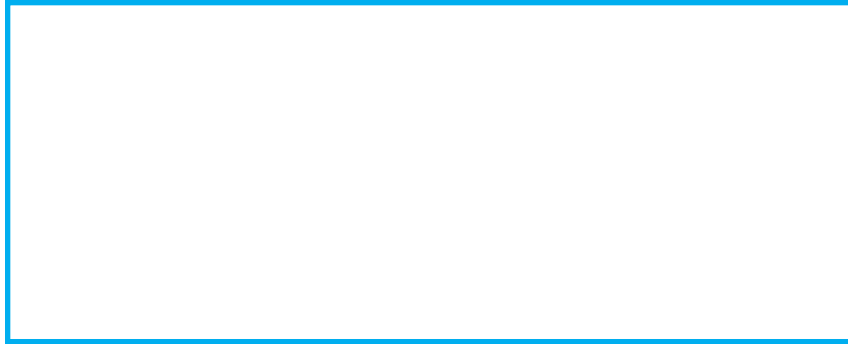

A Message To General Practitioners

ALL OF THE SPECIALTIES WITHIN THE PROFESSION OF DENTISTRY HAVE THEIR INDIVIDUAL ORGANIZATIONS TO LOOK AFTER THE INTERESTS OF THEIR MEMBERS.

THE ORGANIZATION DEDICATED SOLELY TO THE INTERESTS OF GENERAL DENTISTS IS THE **AGD**.

Welcome To Our New Members

Dr. Autumn Abadesco, *Hayward*
Dr. Hatem Abdelhadi, *Los Alamitos*
Dr. Shahrzad Afghani, *San Bruno*
Dr. Maurice Ahdoot, *Los Angeles*
Dr. Jeffrey Brockett, *La Jolla*
Dr. Julie H. Bui, *San Francisco*
Dr. Rosellen Diehl, *Alamo*
Dr. Lady Ann s. Dionisio, *Pomona*
Dr. Ona R. Erdt, *Chino Hills*
Dr. Eilene Espina, *Daly City*
Dr. Edmond Fung, *Pinole*
Dr. Rosemarie Goldstein, *San Anselmo*
Dr. Brien HsuRancho, *Cucamonga*
Dr. Bhumika Jain, *Milpitas*
Dr. Hengameh Jannati, *San Francisco*
Dr. Jaeeun Jeong, *Buena Park*
Dr. Jennifer Jones, *Los Angeles*
Dr. Sally Kashanchi, *Rancho Palos Verdes*
Dr. Derek Kawano, *Clovis*
Dr. Supriya Kazi, *Fremont*
Dr. Laura T. Lam, *Huntington Beach*
Dr. Thu Le, *San Jose*
Dr. Narita Leong, *San Francisco*
Dr. Orson Leong, *Pleasanton*
Dr. roxana Lo, *Mill Valley*
Dr. Mark Materum, *Pacifica*
Dr. Caitlyn McGue, *Modesto*
Dr. Giovanna Medina, *El Cajon*
Dr. Christopher Naranjo, *Claremont*
Dr. Mona Nejad, *San Francisco*
Dr. Sunjoo Parkr, *Pomona*
Dr. Anastasiya Petrovska, *Citrus Heights*
Dr. Alexander Phillips, *Los Angeles*
Dr. Anastasia Pogadajeva, *San Francisco*
Dr. Rodica Popovici, *El Sobrante*
Dr. Jeffrey Proniloff, *San Francisco*
Dr. Andrew Ramirez, *Chino Hills*
Dr. Gurjit Randhawa, *Union City*
Dr. Hossein Rohani, *Ontario*
Dr. Ritesh Salvi , *Diamond Bar*
Dr. Skyler Schubel, *Pomona*
Dr. Shubkarman Sekhon, *Los Angeles*
Dr. Ziad Semrien, *Temecula*
Dr. Ruben Shahbazian, *Elk Grove*
Dr. Nidhi D. Sikka, *San Jose*
Dr. Aparajita Singh, *Oakland*
Dr. Alan Tanisawa, *Castro Valley*
Dr William Thomas, *Los Angeles*
Dr. Neal Vavra, *Fontana*
Dr. Julia Vu, *San Francisco*
Dr. Bianca Yee, *Sacramento*
Dr. Poolak Zand, *Woodland Hills*