CALIFORNIA ACADEMY of GENERAL DENTISTRY

GP NEWS

The Publication Exclusively for the GENERAL PRACTITIONER

Volume 42, Issue Number 3 September, 2018

Understanding Issues Facing Dentistry

The Academy of General Dentistry works to ensure that general dentists can speak up when it matters most. That means making participation easy so that our members can unite their voices on legislative and regulatory activities affecting their practice. As a member, you can access the information and tools to quickly and conveniently impact legislative activities that are underway.

We need our members to get involved and make sure that legislators in our states and on Capitol Hill understand the issues affecting oral health, dentistry, issues affecting general dentists, their patients, students entering the profession and those contemplating a career in dentistry.

AGD President Dr. Manuel A. Cordero and AGD Congressional Liaison Dr. Myron "Mike" Bromberg met with legislators on Capitol Hill in April to discuss AGD priorities. *These issues included:* Continued funding for critical oral health issues in the fiscal year 2019 federal budget and support for AGD's proposed Oral Health Literacy legislation.

Unfortunately, the President's FY 2019 budget proposes to eliminate all funding for HRSA's Title VII oral health training programs. By contrast, in the recently enacted FY 2018 omnibus bill, Congress provided nearly $41 million for HRSA Title VII *(an increase of $4 million over current levels),* to include a $10 million set-aside for Pediatric Dental Residency programs and $10 million for General Dentistry residency programs.

In their meetings, Dr. Cordero and Dr. Bromberg expressed support for HRSA's vital role in oral health training programs, urging legislators to continue Title VII funding. They pointed out that HRSA Title VII Oral Health Workforce programs play a key role in meeting the sustained need for more general dentists with advanced training.

In meetings on oral health literacy, the AGD leaders explained how the importance of prevention in the form of oral health literacy is often overlooked, much to the detriment of our nation's oral health needs. The AGD representatives emphasized the need for research-based strategies that can help inform a national public education campaign.

Impact on General Dentistry:

Oral health literacy and funding for federal oral health programs are key components of AGD's advocacy agenda and will be addressed again at the next AGD "Hill Day."

(more on pages 16, 17...."HILL DAY")

CAGD leaders in Washington on behalf of members, patients and dental students

Left to right: ***Dr. Guy Acheson*** *California AGD Trustee*

Dr. Myron (Mike) Bromberg *AGD Congressional Liaison*

Dr. Mike Lew *AGD Secretary*

YOUR 2018 CALIFORNIA AGD LEADERS

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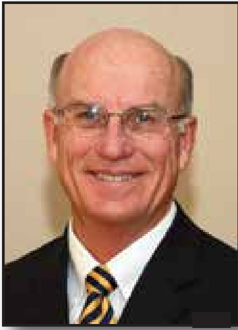

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CAGD's Trustee; author of the "WatchDog Report" and "Tips on Dental Photography" articles
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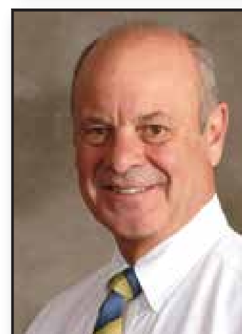

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MasterTrack Course Director
DDS, MAGD
Clearlake

DR. SIREESHA PENUMETCHA
Advisor
DDS, MAGD
Elk Grove
AGD Communications Council Member

as well as FellowTrack and MasterTrack Coordinators

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Advisor; Legislative Committee Chair; Co-Chair Dental Practice Committee
DDS
Reseda
AGD Congressional Liaison; Advocacy Division Coordinator; Professional Relations Committee

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CAGD FellowTrack Mentor-Coordinator
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DR. HARRIET SELDIN
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DR. KATRINA LO
UOP and UCSF FellowTrack Mentor
DDS
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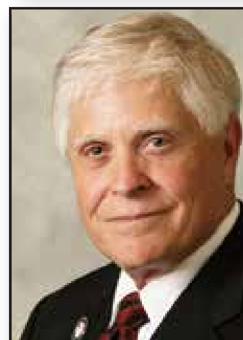

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G.P. NEWS *A Publication of the*
CALIFORNIA ACADEMY *of* GENERAL DENTISTRY

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The GP News is published three times annually by the California Academy of General Dentistry. Inquiries should be made by contacting Terri Wong, Executive Director at 8 River Garden Court, Sacramento, California 95831. *Phone* 877-408-0738 *or fax to* 916-228-4494.

CAGD's Fall Meeting ◆ September 15, 2018

COURSE "1" CHOICE:

Challenges That Dentists Face Today

NEW NAMES, NEW TECHNOLOGY... LONG-FAMILIAR CHALLENGES

SPEAKER: J. HADEN WERHAN, CPA/PFS

Ever since I started working with dentists in the early 1980s I have seen "mega trends" in dentistry, just as there are in any profession. *In the early eighties, a sampling of trends included the following:*

- ***Economic*** – We were recovering from a recession, mired in extraordinary inflation, a monetary policy that saw Prime Rate hit 21.5%, double-digit unemployment, and an unprecedented number of bankruptcies.
- ***Professional*** – The dental profession was in upheaval with the advent of changes to long-standing professional practices: proliferation of auxiliary staff performing procedures previously restricted to licensed dentists; denturism; dental service advertising; pre-paid dental plans including PPOs and HMOs; and shopping center and franchise dentistry, to name a few.
- ***Medical*** – With the AIDs epidemic came the need for new infection control protocols.

Fast forward to today. Surprisingly (or not) dentistry faces many of the same familiar themes. Just search the Internet for "Recession-Proof Your Dental Practice," and you will see what I mean.

- ***Economic*** – There's uncertainty and upheaval galore emanating from Washington, DC, higher interest rates, and the specter of another recession.
- ***Professional*** – Cost challenges remain, this time related to third-party reimbursements, staffing challenges, skyrocketing educational costs, and positioning one's quality practice amidst ever-evolving alternative business models.
- ***Medical*** – Even as dentists must run their business, they face the additional hurdle of remaining leading edge in comprehensive diagnosis and treatment planning and the general delivery of great service and top dentistry.

So, yes, many of the concerns faced by the dental profession today are similar to those of decades past. At the same time, many have evolved and amplified – even logarithmically. First, there's been the dizzying advances in technology, where everything moves faster, for better and worse. In addition, we've been facing deeper economic peaks and valleys. Historically, dentistry has been fairly resilient during economic downturns, but consider that the average length of a recession since World War II was about 11 months. Under those averages, it was possible to tell yourself and your team, *"How bad can it get?"* That changed with The Great Recession which, depending on who you ask, lasted more than three times that average. It was a deal-changer for everyone, the dental profession included.

An immediate problem facing many dentists is the impending reduction in reimbursements from Delta Dental we're currently seeing across the country. The effects are far-reaching. Not only does it impact the cash flow of dental practices that participate in Delta Dental programs, but it is taking its toll on retiring dentists who are suddenly being asked to accept large price concessions depending on their degree of participation. Buyers will be forced to accept lower fees and to participate in Delta's PPO plans. This could cause more senior dentists to work longer to "earn back" that price concession, much like many had to earn back their deflated retirement dollars after the stock market crash of 2008–2009. This information will work its way into the dental schools, where students may realize that their prospects after graduation are increasingly limited.

(continued on page 42 . . . see WERHAN)

*Course "**1**" (lecture) $**129** for Delta/AGD Members; $**229** for non-Delta/AGD members (8 CEs)*

*Course "**2**" (hands-on/lecture) $**450** for Delta/AGD Members; $**650** for non-Delta/AGD members (8 CEs)*

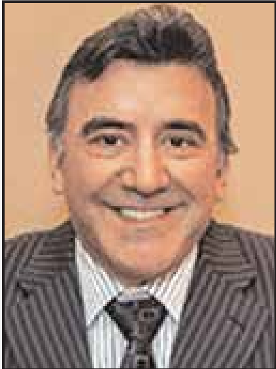
Course Registration GO TO: **http://cagdfallmeeting.com**

Tuition includes Continental breakfast, morning break, lunch and afternoon breaks

Questions? **877.408.0738** or **terri@cagd.com**

COURSE "2" CHOICE:

A Modern Approach To Exodontia



SPEAKER: DR. STEVEN RASNER

The five-wall socket: The primary goal in successful tooth removal is to retain five walls of bone around the tooth if they have not been lost previously due to pathology. As implant therapy becomes the mainstay of dental rehabilitation, the need to minimize socket trauma and expansion becomes paramount. Clearly, the days of "rocking" a tooth from side to side until it loosened have become obsolete.

Different teeth require different techniques: Successful removal requires some understanding the varying anatomy of different teeth. In all cases that are not periodontally involved, the atraumatic extraction embraces sectioning, troughing and the use of myriad of elevators that result in retaining a five-walled socket.

To flap or not to flap: A good rule of thumb is always begin *without* a flap. If you break a root or if your vision is too compromised to succeed, then proceed to flap. It is beyond the scope of this article to address all the types of flaps one could employ, but a simple, full-thickness sulcular flap, one tooth mesial and distal from the tooth being extracted is an easy "go to" skill to hone.

Common complications: Broken root tips, sinus tears or prolonged bleeding are complications that can occur. The best way to prevent any of these is careful patient and case selection, especially in the beginning of your training. In all cases, it is the responsibility of the clinician to make prudent surgical decisions. If you are in a complication that you can't resolve in thirty minutes, the best patient management protocol is to refer to a specialist.

Final Thoughts: It has become extremely challenging to maintain the success we once held earlier in our careers. Toxic insurance reimbursements, corporate care, and a myriad of other factors have contributed to this fact. There are many ways to thrive without giving up. The earliest and greatest skill set to add is oral sedation; and there are many successful clinicians with their own sedation protocol, including yours truly. If in fact you take this road, then masterful removal of teeth will be a skill you will also have to know.

Many of these patients will have their extracted teeth replaced with implant therapy: Another skill, although one that requires a significant lifetime commitment to training, that I advocate for the GP. *The end result:* A rapidly expanding patient base that will become your most powerful source of referrals and appreciation.

Sponsors:

COLLEAGUE MAKES IT THROUGH DEVASTATING SANTA ROSA FIRE; OTHERS, NOT SO LUCKY..!

The Sad Aftermath with Thought-Provoking Considerations:

***EDITOR'S NOTE:** Past California AGD President (1996), Dr. Dan Bornstein, sent a note and photos of what his neighborhood in Santa Rosa looked like a few days after the fire was controlled. These two pages look at what has developed in just a part of that disaster. This should jog our own thought processes.*

Morning flames with still-standing homes

"To All: As you know, Santa Rosa had about twelve days of wild fires that destroyed almost 7,000 structures with the majority of these being homes. Linda and I were among the lucky ones. Due to the great efforts of the firefighters and first responders, our home still stands. As the air cleared and the ash settled, we opened our home to those who were not as lucky.

"Words cannot describe what these areas look like. These photos were taken as we accompanied our house guests to their former home. They literally got out with the clothes on their backs. Construction is moving very slowly up here. Lots of people cannot afford to rebuild or are too old to start over. There's a problem with the water lines and benzene. No home construction can happen until all the water lines are torn out and replaced. This will have a significant effect on people because insurance companies are only obligated to pay for replacement housing (rents) for two years. My estimation is less than thirty homes are under construction. Some people are waiting for the wet weather to finish before starting. There's a ton of lots for sale. I personally have about seventy families in my practice that lost their homes. To date, I know that five have left the area and will not return.

(continued on page 39)

Stairway to Heaven (or Hell...?)

DR. KIRK HOBOCK
San Juan Capistrano

ALAN THOMAS, CPA
Tustin

DR. GUY ACHESON
Fair Oaks

DR. RICHARD ENGAR
Salt Lake City, Utah

DR. KEVIN ANDERSON
Jamul

DR. MICHAEL LEW
Novato

DR. BOB GARFIELD
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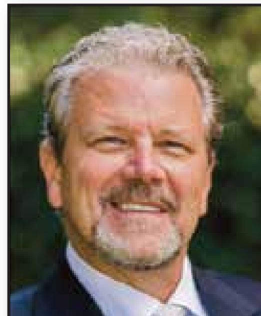
DR. JOHN DiPONZIANO
Laguna Beach

DR. CHERYL GOLDASICH
Torrance

DR. WILLIAM KUSHNER
Danville

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Want to get your Fellowship in the Academy of General Dentistry, but you're not sure how to go about it?

WE ARE LAUNCHING A NEW PROGRAM

Pathway To Fellowship

- **Friday** thru **Sunday, October 12-14, 2018** (8:00 a.m. till 5:00 p.m.) . . . Includes breakfast and lunch
- **Tuition** at **$500** for the three-day session
- 24 CE units — eight per day
- **RENAISSANCE NEWPORT BEACH HOTEL** • 4500 MacArthur Boulevard, Newport Beach, California 92660

Questions? Contact Terri at **terri@cagd.com** or call **877.408.0738**

Friday: FIRST FOUR HOURS

DIGITAL DENTAL PHOTOGRAPHY *with* ***Dr. Guy Acheson***

*You can take very good dental photographs with just about any camera system, as long as you understand the principals of **dental** photography. The course will alternate between lecture and hands-on participation.*

Friday: SECOND FOUR HOURS

COMMON ORAL LESIONS *with* ***Dr. Elizabeth Andrews***

Identifying the features of common oral lesons to provide a differential diagnosis and appropriate treatment.

CAD/CAM RESTORATIONS *with* ***Dr. Steven Gold***

CAD/CAM Restoration Margins: The New 'Gold' Standard?

Saturday: EIGHT HOURS

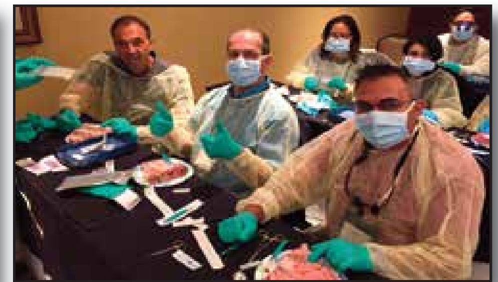
PRACTICE MANAGEMENT *with* ***Dr. Kevin Anderson***

Financial ratios—where you need to be at every stage of your career; practice overhead and strategies for a successful retirement.

Sunday: EIGHT HOURS

IMPLANTS *with* ***Dr. Neema Bakhshalian***

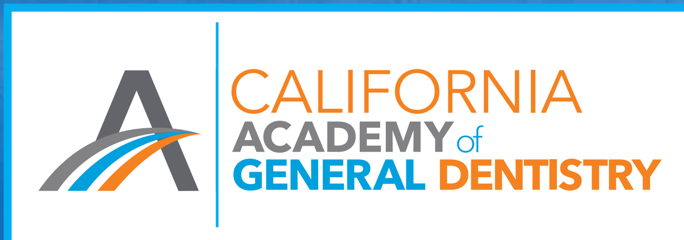
*This course is **HANDS-ON** and will fulfill a doctor's desire to learn implant dentistry with practical, clinical information and techniques. Emphasis is placed on anatomic considerations, treatment planning and prosthetic techniques.*



*The **PATHWAY TO FELLOWSHIP** will help you get the CE hours you need, but more importantly we will provide guidance and mentorship necessary to achieve your goal in a timely manner. Earn the prestigious FAGD award, knowing that there's a direct correlation between the amount of quality post-graduate education a clinician receives and the quality of dentistry you will provide your patients. Fellowship awardees become clinicians who are educated in multidisciplinary subject areas. We believe in your ability to obtain Fellowship and are excited to enable you to reach your potential. We invite you to embark on this journey with us.*

Earlybirds: **The first thirty (30) registrants will be entered into a drawing. The winner will have his/her Fellowship Exam paid for by the CAGD... a value of $600**

Register online at:
http://caagd.org/event/cagd-the-pathway-to-fellowship-24-ce-units/



Approved PACE Program Provider FAGD/MAGD Credit Approval does not imply acceptance by a state or Provincial board of dentistry or AGD endorsement 6/1/16 to 5/1/2022.

DR. KIRK HOBOCK
San Juan Capistrano

CALIFORNIA ACADEMY of GENERAL DENTISTRY

The "Pathway To Fellowship" program with its mentors will provide guidance for you along the way in a timely manner.

SEE THE DETAILS ON THE OPPOSITE PAGE

Mentors, Colleagues and FRIENDS

…The Culture of the AGD

If you're trying to be the best dentist you can be and are continually working on improving yours skills and knowledge, then welcome. You are an integral part of what make up the culture of the Academy of General Dentistry. We have much in common as members of the AGD. The commonality is what brings us together and forms a culture of like-minded individuals.

In California, the culture starts in dental schools with the "FellowTrack" program. Student chapters meet to cover many topics geared to meet the needs and interests of today's students. Dedicated AGD members aid, advise and mentor students that builds a foundation leading to a successful career in dentistry.

The "Pathway To Fellowship" program *(see the opposite page)* continues this dedication and helps both new and experienced dentists along the path of lifelong learning. The Fellowship Award distinguishes the dentist to his peers and community. Less than ten percent of all dentists become fellows, but from these ranks come our leaders, educators, and mentors.

Building friendships and camaraderie is the benchmark of the "MasterTrack Program." Participants gain new skills and techniques in the classroom and hands-on sessions, and use these skills independently while completing assignments. Presentation sessions bring new friends and mentors together for evaluation and critique. As the education continues, the new Masters can achieve the "Lifelong Learning and Service Recognition" as our culture goes on with the experienced dentist.

Every dentist should want to be a member of the AGD, if only to support our efforts in maintaining the use of our training and abilities to serve our patients and communities from the outside forces that wish to limit the focus of the general dentist. In reality, our members are part of a culture that believes in continued education and training and the use of this knowledge and skill for the betterment of dentistry and to the benefit of our patients. ◆

Sincerely,

Kirk

For membership information, go to: www.AGD.org

Congratulations!

THE INDIVIDUALS LISTED ON THESE TWO PAGES MADE SIGNIFICANT STRIDES TOWARD BETTERING THEMSELVES IN THE ART AND SCIENCE OF DENTISTRY.

The California Academy of General Dentistry salutes you on your achievement

Masters What does it take to achieve Mastership status?

The four practitioners pictured immediately below qualified for and received the Academy of General Dentistry's prestigious Mastership award in New Orleans at the AGD's Annual Meeting. They successfully completed a rigorous curriculum outlined by the national Academy of General Dentistry.

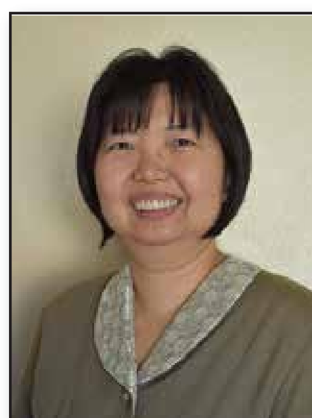
Mastership is the highest award available in the AGD. It is one of the most respected and recognizable designations in the dental profession. Less than one percent of the general practitioner population in the United States have achieved this lofty goal. California has 187 Masters out of a population of over 22,000 general dentists.

To achieve Mastership a dentist must complete a minimum of 1,100 hours of approved continuing dental education. Most who have reached this level of continuing education have many, many more hours than the minimum number. At least 400 hours must be accrued in participation, hands-on courses in sixteen different subjects.

MasterTrack students are involved in the demonstration of a particular skill or technique under the direct supervision of highly skilled experts. ■

DR. JEREMY S. LANSFORD
Paso Robles

DR. COLBY S. SMITH
Los Angeles



DR. NANCY CHU
Tustin

Not Pictured:

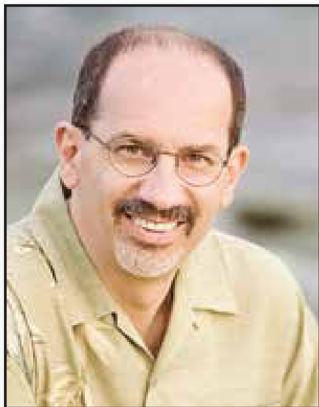
DR. MOUHANNAD ALMAJALANI
Daly City

Lifelong Learning & Service Recognition

In the AGD, continued learning persists even after members have earned Mastership. AGD Masters can continue demonstrating their commitment to lifelong learning and service to the community and/or organized dentistry by earning Lifelong Learning and Service Recognition (LLSR).

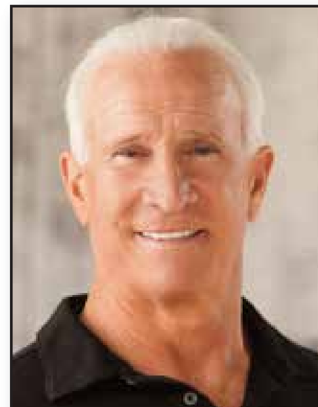
To be eligible for the LLSR, you must complete the following requirements:

Having maintained current AGD membership for three continuous years by December 31 of the year in which the application is received. Be an AGD Master. Earn a minimum of 500 CE hours after receiving the Mastership Award, 150 of which must be participation hours. Hours must be earned in at least eight of the seventeen recognized clinical subject areas. Accumulate 100 service points in any combination of dental-related community/volunteer service and/or service to organized dentistry. Only those services performed since the date Mastership was received or since a previous LLSR was received are eligible. The three CAGD members below were recognized for their efforts. ◆



DR. NAGIB BAHRI
Upland

DR. CHAU LONG T. NGUYEN
Menlo Park



DR. CRAIG R. MERRIHEW
Riverside

Fellowship in the Academy

Candidates for Fellowship in the Academy of General Dentistry must have been members for at least three years prior to becoming a Fellow. They have completed a minimum of 500 hours of continuing education. After that, they must pass a comprehensive 400-question written exam.

That exam is administered by the AGD each year at their annual meeting. Study courses are available at every annual meeting to any AGD members desiring to avail themselves of this.

The California AGD members listed below achieved their Fellowship in the Academy:

DR. ANITA RATHEE
West Hills

DR. SUNG TAK KIM
San Diego

DR. SYDON ARROYO
Torrance

DR. LOUIS E. PAULERIO
San Diego

DR. ANDREW HUANG
Morgan Hill

DR. LINDA JOHNSTONE
Thousand Oaks

DR. BEN AMINI
San Francisco

DR. JOHNNY A. COLEMAN
Oceanside

DR. SUMEET SINGH
Seaside

DR. BRIAN Y. KUO
San Marino

DR. ANNABELLE R. CARNICE
San Ramon

DR. ROMEO DiPASUPIL
Torrance

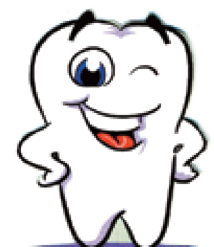
DR. MUSTAFA KOPERLY
Rancho Cucamonga

DR. KIMDUNG TRACY TRAN
San Jose

DR. NATHAN F. CHRISTENSEN
San Diego

DR. MELISSA F. MINGER
La Jolla

DR. ABIR SHBEEB
Sacramento



DR. KEVIN ANDERSON
Jamul

A PATHWAY IN PREPARATION FOR A

Financially Independent "Retirement"

AN EXCLUSIVE SEVEN-PART SERIES OF ARTICLES FOR "GP NEWS" RECIPIENTS DESIGNED TO ASSIST IN MANAGING THE PROCESS

- Savings – It's Never Too Early To Save! *(May, 2017)*
- Finding Your Number---How Much Do You Need? *(Oct., 2017)*
- Lifetime Financial Ratios—Where You Should Be *(Feb., 2018)*
- Insurance Needs and Practice Overhead *(May, 2018)*
- **Risk / Investment Alternatives / Leverage** *(September, 2018)*
- Optimal Portfolio Withdrawal—*Spend Down*
- Priority for Tax Efficiency Diversification in Retirement

Now that you are motivated to save big early (article #1), have calculated "Your Number" (article #2), have found "Where You Should Be" along your journey (article #3), learned some parameters on Practice Overhead as well as knowing what insurance is a must and which are ripoffs (articlle #4), we will now turn our focus to the Definition of Risk, Investment Alternatives and Leverage.

Previous articles are available for reference here:
https://caagd.org/gp-news-archives/

RISK – From an Investing Perspective

Like being struck by natural disasters, there are risks that just cannot be known ahead of time. Sailors at Pearl on December 7, 1941 or unfortunate passengers and workers on September 11, 2001 had no idea that their lives were at risk. We won't dwell on the unknowable or indefinable, but instead focus on known risks taken every day by dentists with their hard-earned money. However, first we must define "Investing Risk." ***Investing is, after thorough analysis, laying out one's capital with the promise of safety of principal and an adequate return. Activities not meeting these requirements are speculative in nature.*** Imagine a line separating investing from speculating and it is your financial responsibility not to get close to the line!

From business schools, Wall Street brokers, certified financial planners and an industry interested more in making profit *from you* rather than *for you,* risk is inappropriately associated with price volatility. Obscure and outdated formulas are taught to aspiring MBAs. It has to be complicated in order to have a longer program in order to charge high tuition! If it boiled down to two courses, "Business Valuation" and "How to Think About Mr. Market," it would be a six month program! Asset allocation models that often work against investors but for the financial pundits are used as industry standard to minimize litigation concern. If everybody loses money at the same time, the argument goes, then it is normal and you have no reason for recourse. A rebalancing strategy deployed by financial planners rests on a weak foundation of so-called non-correlated assets focused on price fluctuation as their definition of risk. When one needed it the most, during The Great Recession, the theory did not hold up as all categories were correlated and broke down. A dentist should not simply place funds in five or ten different asset categories to fulfill some definition of diversifying a portfolio without first giving thought to the price being paid relative to the value being received in each and every investment. Simply dividing one's portfolio and placing hard-earned funds into many different buckets to satisfy a theory that insures lower than normal stock market returns is ludicrous. This is speculation and, if you should do it, do it only with your eyes wide open, knowing that you will probably lose money in the end. Limit the amount at risk and separate it completely from your main investment operations.

"I was spreading some risk around and apparently it all wound up in your portfolio."

There's a recent quote by Warren Buffett's genius Vice-Chairman Charlie Munger that strongly emphasizes his aversion to speculation: ***"I wouldn't bet $100 against House Odds between now and the grave."***

The words risk and safety are often confused among investors. For example, bonds that default on interest and principal payments are clearly unsafe, as are the stocks of companies that go bankrupt. However, this "unsafe" label is often wrongly attached to bonds and stocks even though their price pullbacks are cyclical or temporary. ***Market price fluctuation is not a true risk.*** This is where Wall Street has it wrong.

A group of good stocks that shows a reasonable overall return, as measured over a "fair" number of years, should be considered safe. During those years, the stocks will fluctuate, and perhaps even dip under the buyer's cost, but eventually will be sold at a satisfactory price. Risk is significantly large when paying more than an asset is worth and expecting the market price to magically gyrate higher. Many people think that someone will necessarily pay more than what they paid regardless of the price paid. This can be termed The Greater Fool Theory. People that buy gold, Bitcoin

cryptocurrency and other assets that don't produce income operate under this speculation theory that some "greater fool" will come along.

Price fluctuations do not signal risk or safety. It's in the nature of long-term shareholding in the normal vicissitudes, worldly outcomes and markets that the long-term holder has his **quoted** value of his stock go down by 50%. You can argue that if you're not willing to act with equanimity to a market price decline of 50% two or three times a century, then you're not fit to be a common shareholder and you deserve the mediocre result that you are going to get compared to the people who do have the temperament who can be more philosophical about market fluctuations.

Investment Alternatives

The two most important rules for investing are first, to never lose capital and second, to never forget the first rule. It is critically important to stay within your circle of competence and to also be able to initially value the investment where you are placing your funds. This will prevent you from overpaying. Keeping the odds in your favor and staying simple are also critical. Unlike platform diving, being financially successful does not require adding degrees of difficulty. The more complicated an investment becomes, the more likely that you do not understand the ways that you could lose. Such can be the case in highly-commissioned products like annuities, commodities, futures, universal whole life insurance, options and an advisor directing you to specific mutual funds whereby the advisor a gets a "kick-back" (12b-1 fee). In a few sentences, you should be able to describe to an intelligent fourth grader so that they understand why you have selected a particular investment. Do write it down so that when the investment is quoted for less than you paid, you will have comfort knowing that your research and reasoning are well founded.

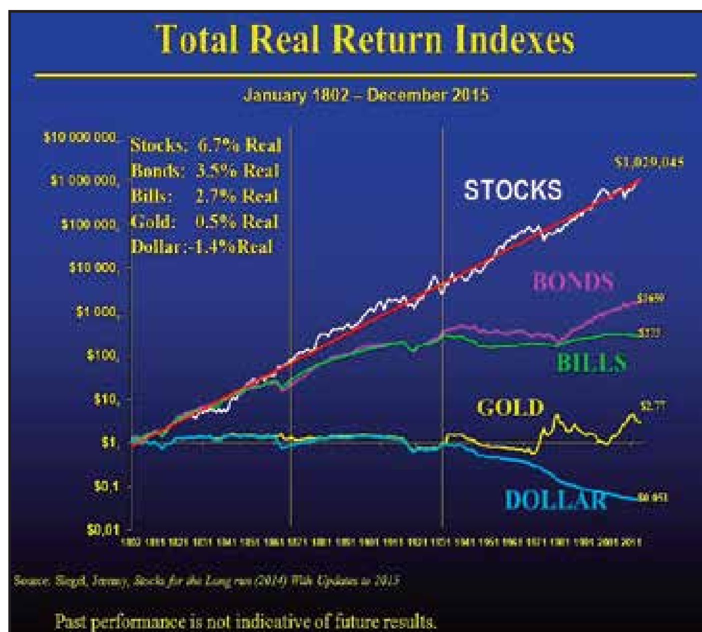
While this article cannot possibly address all of the investment alternatives available, the major ones are plotted in the logarithmic chart in the upper right of this page by Jeremy Siegel. The chart represents the return of $1 invested over a 200+ year time period with returns over the rate of inflation or 'real return.' The contest isn't even close. In fact, the chart had to be reconfigured to a logarithmic format on the dollar side so that all of the categories would be on it! A cross section of diversified stocks (like the Vanguard S&P Index 500) has trounced the other categories over time. One key to financial success is to survive the fluctuations in market price quotations over a lifetime. ***If an investor's lifetime can be represented by a deck of 52 cards, we want to play the entire deck, one card at a time.*** While we don't know which card will be turned over next, we do know that playing them all will be incredibly profitable.

Looking at the white line of stocks, most of us can remember the last two downward juts. Most recently, the 2008 Great Recession and before that was the 2000 Dot Com bust. If you look back before that, there was the recession of 1973-74. Black Monday, October 19th of 1987 when the market lost 22% or 500+ points ("Worst day in Wall Street history") doesn't even register as a blip on the white line as a turnaround correction helped propel the market to a winning return of 5.2% for 1987.

"I want to quickly acknowledge that in any upcoming day, week or even year, stocks will be riskier – far riskier – than short-term U.S. bonds. As an investor's investment horizon lengthens, however, a diversified portfolio of U.S. equities becomes progressively less risky than bonds, assuming that the stocks are purchased at a sensible multiple of earnings relative to then-prevailing interest rates," he wrote. "It is a terrible mistake for investors with long-term horizons – among them, pension funds, college endowments and savings-minded individuals – to measure their investment 'risk' by their portfolio's ratio of bonds to stocks. Often, high-grade bonds in an investment portfolio increase its risk."

— Warren E. Buffett, 2018 Annual Report to Shareholders

At a recent annual meeting of Berkshire Hathaway, Warren Buffett blasted the belief that bonds were a lower risk investment over the long-term. He recommended investors stay in equities due to the negative impact from inflation on the purchasing power of fixed income holdings.



Leverage

The idea of using leverage (debt, borrowed money, margin) to make purchases has been a popular financial tool for a long time. In fact, some important things in life would not be possible without borrowing money like home ownership, car purchases and college/dental education *(see the WSJ article about local dental school graduate owing $1m in student debt: https://www.wsj.com/articles/mike-meru-has-1-million-in-student-loans-how-did-that-happen-1527252975).* However, ***when it comes to investing, investors should avoid the use of borrowed funds.*** If you possess the potential winning combination of average IQ and a reasonable investing temperament, you do not need to use leverage to become wealthy. If you do not have this combination, margin or leverage can be rat poison. I have countless friends that were already rich and retired when they bet the house (literally and figuratively) on different get-richer-quicker products like futures and options. At age 75, one retired Santa Barbara dentist went back to waiting tables and renting an apartment after he lost it all when he already had his house paid and $5 million in the bank!

There is simply no telling how far stocks can fall in a short period. Even if your borrowings are small and your equities aren't immediately threatened by a plunging market, your mind may well become rattled by scary headlines and breathless commentary. An unsettled mind will not make good rational decisions.

No one can tell when a market plunge will happen. The light can go from green to red without pausing at yellow. With a margined equity or stock account, a broker can ask for additional funds or sell you out on a small price movement at the worst financial time for an investor. I have seen it happen. While things are going up, everything is rosy, but when the table turns (and it always does!), you can end up in a world of financial hurt. It can be far worse than you ever imagined possible. Leverage is not necessary to build wealth.

However, the good news about market slides is that when major declines occur, they offer extraordinary opportunities to those that are not handicapped by debt. *Keep smiling!* ◆

ABOUT THE AUTHOR:

Kevin Anderson, DDS, MAGD, is the Founder & General Partner of The Anderson Investment Fund. The Fund is limited to high net-worth individuals, companies and retirement plans and utilizes a value-based investing approach. Kevin achieved financial independence and the freedom to retire early from dentistry at age 43. Dr. Anderson is available to speak to dental groups on financial topics like Successful Investing for Retirement, Practice Overhead and Financial Ratios and can be reached at (619) 248-7379, sdkevindds@aol.com or you can visit the fund web site at:

www.AndersonInvestmentFundLP.com

An Atraumatic Extraction Technique for BONE and SOFT TISSUE PRESERVATION

John DiPonziano, DDS, MAGD, DICOI

DR. JOHN DiPONZIANO
Laguna Beach

Over the years, several methods have been developed for the extraction of teeth with the least amount of destruction to the surrounding bone and gingiva. These atraumatic extraction techniques are especially important in cases where a dental implant will be placed in the extraction site, either immediately, or after a waiting period.

The conventional technique involves the use of manual or piezoelectric periotomes. These are thin bladed instruments which are placed between the tooth root and socket, and pushed apically, severing the periodontal ligament (PDL) as it progresses. The manual technique is very time-consuming and not always effective in completely severing the PDL due to access limitations.

The piezotome method is effective and relatively fast, but the device is expensive, and there exists the risk that, because of access issues, the saline coolant will not reach the tip of the instrument. This can cause burning of the bone at the PDL/osseous interface, and may hinder osseointegration if an implant is placed immediately into the socket area.

Another method for atraumatic extraction requires the crown of the tooth to be removed and a special post screwed into the root canal space. Then, a small cable is attached to the post and, using the surrounding teeth for anchorage, the root is slowly lifted from the socket via tightening the cable. This device is also expensive and works well in an intact root. But if the root is heavily carious, or split vertically, the post may not engage securely enough to pull the root from the socket.

SPECIAL HANDPIECE AND BUR

The method I have found to be very fast and effective, involves the use of an electrically powered, high speed, friction-grip handpiece *(**Fig. 1**: NSK X-SG93 – approx. $900 from dental dealers),* and a special tapered bur to create space for a small elevator to gently lift the tooth from the socket.

This handpiece fits onto an "E-type" motor, which is the standard implant motor included in all of the implant consoles made today.

The difference between this friction-grip handpiece, and the handpiece included in the manufacturers' consoles, is that the standard implant handpiece uses latch-type burs and runs at a relatively slow speed of 2000 rpm or less.

The friction-grip handpiece runs at speeds approaching 100,000 rpm with very high torque. And, since it fits onto the manufacturers' implant motor, it can also be attached to the sterile irrigation tubing that is part of the implant console, insuring that the bur will be cooled with sterile water or saline. In addition, no air is emitted from this high-speed handpiece, eliminating the concern of air embolism forming in the soft tissues.

The specialty burs are extremely strong — much more durable and longer lasting than a typical 701 carbide — and are very effective in cutting teeth and bone. In addition to atraumatic extractions, these burs also work well in the decortication of bone in preparation for grafting *(**Fig. 2**: Komet 254LE — approx. $12 each, 888.566.3787).*

TECHNIQUE STEPS

The bur is used to provide space for the elevator by carefully removing vertical root structure, not bone. In other words, the space is created at the expense of the tooth.

At first, only 3 to 4 mm of tooth structure is removed on the mesial and distal, from line angle to line angle *(**Figs. 3** and **4**).* A radiograph is then taken to verify that the correct cutting trajectory is being developed *(**Fig. 5**).*

Redirection of the bur can be done if needed, and the cuts are then carried to an approximate depth of 8 mm on each side of the tooth. A straight, small bladed elevator, is alternately placed into these mesial and distal cut areas and twisted slightly to move the tooth back and forth, as well as occlusally *(**Fig. 6**).*

Once occlusal movement is established, the tooth can be easily extracted with small beaked forceps *(**Fig. 7**).* ***It is extremely important that the forceps not be used until there is a definite mesial/distal/occlusal movement of the tooth, or root fracture could occur.***

After the tooth is extracted, the socket can be grafted and/or an implant fixture inserted *(**Fig. 8**).* Since bone and soft tissue was preserved, a favorable esthetic outcome is more predictably achieved *(**Figs. 9** and **10**).* ◆

Disclosure: Dr. DiPonziano received no compensation from any manufacturer mentioned in this article.

Fig. 1

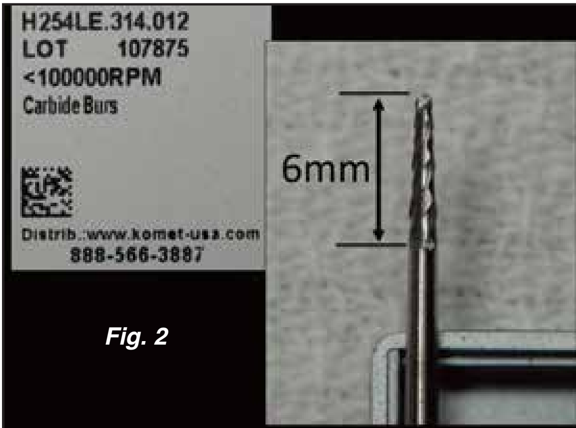


Fig. 2

Fig. 3

Fig. 4

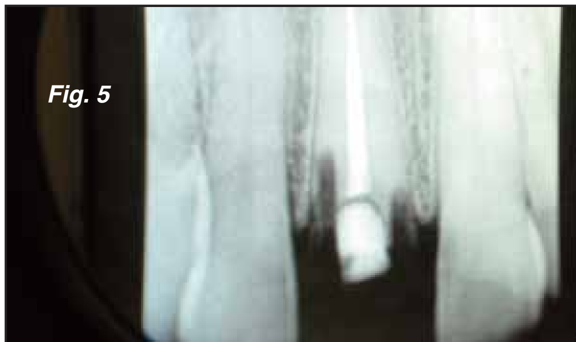


Fig. 5

Fig. 6

Fig. 7

Fig. 8

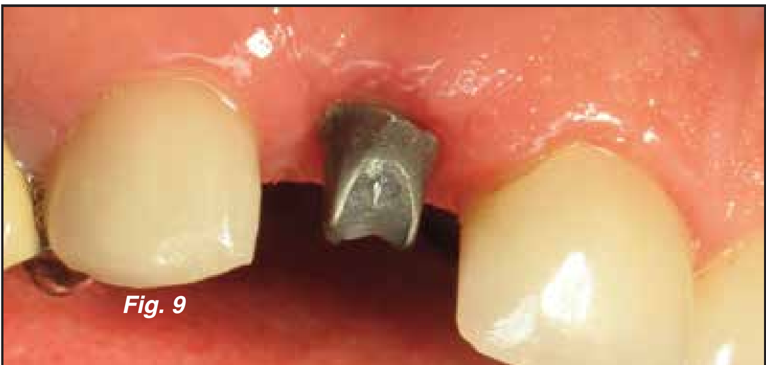


Fig. 9

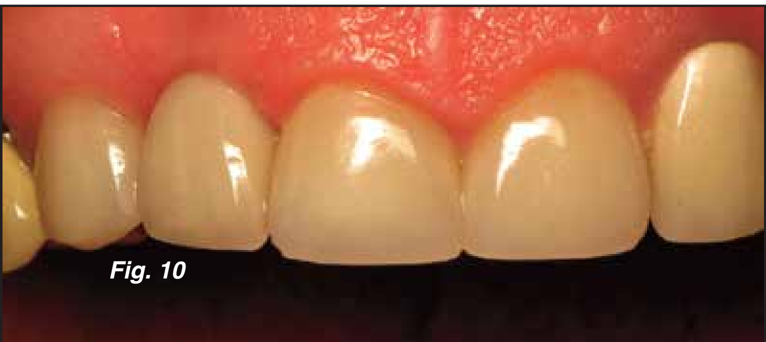


Fig. 10

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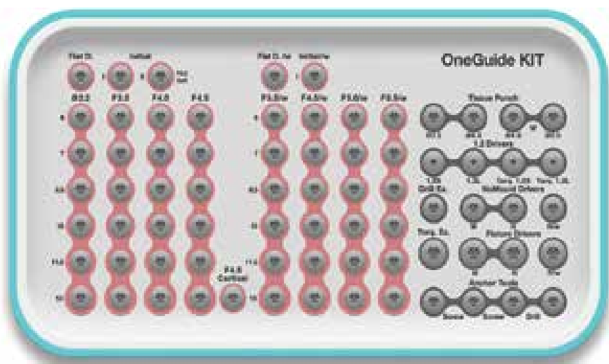

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INTERIM *Regional Director's Report*

Dr. Cheryl Goldasich

CAGD Interim Regional Director
CAGD FellowTrack Chair

DR. CHERYL GOLDASICH
Torrance

"...I would say that the California AGD is on the cutting edge of leadership and membership and involvement with AGD programs. We lead the way in terms of dental school programs (clearly the best way to grow our membership) and leadership development."

I attended the Regional Directors' meeting at the AGD Headquarters in April. There was some very spirited discussion that covered a multitude of topics.

Among the topics covered, it was agreed that the AGD:

- Needs to help underserved constituents where the market share has dropped.
- Needs to change the model for how a successful constituent operates in order to help expand membership and involvement in underserved areas.
- Needs to focus on leadership development. The AGD would like to help out certain constituents *(in underserved areas of the country)* who have inactive, ineffective leaders by asking those particular constituents to consider putting term limits into their bylaws. In this way new leaders have a chance to effect change and those who are not contributing can be rotated out.
- Needs to develop our student chapters and groom them to take leadership spots.

The AGD is making it easier for Executive Directors from underserved constituents to attend the AGD Annual Meeting by funding them or other constituent leaders.

We talked about the value of Star Visits made by past AGD leaders to components who would like some help with their programs/practices or budget needs.

There was also discussion on how the AGD may help constituents expand and better serve their members; one is the Constituent Mini Grant. The two winners this year are Puerto Rico and Wyoming.

The AGD also offers a constituent leader workshop that is free for presidents and executive directors to help them pay for travel expenses. We discussed the Universal Award Program (UAP), which is awarded to the constituent with the most successful new program. We decided to recognize all constituents *(even those who didn't win)* for their ideas and efforts.

An important program is the Dental School Initiative and RD Involvement Program; this allows money for each RD to use to foster relationships with dental school faculty and dental schools.

There was discussion to add a Vice Chair position to the Regional Director Chair position, with the title "Vice Chair" for one year and "Chair" for one year. This makes the position a two-year commitment rather than one. We voted to approve this change.

We passed a resolution to have a leadership symposium for 2019 for new ideas and non-dues revenue initiatives.

Our President Elect for the AGD, Dr. Neil Gajjar, would like to include everyone at the President's Reception for the 2019 year and the board voted unanimously to do so.

All in all, we covered a lot of ground and I gained a lot of insight into what makes a constituent successful and what grows membership. Based on the information I came away with from our Regional Director meeting, I would say that the California AGD is on the cutting edge of leadership/membership and involvement with AGD programs. We lead the way in terms of dental school programs *(clearly, the best way to grow our membership)* and leadership development.

The California AGD is an example of what can happen when the best and most talented people come together to take on the challenges of increasing involvement and membership to the Academy. It was my pleasure working with them and the other Regional Directors to better serve our membership. ◆

"Hill Day"

THE ACADEMY OF GENERAL DENTISTRY GOES TO WASHINGTON, D.C.

(continued from page 1)

Advocacy at Work...!

Dr. Manuel Cordero, AGD President and **Dr. Myron "Mike" Bromberg**, AGD Congressional Liaison, in Washington, D.C. in April of this year. They met with legislators regarding items of importance to the AGD. An issue of concern was making certain that funding for critical dental issues is not removed from next year's budget. Additionally, support for AGD's proposed Oral Health Literacy legislation was emphasized.

Returning in June, they discussed these issues along with concerns about student debt, access to care and other issues identified by the AGD as being important to the practice of general dentistry and the protection of our patients.

Left to right:

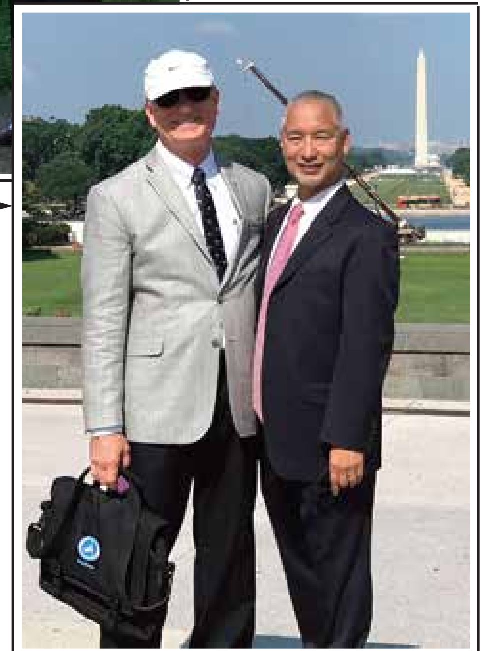
Dr. Mike Bromberg
AGD Congressional Liaison

Dr. Katrina Lo
NCAGD Secretary

Dr. Mike Lew
AGD Secretary

Dr. William Kushner
CAGD President Elect

Dr. Harriet Seldin
CAGD's Public Information Officer



Dr. Guy Acheson, CAGD Trustee (left) and **Dr. Mike Lew**, AGD Secretary

The text and photos on pages 1, 16 and 17 were compiled from a series of emails from various sources to present some of the story on national issues facing dentistry and how they are addressed on AGD's "Hill Day"

 (continued from the adjacent page)

Our AGD leaders from across the USA in "DC" on behalf of dentists, their patients and dental students

2017 NATIONAL DELEGATION

Dr. Guy Acheson and **Dr. Mike Lew** met with the offices of **Sen. Diane Feinstein** (D-CA), **Sen. Kamela Harris** (D-CA), and **Rep. Jared Huffman** (D-CA). The group photos *(above and below)* were taken on two "Hill Days" *(2017 and 2018).* These AGD representatives from all over the country met with Senators, Congressmen and Regulators. Presentations were made by **Rep. Mark Meadows** (R-NC), **Rep. Mike Simpson** (R-ID) and **Capt. Renee Joskow**, Chief Dental Officer, Health Resources and Services Administration. Additionally, **Dr. Manuel Cordero** *(AGD President)* and **Dr. Mike Bromberg** *(AGD Congressional Liaison)* met with representatives of the Institute of Medicine at the National Academies of Sciences, Engineering and Medicine to discuss collaboration on various issues including Oral Health Literacy. ◆

2018 NATIONAL DELEGATION

DR. GUY ACHESON
Rancho Cordova

WatchDog REPORT

New member of the Dental Board

The Dental Board of California (DBC) has a new member, Lilia Larin, DDS. I am happy to announce that she is an AGD member and a Past President of the San Diego AGD. She is also a Past President of both the American Association of Women Dentists and the Hispanic Dental Association. We should all look forward to such a talented and engaged general dentist being a member of the DBC.

Is CURES 2.0 the cure for California's opioid abuse problem?

The roll-out of CURES has been slow, painful, and not very popular with dentists. Registration on the CURES system has been mandatory since early 2017, yet less than half of dentists in California are registered. The screws are continuing to turn and it will be mandatory to actually use the CURES system for every opioid prescription beginning October 2, 2018. Actually, you will be required to do a patient search with every prescription for any controlled substances, which means Class 2,3,4 medications. However, dentists have been given one "get out of jail card." *Dentists are relieved of this requirement for single, non-refillable prescriptions of no more than a five-day supply when written for a surgical procedure.* You should know that the definition of a "surgical procedure" is not stated. This also allows for what most dentists would consider to be a very large prescription since a five day supply of 5mg hydrocodone would be 60 tablets.

I have been using CURES since the beginning. Is has not been a happy experience. There is a mandatory password change every 90 days. The system is not always up and running. My computer system or internet connection is not always up and running. And this takes TIME. A glitch always seems to happen when a surgery has run late, the next patient is anxious, and my staff are thumping their watches reminding me I am behind. But take heart. No one has any idea how to monitor our activities and enforce this requirement. The narcotic police have not heard my first rule of business management, That is: "Inspect what you expect." However, I urge you to be a good citizen.

Sedation regulations continue to evolve

I wrote earlier about the American Dental Association updating their sedation training and practice guidelines. The most significant change is basing all the guidelines on the intended level of sedation and not considering the route of administration. Currently in California there are two permits for moderate sedation that are based upon the route of administration, strictly oral sedation and intravenous sedation. There is strong pressure to change that and have only one moderate sedation permit. This would mean that the training requirements for those who only want to practice oral sedation will be increased to be the same as those who practice intravenous sedation. I expect that this change will happen. The questions we need to address are whether the existing oral sedation dentists will be grandfathered in or will they need to obtain additional training. The training will not be cheap because it requires the demonstration of twenty moderate sedation cases. Don't panic yet because it will take years to sort this all out.

Access to care and "Inspect What You Expect"

The approach to the access to care problem in California has been monolithic. It has been and continues to be argued that the problem is too few dentists. *It assumes* that more dentists equals more access. *It assumes* that flooding the state with dentists will force dentists to practice in currently underserved areas. *It assumes* that ethnically and culturally diverse dentists will choose to work in ethnically and culturally similar areas.

This thinking includes expanding the provider pool by creating expanded duties for auxiliaries and creating independent practice by non-dentists. *It assumes* that these non-dentists will choose to practice in currently underserved areas. *It assumes* that these non-dentists will charge lower fees. *It assumes* that these non-dentists will provide the same level of safety as dentists.

A huge step that California took in this effort to solve the access to care problem was approving foreign dental schools so that their graduates could qualify to apply for a California dental license without taking the two-year foreign graduate dental school program. University de la Salle in Mexico was the first to be approved in 2002 (the dental school in Moldova was just approved). The arguments to do this were that these Hispanic dentists would choose to practice in predominantly Hispanic communities in California. I have been asking whether this has worked for years and no one has been able to provide any answers. Finally, the DBC responded to my request with some basic information. 93% of University de la Salle graduates who have applied for a California license have been successful with 257 obtaining licenses. 230 are currently practicing in California, 22 are in other states and 5 are practicing in Canada. There is NO DATA on exactly where these dentists are practicing. I will keep asking. *Inspect what you expect!*

(continued, bottom of next page . . . WATCHDOG)

TIPS ON IMPROVING *Dental* PHOTOGRAPHY

by **Dr. Guy Acheson**, *Rancho Cordova*

For faster, better photos, ditch the dental chair and use two adjustable operatory stools

This is poor body posture. Not steady. Hurts your back and shoulders.

Dental photography is not a casual event like taking vacation photos. It should be a standardized office procedure with every step carefully preplanned. No different than preparing for completion of a quadrant of anterior composite restorations.

Do you struggle to have every shot perfect? The face is not square to the camera? The occlusal plane is not straight across the frame? The patient's chin is tipped down or up? Or taking the photographs is physically stressful for you. Are you bending, twisting, leaning or squatting to get the shot? If so, I am sure you have the patient seated in the dental chair.

After teaching my staff and other dentists to take photographs for decades, it is clear that the two-stool method is a much better setup to take dental photographs. Use two operatory stools. You and the patient can be comfortably seated and stable with both feet on the ground. Any differences in height is quickly eliminated by raising or lowering stools so you and the patient are seated with your faces level to each other. You can hold the camera very steady with both feet on the ground with no bending, twisting, leaning or getting up on your tippy toes. If the patient can't turn their head simply just rotate the stool. ◆

Dr. Acheson is in private practice in Rancho Cordova. He periodically conducts courses on dental photography. He is the trustee of the California Academy of General Dentistry as well as a past president of the CAGD. He is the United States National Champion, Glider Aerobatics, Advanced Category (2015 and 2016).

WATCHDOG *(continued from the adjacent page)*

Should dental be included in Medicare Part B?

Finally, a question to all my fellow AGD dentists: Should dental care be added to Medicare Part B benefits? The American Dental Association says "YES." The AGD is developing a "NO" position. The ADA position sees inclusion of dental benefits in Medicare Part B as further validation that dentistry is part of overall health. The AGD position is based on the opinion that Medicare is an unsustainable program and if dental benefits are included, the fees will be unrealistically low. I just do not recall being asked as an AGD member what my opinion is. So….here is your opportunity to give your opinion. ◆

Let me know at: **guyacheson@aol.com**

DR. RICHARD ENGAR
Salt Lake City

Ethics and Abandonment

By **Richard C. Engar, DDS, FAGD**

What do patients consider or know about the role of ethics in dental treatment? Does the ADA Code of Ethics deal with abandonment and what is true abandonment? For this column, I thought it would be interesting for my readers to consider these questions and contemplate some thoughts on ethics and getting rid of bad patients.

Patients have many reasons for coming to the dentist and for staying away from the dentist, unfortunately.

Generally patients are concerned about the following items which have to do with ethics:

1. ***Bottom Line Cost***. Most patients are concerned about what their treatment will end up costing them, especially if they do not have any kind of dental insurance. There are a plethora of consultants and gurus out there, self-proclaimed or legitimate, that have all sorts of advice for you as far as how to convince patients that any dentistry you plan to do is worthwhile, whether it is a single filling, implant, or full mouth reconstruction. However you handle your presentation, patients want to know what their dentistry is going to cost and how far their money is going to go. As far as ethical considerations, the patient mainly hopes for a dentist who is being honest with them about what needs to be done and hopes that they are being charged a fair fee and not getting ripped off.

2. ***No Re-dos***. Once patients agree on a treatment plan and understand the cost, they generally do not want to have to pay for something more than once. Therefore, they do not like situations where a general dentist starts a root canal, for example, only to make a determination midstream or months later that the procedure has not been successful and they now are referred to a specialist to have the procedure redone. The natural train of thought becomes *"Why didn't they send me to the specialist in the first place?"* The same thought may apply to a crown that fails within a short period of time such than less than a year due to an open margin or other problem. The main thing the patient considers as far as ethics is something they hear on TV shows, etc.: *"Do no harm."* They expect the dentist to do it right the first time.

3. ***No Pain***. Dentists often get a bad rap on this one as hopefully the horror stories about the cruel dentist inflicting all sorts of torture in the dental chair are just that, stories. Better anesthetics and delivery mechanisms are ways to minimize patient discomfort and keep them pleasantly surprised at the lack of expected pain. Again, the concept of *"Do no harm"* may resonate in their minds. In court, any discomfort is usually labeled "pain and suffering" and attorneys use this concept to up the ante as much as possible so the share they get in any judgment or settlement, usually 33.33% or 1/3, is maximized. In California, although the standard contingency fee is one third of the amount of a settlement negotiated or court verdict, the plaintiffs' lawyer's rate can range from 25% to 75%, depending upon various factors such as costs incurred by the lawyer to hire experts, deposition fees and so forth.

4. ***Proper Billing Management***. Patients expect dentists to understand how their dental insurance works and expect the dental office to bill their insurance properly and ethically in terms of being accurate and only billing for procedures that were actually performed. Any discrepancies in billing will certainly be brought up during trial and the patient's lawyer will do all they can to portray the dentist as a dishonest wretch who had no regard for the patient's well-being whatsoever. Any examples they can find of improper insurance billing or otherwise will be emphasized. The shoe may fit the other foot, however, if the patient plaintiff was the one who received the insurance check and cashed it rather than signing it over to the treating dentist or immediately paying the dentist the value of the check. Dental ethics often play a role in abandonment scenarios.

Consider the following scenario and decide as you read what your treatment obligations are when confronted with an emergency telephone call:

<u>*Situation 1:*</u> You have a tee time at your favorite golf course Friday morning at 10:00. You are playing with some visitors from out-of-state and look forward to a great outing of golf. As you are about to leave home, the phone rings and you see the name of one of your favorite patient families on the caller I.D. You pick up the phone and the mother sounds pretty distraught. She explains that her ten-year-old son was horsing around with his friends on the way to school, had a wipe-out on his skateboard and knocked one of his front teeth clean out. She has learned that if the tooth is immediately replanted it might be preserved. She knows it is your day off, but asks if you would be willing to come in to the office to treat her son immediately. Are you ethically obligated to see this patient?

There is no question that dentists are *"obliged to make reasonable arrangements for the emergency care of their patients of record"* per Section 4.B. of the Code of Professional Conduct. Most dentists work out reciprocal agreements with colleagues to provide coverage during days off or vacation-related absences. The name of the covering dentist is left with an answering service or on a voice message that can be accessed by telephone. Many of these so-called emergencies can be handled by telephone. Infrequently, the covering dentist will need to meet a patient at the office after hours to deal with an urgent problem.

I am often surprised when I attempt to call certain dentists midday only to find their telephone ringing with no answer. I put myself in the position of one of their patients and wonder how I would feel if I had a toothache and could not contact my dentist. It is ethically inappropriate for dentists to leave patients with no recourse for follow-up should they have complications from a procedure done that same day. Many dentists will implement higher protocols and actually call patients in the evening to see how they are doing; the opposite extreme

is to leave no phone number and no recourse, which is inappropriate. It is also inappropriate for dentists to expect hospital emergency rooms to take up the slack, particularly where dentists are not on call or not available to consult with the emergency room physicians. If a malpractice case involves the scenario described and the patient was left with no recourse as far as their "own" treating dentist is concerned, the lawyer representing the patient will certainly quote the Code of Professional Conduct and will certainly have an expert witness on board to be critical if you refuse to handle the emergency.

Situation 2: The Lakers, with LaBron James now on the team, are in the NBA Finals again (use your imagination here). It is the deciding seventh game. As a season ticket holder you have looked forward to being a part of this game for some time and you are looking forward to seeing a little bit of history take place (and getting a return on your investment in purchasing season tickets). As you are walking out the door your land line phone rings. Your teenage daughter picks it up because she is expecting a friend to call and you have taken away her cell phone for a violation of house rules. Instead, someone else is on the line who asks to speak to you regarding an emergency. You reluctantly pick up the phone and hear a spiel given by someone who is not a patient of record, but claims that they have had a toothache on and off for over a month that has finally flared up and has caused swelling and a fever.

The person demands to be seen immediately and claims that another one of your patients (whose name you recognize as a deadbeat on your accounts receivable list) said you would be able to see them immediately. Would you be willing to drive across town to your office to see this patient now and miss at least one or two quarters of the big game? Are you ethically obligated to see this patient?

The issue is also mentioned in the Code of Conduct in the situation of a non-patient calling after hours where there is a questionable obligation to treat. In the example given where you are just about to leave your home to see a deciding NBA finals basketball game, which you have looked forward to seeing all day and for which you spent a substantial amount on tickets, and someone calls you out of the blue demanding that you meet them at the office to deal with their tooth that has been bothering them for weeks, the Code states that you are obliged when consulted in an emergency by patients not of record to make *"reasonable arrangements for emergency care."* It is not crystal clear how Section 4.B. defines "reasonable arrangements for emergency care." If this means that ethically you can simply tell the patient that you cannot help them, but there are dentists who advertise 24-hour emergency care in the telephone book that can be contacted, then section 4.B is reasonable as written. However, if it means that you must forsake your family and plans for someone who may be a drug addict or someone who has no means or intention of paying you, then it may be argued by some dentists that the section is unclear and should be changed or clarified.

Perhaps the Code should be rewritten to read: *"Dentists, when consulted in an emergency by patients **not** of record, may consider making reasonable arrangements for emergency care, but are not obliged to do so. If treatment is provided under these circumstances, the dentist, upon completion of treatment, is obliged to return the patient to his or her regular dentist unless the patient expressly reveals a different preference."*

The gist of the argument is this: Is a dentist entitled to have a life with his/her family outside of dentistry? Should a dentist be obligated to handle every drug addict or deadbeat on his telephone who are not patients of record? Of course, if you have an associate in your practice who is expected to cover for you when you are unavailable you can have the patient contact him/her. If you are in a group practice, then one or members of the group should be available to handle the problem and you can have the patient contact them.

A harder stance must be taken, however, for legitimate patients who are indeed patients of record and deserve proper emergency care or follow-up care. There is little ethical debate that dentists must have mechanisms in place to enable patients of record to obtain proper emergency care after hours or at any other times that their availability is a problem.

Finally, you may wonder how to define true abandonment. My pat answer is that a dentist collects a bunch of money in advance from a patient for planned treatment and then disappears in the middle of the night, not to be found. Is this preposterous? We had an instance in Utah years ago where this actually happened – the dentist had the IRS on his case and decided to simply disappear.

In a court case, abandonment may be defined as unilateral or one-sided withdrawal by a dentist from treatment of a patient without giving reasonable notice or providing a competent replacement. This means that the patient would claim that termination of treatment was not desired by them nor were they given adequate notice. The patient could claim that dental care was unreasonably stopped or put off, and they were not given any help to find or be referred to a competent practitioner. The attorney would argue that the patient suffered harm or financial loss due to care being terminated.

In practice, you can get in trouble if you do not make clear financial arrangements, but then withhold treatment until the patient pays you something. You can get in trouble if you leave patients with no way to get in touch with you or a designee if you are out of the office. Finally, you get in trouble if you simply terminate a patient without giving them a valid reason for having them leave your practice and without giving them a referral or names of alternative dentists. If you cannot have a face-to-face conversation to clarify the termination status, you should notify the patient via regular mail, either sent by certified mail or sending the letter

(continued on page 33 . . . see ABANDONMENT)

Spirit of Leadership Awardee

DR. SUN COSTIGAN

Dr. Bob Garfield, *Awards Committee Chair*

The California AGD has named Dr. Sun Costigan the recipient of the prestigious Dr. Deon Carrico "Spirit of Leadership Award." The award was created in the memory of Dr. Carrico who was a founding member of the CAGD and served as our Executive Director for many years. The criteria for this award states that it shall go to a member who has contributed time, effort and talent toward the betterment of the CAGD. Dr. Costigan clearly fits the criteria.

Sun Costigan has been a key member of the NCAGD and the CAGD, proceeding through various positions and presidentcies, always willing to accept the most diffficult assignments and tasks, most often those that required a "roll-up your sleeves, pave-the-way and get-to-work" commitment. Her results have been an increase in the numbers of several new younger members and the stirring of enthusiasm within our AGD organization, much of it while serving as president of the Marin County Dental Society along with other Marin County board positions.

DR. SUN COSTIGAN
Novato

Sun was born in South Korea and moved to the United States after high school, graduating from the University of Nebraska with a B.S. degree in chemistry. She worked for Chevron in its research center, then decided she wanted to become a dentist. Shortly after graduating from the University of the Pacific Arthur A. Dugoni School of Dentistry she started a general dental practice in Novato, in Marin County.

While in college at Washington State University Sun met her husband, Ben Costigan, who was an army officer at that time. Sun and Ben have been married for 38 years and have two children, Shawn, 37, and Leah, 35, along with grandchildren, Easton and Holly. As you can imagine, Sun has been a very busy lady.

Sun's early scientific background has encouraged her to become involved into a quest of life-long learning in her dental career, then involving herself in AGD dental education, and on to hands-on continuing education for many students at UOP and UCSF. All of this lead her to the development of CAGD's FellowTrack program working with Cheryl Goldasich, DDS, and later collaborating with Richard Ringrose, DDS to develop CAGD's Master-Track activity.

Sun's interest has not only been limited to dental students and the NCAGD/CAGD. She is also involved in several outreach programs through her being a member of the Flying Doctors and providing dental care to underserved desert communities in southern California and Mexico, including some CDA outreach activities, and more recently providing dental services in three cities in China.

Sun has certainly, as we say, "made a difference." It would also be appropriate if we referred to Sun Costigan as the CAGD "Poster Girl," as well as the very deserving recipient of the CAGD Spirit of Leadership Award. ◆

Working with students at CAGD's 2009 Leadership Conference

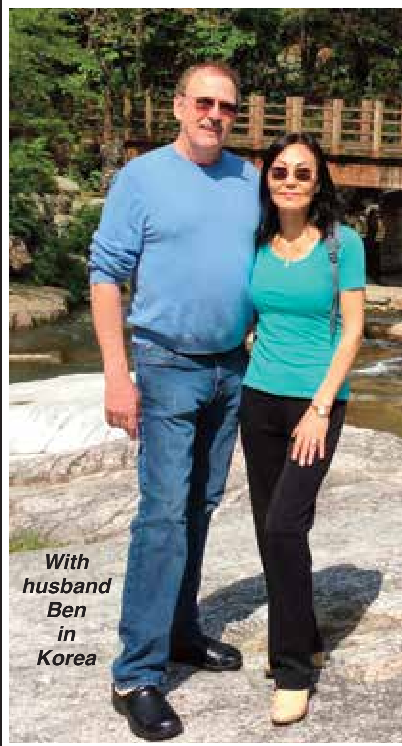
Treating a patient at the outreach program in Indio, California

FellowTrack meeting with UOP and UCSF students

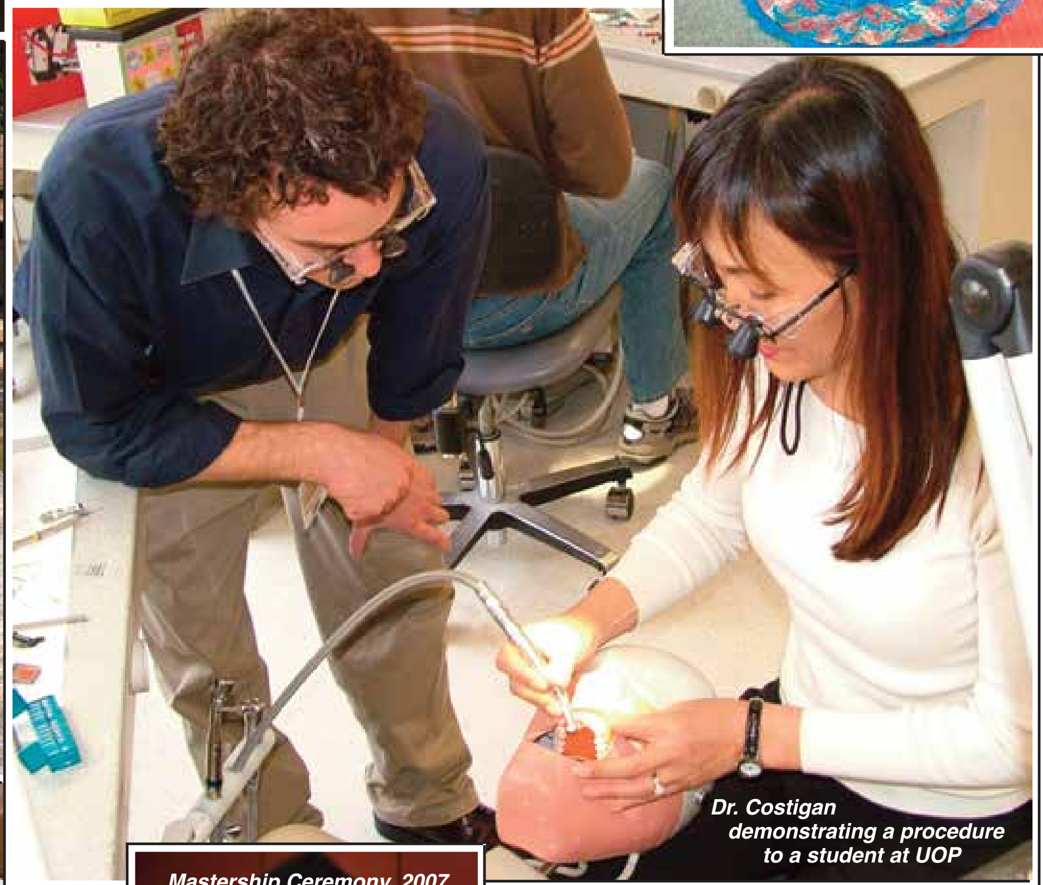
Childhood friend, Kim Heeyuon

Great Korean food

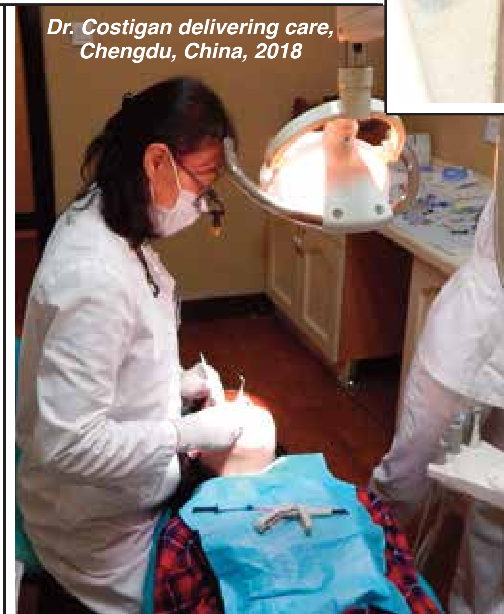
Dressed as a Chinese Empress



With husband Ben in Korea



Dr. Costigan demonstrating a procedure to a student at UOP



Dr. Costigan delivering care, Chengdu, China, 2018

Mastership Ceremony, 2007

2009 Student Leadership Conference

ALAN THOMAS RICHARD BENNER

How Leadership Skills Impact Ov

A few weeks ago, a young practitioner was referred to our office. He came in complaining about his production.

"I'm not making enough money in my practice. Can you give me some ideas on how to increase production?"

While it is true that production is the cornerstone of a successful dental practice, low production was not the problem in this clinician's case. On the contrary, his production was good. He was grossing over $70,000 per month ($840,000 annually). A quick review of his office profit and loss statement (P&L) revealed that high overhead was the culprit. At almost 80 percent, his take-home pay was around $170,000. His problem was not gross production. It was net return.

We know that the average dental office overhead in the western United States is approaching 65 percent. But, after forty-plus years working almost exclusively with dentists, we know that dental office overhead can be kept in the 50 to 60 percent range. It's a matter of being aware of expenses and having the leadership skills to keep overhead under control. If your overhead is at the higher end of the spectrum, you may need to work on your leadership skills.

There are two ways to handle overhead. You can be an active participant in the process and decide what you will spend each month in each overhead expense category. Or, you can pay all the bills at the end of the month and what is leftover will become your take-home pay.

"I know my staff salaries are high," the new dentist lamented after we questioned him about his employees. "But my office manager says she'll quit if I cut back. So what can I do?"

We often see dentists being "held hostage" by their staff. It's not an intentional takeover by staff members, it's the result of poor leadership. Here's an excellent example of what we mean, taken from an article on the website of Philip L. Kempler, DMD, broker at Thomas & Fees Practice Sales (tfpsales.com).

Your front office worker says, "I need more help doctor. I'm swamped up here." Do you automatically hire another person, or do you take time to analyze the situation and come up with a solution that keeps your overhead percentages in line? If you don't, you've just reduced your take-home pay.

Let me explain. My front office worker told me she didn't have time to make hygiene recall appointments. And my hygiene schedule was suffering. I could have hired a full-time person and reduced my net by $35,000 per year. But instead, I hired a woman to come in three hours two nights a week, when patients were at home, and do recall appointments. For an investment of $60 weekly, less than $3,000 per year, I more than doubled my hygiene practice and increased patient treatment across the board.

The doctor in this scenario took the time to investigate the situation instead of just "hiring a new person." By doing so, he found a solution that increased his take-home pay, instead of reducing it by $35,000 per year.

Don't blame your staff when a situation like this occurs. It's up to you, as the leader, to keep team members aware of budget concerns, overhead percentages, and practice goals. Good leaders make team members accountable for those numbers by establishing an equitable bonus system and weekly meetings to review the budget.

Dr. Kempler goes on to say, "Everyone should treat the practice like their very livelihood depends on it–because it does."

Many dentists go into practice without any training on how to run a business, and dentistry is a business. The most successful dentists we see are those who took business courses in college, worked in a family business before college, took practice management classes after graduation, or worked beside a seasoned and highly successful older dentist. If you don't fall into one of those categories, you are not doomed to failure. You simply need to get more education in the business side of dentistry. It is going to take due diligence to change your ways. But it will be well worth your efforts. A loss of $35,000 per year in ten years is well over a quarter of a million dollars.

Let's talk about budgets. Some folks think "budget" is a dirty word.

"I can't stand to be on a budget. I want what I want now!" one dentist told us quite honestly. "I budgeted all the way through college. Now that I make good money, I don't want to feel restricted."

While we can totally understand this dentist's emotional reaction to budgeting, it's just not rational. A good, solid budget allows you to plan for things you will need in the future, such as equipment, office improvements, and continuing

erhead and Your Take-Home Pay

Alan Thomas, CPA
Richard Benner, CPA

education. A monthly and quarterly budget based on percentages allows you to control your expenses and make choices in a systematic way that protects your take-home pay.

What are the percentages for each budget item in the typical dental office? After decades of working with dentists, we've established overhead analysis templates for the various kinds of dental practices (available in Philip L. Kempler's book, *The Business Side of Dentistry*–free to AGD members and at our website: thomasandfees.com). Compare your practice overhead percentages to our templates and you'll quickly determine where your overhead may be out of control. Labor, lab, and supplies are three areas in the practice that can and should be controlled.

Staff salaries vary depending upon the type of dental office you operate. But in all cases, staff salaries are a big budget item and deserve attention. Ask yourself, do you have staff members who have little or no contact with patients? Are there more people working in the front office than producing dentistry? Do you have layers of managers or supervisors? If you answer yes to these questions, you are probably overstaffed.

About lab fees, many dentists have been using the same lab for years. They get in a rut and don't compare lab fees from one lab to another, and they don't compare quality. Check out the various labs in your area and compare costs, quality, and service. It could save you thousands.

Supplies is another budget item that deserves close attention. If you're like many dentists, you have shelves loaded with products that are expired and can't be used. That's money down the drain. Put a good ordering system in place to control purchases and avoid waste.

Lastly, pay attention to your practice P&L. Compare costs for your line items, at least quarterly. Did costs go up? *Why?* Is production up or down? *Why?* Are your collections up or down? *Why?* What was your hygiene production for the month? Even if your practice overhead is just a few points above 55 percent, you have an opportunity to increase your income by thousands of dollars. Controlling costs is a key element in practice profitability.

What makes a good leader? Here are six common traits we have recognized in successful dentists. First and foremost, know what you want from staff and ask for it. Staff members are not mind readers, so make your expectations clear. The best time to do that is when you first hire a person. State clearly, "I expect you to be on time every day and arrive at the office with a smile and be ready to work. Can you do that?"

Second, delegate. Let go of jobs that can be done by others. You are the primary money maker in the practice. Don't get sidetracked doing non-production duties. If your employees can't handle the other stuff, then you have the wrong employees.

Third, set a good example. Show respect for your patients by being on time and by arriving at the office in a good mood and ready to work. If you go into the operatory without even looking at the patient's chart, your employees will follow your lead. If you want employees to care about your patients, then exhibit that attitude yourself. Keep home problems at home. Remember, attitude is contagious, good or bad.

Fourth, compliment good behaviors, "I really like the way you spoke to Mrs. Jones and remembered her grandson was coming to visit. That shows patients that we really care." Also, brag about your chairside assistants in front of patients. Compliments make the patients feel like they have chosen the right dental office. "Wow, Susie, nice job cleaning Mary's teeth. They look great.!" Maybe Susie will return the compliment saying, "Awesome crown, Dr. Do Right. The color and fit are perfection."

Fifth, look for training opportunities. Show your staff that you care about them by helping them improve their skills. One way to accomplish this is to implement step-by-step management systems and insist that your employees follow them. It is amazing how quickly team members become trained simply by following excellent systems.

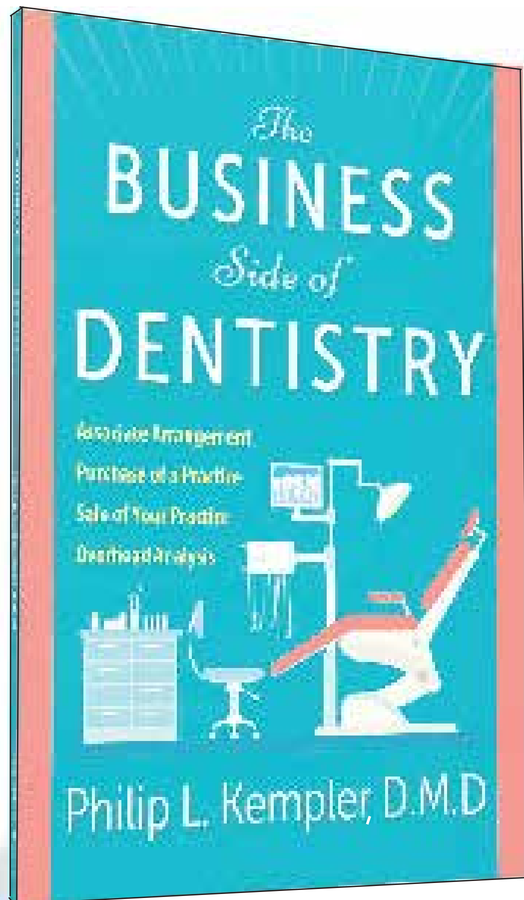
Sixth, don't be wishy-washy about making decisions. Procrastination is a stress maker and a time waster. But don't make snap decisions that you'll have to reverse later. When a problem surfaces, take the time to investigate the problem and come up with a good decision. Then, stick to it. Remember, decisions must be made, popular or not. If you determine your patient base needs evening appointments, then do it. That is good leadership.

In conclusion, your leadership skills will impact your overhead and your take-home pay. If you find your leadership skills lacking, rejoice. You have discovered the obstacle between you and your money: you know what you don't know. Take a class online, purchase a leadership CD series and listen to it while driving to and from the office, sign up for a college course on business management. The possibilities are endless. ◆

The title of our next article is:

Which Retirement Plan Is Best for You?

—Thomas & Fees Accountancy, Tustin

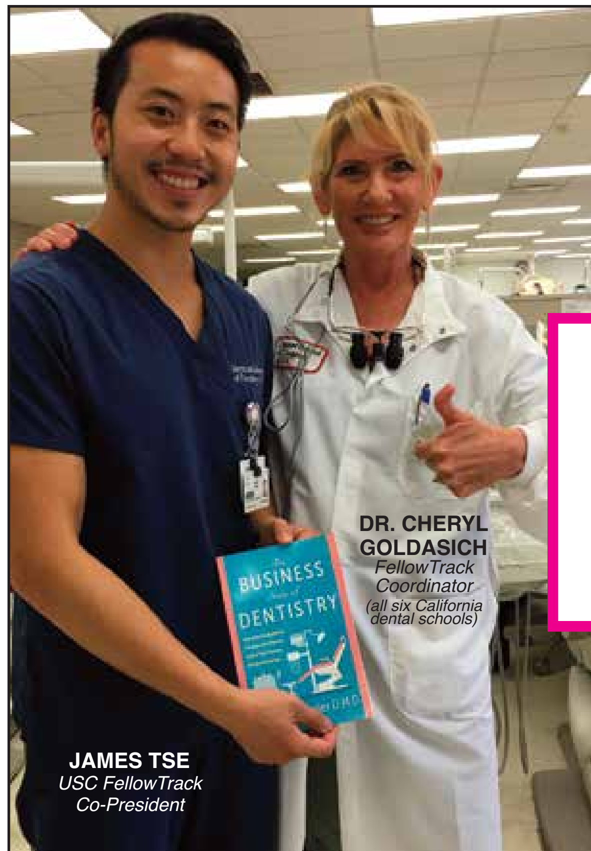


"The best book I've ever read on dental prosperity!"

— *Los Angeles Dentist, Dr. L. Chen*

Dentistry is a business and this book is the business side of dentistry. Whether you are just out of dental school, buying your first practice, or selling your dental practice and heading into retirement . . . this book will be beneficial.

- ✦ Associate arrangement—What to expect on your first job
- ✦ When and where to buy a practice
- ✦ How to value a dental practice
- ✦ Due diligence—What are you really buying? Look deeper!
- ✦ Overhead Analysis—Poor overhead control reduces your take home pay!
- ✦ Tax consequences of buying or selling a practice "Asset Allocation". . . two words that can make or break the deal.
- ✦ Practice brokers . . . *the good, the bad and the ugly!*
- ✦ Includes overhead analysis templates and retirement income planners



DR. CHERYL GOLDASICH
FellowTrack Coordinator
(all six California dental schools)

JAMES TSE
USC FellowTrack Co-President

Complimentary Copy

Free to **CAGD** dentists and dental students

Email us your contact and credit card information and pay only $5 for shipping.

Buy on Amazon by searching:

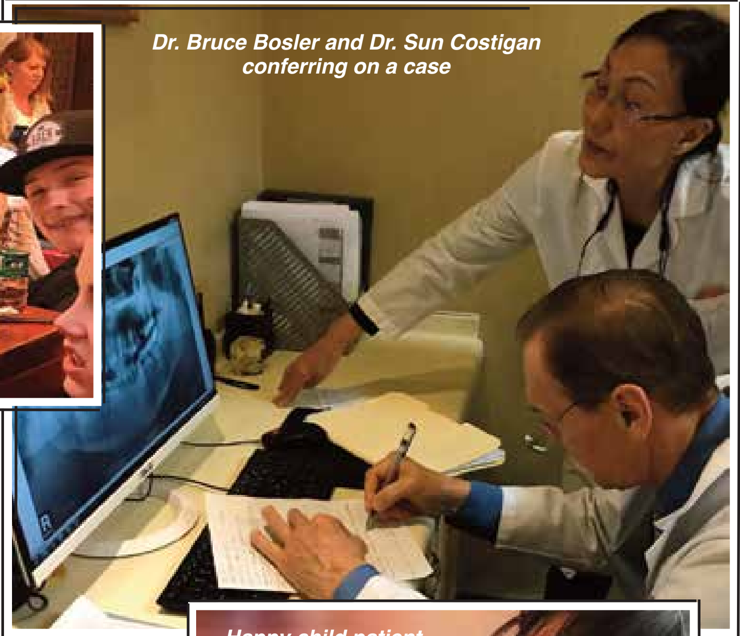
THE BUSINESS SIDE OF DENTISTRY

by Philip L. Kempler, DMD

or

Email: bizsideofdentistry@gmail.com

Dr. Karl Koerner, Team Leader


Dr. Bruce Bosler and Dr. Sun Costigan conferring on a case

DENTAL Humanitarian TRIP

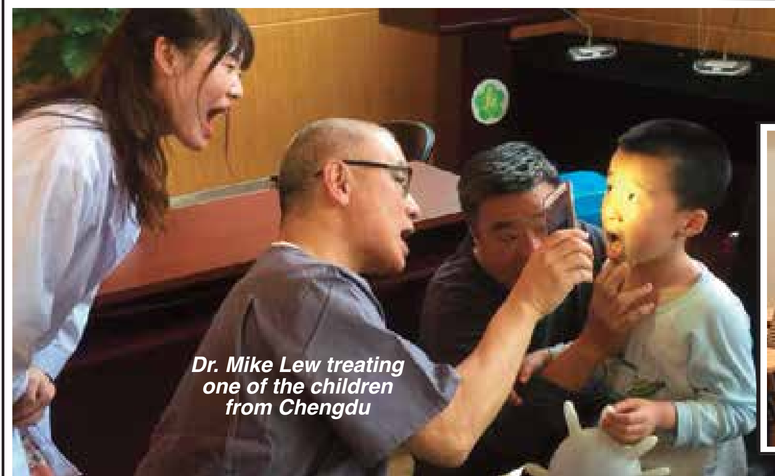
Chengdu, Sichuan, China

By **Dr. Mike Lew**
of Novato

Happy child patient with a dental nurse-assistant

CAGD members Dr. Bruce Bosler, Dr. Sun Costigan and Dr. Michael Lew joined other AGD dentists from Utah and Massachusetts to provide donated dentistry to economically challenged families in China. Our focus during our five clinical days was providing dentistry to the local Chinese and teaching dentistry in the late afternoon. Our goal was to serve as ambassadors of American goodwill by providing restorative dentistry and reducing dental pain through extractions. We treated around fifty patients. A second goal was to introduce the local Chinese dentists to the Academy of General Dentistry. Lectures were given in English on Regenerative Endodontics, Pediatric Oral Pathology, Utilization of PRF with Dental Implants, Success in Dentistry and Patient Management of Dental Trauma. These were conducted in a study club format. The lectures were excellent with many questions from the local dentists on standards and techniques. Thus, we introduced AGD education to over thirty dentists practicing in Chengdu. Our trip included visiting hillside Buddha carvings, night market adventures and Chinese Opera. And, everyone tasted the famous Sichuan peppers. ◆

*We wish to recognize and say thank you to **Ultradent** and **Henry Schein** for helping support our trip with their donation of dental supplies. And, a big thank you to both Avani Chetty and Terri Iwamoto-Wong for helping us with the trip.*


Dr. Mike Lew treating one of the children from Chengdu

Sharing ideas on Non-Surgical Perio Tx.

Panda enjoying the view

2018 Chengdu Humanitarian Team

CALIFORNIA ACADEMY of GENERAL DENTISTRY

Northern California COMPONENT

DR. CHRIS CHUI
President
San Francisco

The Northern California AGD has had two very successful continuing education courses to date.

In February, the NCAGD hosted a course on *"How To Treat Obstructive Sleep Apnea Patients in Your Office and Get Reimbursed by Medical Insurance."* The presenter was Dr. Kent Smith. He is a Diplomate of the American Board of Dental Sleep Medicine and President of the American Sleep and Breathing Academy. He has two sleep practices in the Dallas/Ft. Worth area and has been speaking on sleep related topics for the last fifteen years. This full-day course included breakfast and lunch and was held at the spectacular Silicon Valley Capital Club in Downtown San Jose.

Among the roomfull of guests were third- and fourth-year dental students from UCSF and UOP. The course gave students exposure to a very important topic not covered in the dental school curriculum. It also gave them the opportunity to network with experienced dentists and learn about resources and benefits available to them as AGD members.

In March, we presented a course titled *"What Does the 2018 New Tax Reform Mean To Dentists?"* The speaker was Peter W. Ling, CPA. He is the CEO of Morling & Company. The event was held in Corte Madera.

Both of these courses were very informative and had exceptional turnout. The NCAGD strives to offer continuing education courses that are relevant and significant to the general practitioner.

We are looking forward to upcoming courses for this year and next year, that will include topics such as:

- Successful Retirement
- Cone Beam Imaging for Orthognathic Surgery
- Orthodontics
- Implant Placement
- Obstructive Sleep Apnea
- Oral Surgery: Third Molar Extraction Techniques
- Endodontics

Most of the above will be hands-on, full-day presentations.

We are currently working on the arrangements and invite you to explore our progress with them at **NCAGD.com** ◆

NCAGD Board with Peter Ling, CPA

NCAGD Board

Dr. Myrna Gray · *Dr. Dinu Gray* · *Dr. Chris Chui* · *Dr. Kent Smith* · *Dr. Sun Costigan* · *Dr. Katrina Lo* · *Dr. Rajvir Kaur*

Peter Ling's Tax Course

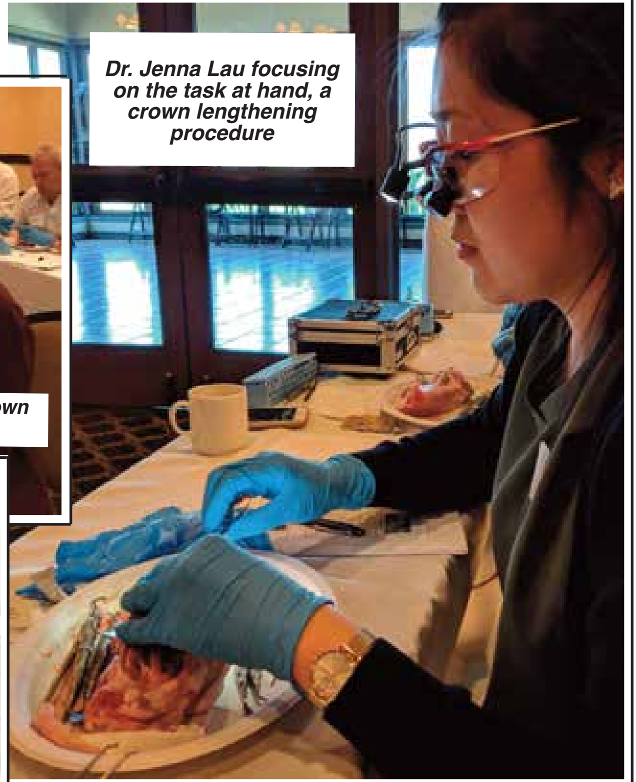
Dr. Kent Smith "Sleep Apnea Course"

San Diego
COMPONENT

DR. ERIKA KULLBERG
President, El Cajon

We held a crown lengthening continuing education course featuring Dr. James Kohner. It was a joint venture by both the San Diego AGD and the San Diego County Dental Society. Sixty-six doctors were in attendance for the first half of the program with thirty-one participating in the workshop. They practiced surgical techniques on pig jaws. The SDAGD would like to emphasize our cross-collaboration with the SDCDS as it is important for creating community amongst all of our San Diego colleagues.

Six of the 31 attendees practicing a crown lengthening surgical technique

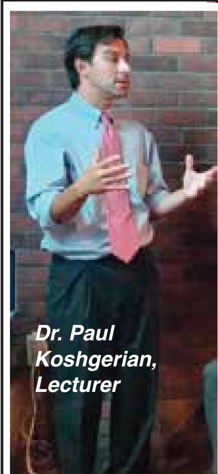

Dr. Jenna Lau focusing on the task at hand, a crown lengthening procedure

Dr. Jenna Lau *Dr. Zeynep Barakat*

Dr. Erika Kullberg and Dr. Maria Thompson were featured on the cover of the San Diego County Dental Society publication, "Facets." They were participating in the GIVE KIDS A SMILE event at Mira Mesa Operation Samahan

"From Extraction To Restoration"

Our July course was with Dr. Paul Koshgerian, oral surgeon. Discussed pre-operative planning, digital workflow, ridge augmentation techniques and the implant restoration. We had 33 in attendance. BioHorizons was our sponsor. ◆


Dr. Paul Koshgerian, Lecturer

Dr. Chirag Vaid, *SSAGD President, Sacramento*

Digital Dentistry and Implant Dentistry

Speaker:

DR. QUINCY GIBBS
PROSTHODONTIST

When:

Thursday, September 6
(6:30 p.m.-8:30 p.m.)

"We will review... possible pitfalls."

Course Description:

Implant and digital dentistry are quickly changing with challenges to the clinician on where to invest their time and money. Knowing which digital concepts and techniques can help with planning and restoring implant restorations, is key to working with our dental technician partners.

We will review what you need to know to get going and how it can improve patient outcomes as well as possible pitfalls.

Venue:

Zinfandel Grille *2384 Fair Oaks Boulevard, Sacramento 95825*

Tuition:

AGD Members @ $**40** *(dinner included and free parking) . . . two "CE" units*

Non-AGD Members @ $**60** *(dinner included and free parking) . . . two "CE" units*

About Dr. Gibbs:

Dr. Gibbs completed his DDS at the University of Pacific Arthur A. Dugoni School of Dentistry in San Francisco in 2004. He then returned to Northern Nevada where he worked in general and implant dentistry for more than eight years in a multi-doctor private practice. During his time as a general dentist, Dr. Gibbs was active with the local and state dental component societies. He served on multiple committees and his time in organized dentistry culminated as the President of the Northern Nevada Dental Society. Dr. Gibbs then sought to pursue additional specialty training at the UCSF School of Dentistry, Graduate Prosthodontic Program. He completed his Prosthodontic Residency and Specialty Certificate in 2015 and worked in the Sacramento Valley prior to joining the Dental Implant Center at Walnut Creek in 2017.

Questions: **877.408.07**

Registration at **http://caagd.org/event/digital-dentistry-and-implant-dentistry/**

California AGD Welcomes Our New Members

March 27, 2018 thru July 16, 2018
(all Californians except where noted otherwise)

Dr. Thaer Alqadoumi *Yucaipa*
Dr. Marilou Alquiros *Glendora*
Dr. Monica E. Azer *Santa Monica*
Dr. Brian M. Baliwas *San Francisco*
Dr. Dan P. Benyamini *Los Angeles*
Dr. Alina Borchardt *Oakland*
Dr. Matthew Catuna *Folsom*
Dr. Alexander Chaney *Vallejo*
Dr. Brian Choi *Loma Linda*
Dr. Eunice Choi *Fullerton*
Dr. Elmirra Dayrit *Hayward*
Dr. Anthony Edward Deza *Riverside*
Dr. Jonathan Feller *Concord*
Dr. Jonathan Ford *Huntington Beach*
Dr. Oscar Armando Gochez Jr. *Chino*
Dr. Jaskiran K. Grewal *Patterson*
Dr. Jennie M. Gutierrez *Cerritos*
Dr. Tigran Gyokchyan *Glendale*
Dr. Bronwyn Patricia Hagan *San Francisco*
Dr. Walter Benedict Havekort *Sonoma*
Dr. Kerri Hill *Beverly Hills*
Dr. Heather Elaine Houston *Redlands*
Dr. Patrick D. Huebner *Santa Rosa*
Dr. Shifteh Iranmanesh *San Francisco*
Dr. Tariq W. Jabaiti *Los Angeles*
Dr. Yurim Jang *Los Angeles*
Dr. Samuel V. Karavan *Carmichael*
Dr. Michael Kim *San Francisco*
Dr. Yejin Kim *San Francisco*
Dr. Rodney Kleiger *Pasadena*
Dr. Ashamani Kode *San Mateo*
Dr. Vijeta Krishnamoorthy *Los Angeles*
Dr. John Lamp *Los Angeles*
Dr. An Le *Mountain View*
Dr. Valerie Le *Mountain View*
Dr. Viet Quoc Le *San Diego*
Dr. Albert Luan *Fullerton*
Dr. Stuart Mauger *Ukiah*
Dr. Ivan Alejandro Medina-Martinez *Bakersfield*
Dr. Rima Melik-Bakhshyan *Upland*
Dr. Shervin Moshashaei *Los Angeles*
Dr. Kelly Elizabeth Nelson *Chino Hills*
Dr. Chung "Wilson" Ng *San Francisco*
Dr. Kenneth Nguyen *Rosemead*
Dr. Dong Hoai Nguyen *San Jose*
Dr. Luong Nguyen *Fountain Valley*
Dr. Nirav Suresh Patel *Souderton, Pennsylvania*
Dr. Janet Pezold *Monrovia*
Dr. Son David Phan *Corona*
Dr. Thy Pham *Rohnert Park*
Dr. Yigal Prilutsky *Burbank*
Dr. Hossein Rohani *Irvine*
Dr. Ben Rosenbaum *Los Angeles*
Dr. Joshua Schaepe *Chula Vista*
Dr. Mason Slunceford Segura *Vista*
Dr. Lina Shahinyan *Glendale*
Dr. Charles Stewart *Santa Paula*
Dr. Joy A. Tawadrous *Cerritos*
Dr. Khyati K. Thakkar *Diamond Bar*
Dr. Sharon Torres *Los Angeles*
Dr. Iriff Keisha D. Ulep *Los Angeles*
Dr. Milton Melvin Vega *Moreno Valley*
Dr. Tuan A. Vo *San Jose*
Dr. Safina Waljee *Redlands*
Dr. Christina Woo *San Francisco*
Dr. David Aaron Woodruff *Modesto*
Dr. Peter Yoon *Irvine*
Dr. Miyoung Yoon *La Crescenta*
Dr. Bing Zheng *Los Angeles*

ABANDONMENT *(continued from page 23)*

First Class with the envelope bearing the notice "return service requested" written under the return address. E-mail is another method some dentists use as long as there is a way to verify that the message was received and that no information is furnished that could be construed as a HIPAA violation.

I have had to deal with very few cases where abandonment was the sole reason for a lawsuit but attorneys will try to incorporate aspects of that issue in their complaint in any case if they can. Hopefully, this column will have served to educate readers such they now have a better understanding of what a claim of abandonment entails and how they can avoid it. ◆

ABOUT DR. ENGAR:

Dr. Richard C. Engar was graduated with a B.A. from the University of Utah in 1976 and attended the University of Washington School of Dentistry until graduation in 1980. From there he completed a GPR at Sinai Hospital of Detroit, Michigan and entered private practice in Salt Lake City as a general dentist. In 1991 he became CEO of Professional Insurance Exchange Mutual, Inc., a company which provides malpractice insurance to Utah dentists which is his current position and occupation. He also maintains A faculty position with the University of Utah General Practice Residency Program, now part of the University of Utah School of Dentistry.

Jonathan Winfield, *President, AGD FellowTrack Student Chapter at UOP*

JONATHAN WINFIELD
San Diego

This year has been an exciting and eventful year for UOP's AGD FellowTrack Chapter.

Our first event: We teamed up with UOP's ASDA program and had a discussion with Dr. Allen Wong about ways in which the students could improve their chances of **Getting Accepted into a GPR Program or an AEGD Program**. This presentation provided students with tips on what to include, or not include, in their personal statement. Also, students were shown what types of qualities and characteristics many of the specialty programs were looking for in candidates.

Takeaway:

1. *Do research on the programs of interest and talk to current residents to hear about the cases they are doing.*
2. *Every interaction with a program, whether it is over the phone or in person, is a part of the applicant evaluation and should be taken seriously.*
3. *A portfolio of cases that were photographed and completed during dental school can strengthen your application.*
4. *Contact and identify letters of recommendation early so they have time to personalize the applicant's letter.*

Our second event: About **Aesthetics**, where we were shown how to **Close Black Triangles**. The program was presented by Dr. Stan Siu using the Bioclear Matrix System. Many of the participants were fully engaged, excited to learn a new way to close black triangles without having to prepare any teeth. Participants were then given the opportunity to practice the technique on typodonts provided by the company.

Takeaway: A study was done asking patients what is more concerning esthetically between black triangles or crooked teeth? Many patients are more concerned with black triangles. That is a major issue preceeding ortho or invisalign. Although patients are completing treatment with straight teeth, they might not be satisfied due to the development of black triangles. Dr. Stan Siu, utilizing the Bioclear Matrix System, showed us a cure for this black triangle disease, providing patients with an esthetically pleasing outcome.

"...members brainstormed on aspects of dentistry they felt... they wanted to learn more about."

The next presentation: Rob Eagleston from Eagleston Financial Group taught us the necessity of learning **How To Create a Financial Budget** and how to be organized in doing so. Further, the members of this group emphasized to the students how critical it was to begin thinking earlier about their financial future, rather than later. Additionally, students were given an introduction on ways in which they can use online platforms to manage all the different types of loans which would be accrued over time.

Takeaway: Start in dental school and seek professional help.

The next presentation: Loni of Zimmer Implants presented on **Using Digital Dentistry To Take Digital Impressions of Implants** using a digital-based healing abutment and scanning body which would improve the accuracy of the impression using a digital scanner.

Takeaway: Digital impression-taking, done correctly, can yield a more accurate impression than traditional techniques. Combining the healing abutment, a scan body/impression coping makes the procedure more efficient as it utilizes fewer parts.

Finishing off the year: An AGD panel of dentists *(UOP alums)* and UOP student-participants had an open discussion followed by a question and answer session. The group of alums provided **Tips and Advice** about what things students should be doing before they head out to practice, away from the school setting.

"Tips and Advice" Presentation

Takeaway: There are many post-graduate options: Working as an associate in a small private practice, working in a corporate office or going into a residency. Having a vision of where you want to be in the next five to ten years is important in deciding on a post-graduation direction.

Conclusion: Each and every event averaged twenty to thirty students. Our UOP FellowTrack Chapter met two times each quarter. During each meeting, members brainstormed on aspects of dentistry they felt were not being covered in the curriculum that they wanted to learn more about.

Overall, this year was very successful. Our AGD FellowTrack Chapter members feel that we were able to learn a lot from each area outlined above. ◆

AGD FellowTrack Student Chapter at UOP

University of California, Los Angeles

Tanya Kavoussi, Co-*President, AGD FellowTrack Student Chapter*

TANYA KAVOUSSI
Memphis, Tennessee

During this past spring quarter, our student chapter worked closely with AEGD/GPR residents and recently accepted residents to host a Question/Answer session for students interested in applying to these programs. The panelists included Dr. Eric Scott representing UCLA AEGD, Dr. Victoria Lai, an incoming NYU Lutheran AEGD resident in Santa Barbara and Dr. Stella Stavrou, a resident at the Greater West Los Angeles Veterans Hospital.

The residents shared many helpful tips during the meeting including the importance of talking to other residents that are currently in the programs to see if the program would be a good fit. It is beneficial to talk to current residents because it gives insight into the culture of the program, how efficiently it is run, how much experience one can expect to gain, and how the residents enjoyed the program overall. The residents also mentioned another great source of knowledge was the fourth-year dental students that just went through the interview/application process. They also discussed that they based their decisions on where to apply to AEGD/GPR programs based on the location because it is a great time to be able to experience a different part of the country and it is not a long-term commitment. Doing so also gives students an opportunity to learn about various treatment philosophies that exist in different regions of the country. Another aspect that helped the residents choose their programs was the scope of the program. For example, Dr. Victoria Lai shared with us that she wanted to broaden her knowledge in as many areas of general dentistry as possible, including implant dentistry. She mentioned it is important to realize that there are very few programs that give you experience in every single aspect of dentistry. For example, VA programs do not treat children. Medicaid community clinics have limited opportunities for molar endodontics and cosmetic dentistry. Very few programs give you experience in orthodontics. She also discussed with us how AEGD/GPR programs that are in the same school or building as specialty programs (e.g. oral surgery, pediatrics) would refer those specific procedures out. Dr. Lai made a list of the top five areas in dentistry in which she wanted to gain more clinical experience and filtered out programs that did not meet her criteria.

Some of the students were interested in learning more about the VA program and the level of involvement with treating medically compromised patients. Dr. Stella Stavrou shared that by working at a hospital, she has grown more comfortable with working with medical colleagues, placing orders, interpreting lab results, and working on inpatients. Dr. Stavrou's time at the VA has allowed her to receive more complex dental treatment planning experience as well as a stronger background in treating medically complex patients.

Our AGD chapter was able to provide our members with invaluable knowledge from the residents. The information gained will hopefully make the application cycle less daunting for our members. We are looking forward to having more events planned for this upcoming year. ◆

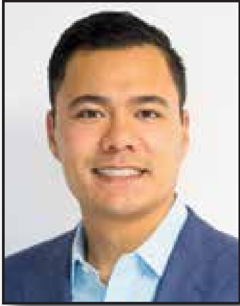
AGD cabinet members with AEGD/GPR residents.

From left to right:
Josh Johnson ('20)
Delaram Salamati ('20)
Kearny Chang ('19)
Tanya Kavoussi ('20)
Dr. Eric Scott
Dr. Victoria Lai
Dr. Stella Stavrou

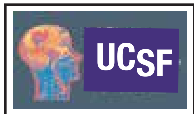
Question/Answer Session with General Practice Residents *(left to right)* **Dr. Eric Scott, Dr. Stella Stavrou and Dr. Victoria Lai**

University of California, San Francisco

Steven Phan, *President, AGD FellowTrack Student Chapter at UCSF*



STEVEN PHAN
Mission Viejo



The Academy of General Dentistry student chapter at the University of California, San Francisco, or AGD@UCSF for short, has grown by leaps and bounds. Like any organization trying to expand and become successful, it was imperative for us to identify a viable niche amongst the vast sea of student organizations that addressed a pre-existing need on campus. Over the last couple of years, I can confidently and proudly say we have done so, given our recent accomplishments.

Using funds provided by the school and the California AGD, we established numerous dinner and learns and interactive continuing education classes for the student body here at UCSF. AGD@UCSF's dinner and learns, which occurred once or twice a quarter, focused on both practice management and clinical topics. The varied subject matter ranged from techniques for accurate dental impressions to practical advice on how to enhance a patient's dental journey in our future practices. Even more exciting, we've arranged various multi-day, hands-on continuing education courses held on the weekends, which have never been done before by a student organization.

Over the last couple of years alone, AGD@UCSF established a course where we learned to treatment plan, prepare, and deliver various types of veneers. With the help of CA Dental Labs, who graciously offered to process the veneers for educational purposes, we were able to cement and deliver the veneers in our simulation lab. We, furthermore, partnered with Straumman to educate our student body about implants and actually placed numerous implants on synthetic jaws. Attendance for these said events averaged around sixty students, which is something we are extremely proud of. Not resting on our laurels, AGD@UCSF is currently in the process of organizing a socket preservation and suturing technique course with help from Hu-Friedy and Nobel Biocare. This event is scheduled to happen this summer.

AGD@UCSF's objective for these above-mentioned events was three-fold. First, we hope to provide a brief overview of topics that are of direct interest to the students. Secondly, and more importantly, we hope to instill the values of proactivity and intellectual curiosity in our participants, which will hopefully serve as the basis for their pursuit of lifelong learning in dentistry. And thirdly, we aim to introduce students to the Academy of General Dentistry as an organization that has the resources and support structure in place to encourage all soon-to-be dentists to continue their education and provide the best care possible to their patients via the organization's fellowship and mastership tracks.

On behalf of the AGD@UCSF executive board and the UCSF student body, I would like to extend special thanks to all the individuals that have made our aforementioned accomplishments possible. Although it will be disservice to attempt to specifically name every individual, we are truly indebted to the following:

1. The AGD@UCSF executive board, who handle the logistics behind every one of our events.
2. The above-mentioned dental lab and companies for donating the required supplies.
3. The California AGD for their support.
4. The extremely gracious faculty members at UCSF, who volunteer their valuable time to provide instruction at our courses.

In helping AGD@UCSF find its niche on campus, I have personally have found a niche, specifically, the subset of dentists that prioritize staying on top of their profession by choosing to be a part of the Academy of General Dentistry, that I look forward to becoming a part of as a newly-minted dentist. Thank you again and congratulations to the Class of 2018! ◆

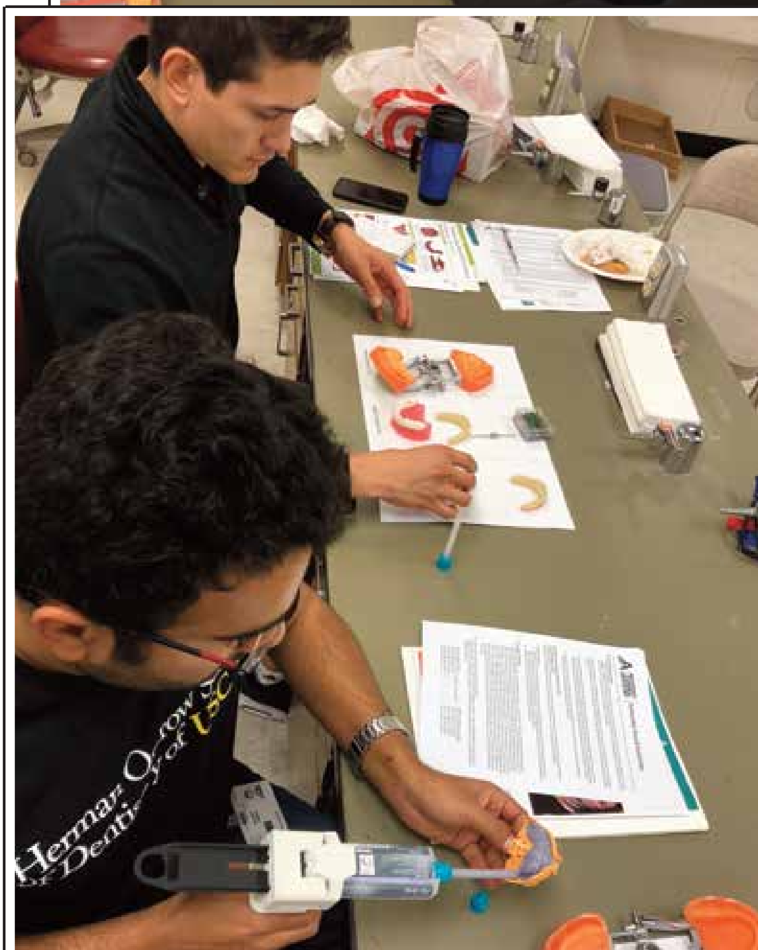
The Academy of General Dentistry
— dedicated exclusively to the General Practitioner

Katie Kim, *Co-President '19, AGD FellowTrack Student Chapter at USC*

The AGD Fellowtrack Chapter at USC aims to provide the highest level "Lunch & Learn" courses to complement the dental school curriculum and prepare students for real-world dentistry. Over the past year, we have been able to introduce new, exciting topics that hold great value for future dental practice.

In the fall, we hosted a course with Dr. Drew Eggebraten discussing dental photography in the private practice. It detailed the importance of dental photography for the purpose of lab communication, patient education, and record keeping as well as the necessary camera set-ups and tools to capture the most accurate, high resolution photos.

A newer innovation in dentistry that was discussed was the "Micro-Invasive Management of Caries Using Resin Infiltration" with Dr. Jin-Ho Phark. Dr. Phark discussed the indications for resin infiltration (ICON) and the pros and cons of using such a system. Resin infiltration can be utilized to arrest incipient decay and to fade white spot lesions, such as those that might be present following orthodontic treatment. However, the patient who receives such treatment must be carefully identified. The patient must be able to tolerate this procedure, which requires long etch and infiltration times. This may make the system unsuitable for pediatric patients who are unable to sit through long treatment times. Additionally, the material does not present radiographically. Using the system on a patient with poor recall may result in another practitioner restoring a lesion that was already arrested with resin infiltration. However, for the reliable patient with good home care, resin infiltration can be an effective and minimally invasive treatment for incipient lesions.



We hosted a hands-on course on digital full-mouth reconstruction with Dr. Tae Hyung Kim, Chairman of Removable Prosthodontics at USC. Dr. Kim brought 3D printed CAD/CAM dentures to our predoctoral program and we have been fortunate enough to become familiar with the DENTCA system and provide this new technology to our patients. In the hands-on course, Dr. Kim discussed the use of this same system for a full-mouth reconstruction case. We received a donation of all materials to offer this course to a group of ten graduating seniors. The students were able to simulate the full three-visit system with a typodont patient case.

These are unique experiences that we have been afforded due to the world-class faculty at our school. We look forward to providing similar high-caliber courses to our student body this upcoming year. ◆

Fight On...!

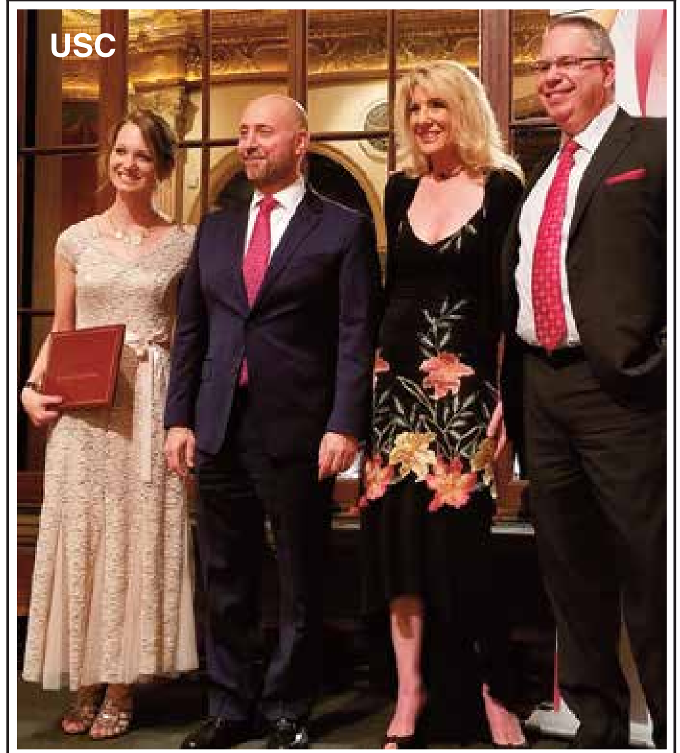
"Senior AGD Awards" at California's Schools of Dentistry

Dr. Cheryl Goldasich, FellowTrack Mentor-Coordinator (all six Schools of Dentistry in California)

The criteria to qualify for this award is set forth by the Academy of General Dentistry. The award recognizes the senior with the highest "operative" GPA and the most points in operative procedures along with the quality of the student's work.

The AGD Award winners are known to the faculty and staff as "the best."

The award is presented at all six dental Schools of Dentistry in California every year. This year, three schools had two students tied to qualify. ◆



Left to right:

Dr. Janet Pezold
Senior Awardee

Dr. Avishai Sadan
Dean, USC School of Dentistry

Dr. Cheryl Goldasich
CAGD's FellowTrack Coordinator

Dr. Sillas Duarte
Chair, Division of Restorative Sciences

Awardees for 2018 are listed below:

University of Southern California

JANET PEZOLD, DDS

University of California, San Francisco

STEVEN PHAN, DDS
ERIC SEJIN JOO, DDS

Left to right:

Dr. Steven Phan
Senior Awardee

Dr. Mark Kirkland
UCSF Associate Dean Clinical Affairs

Dr. Eric Sejin Joo
Senior Awardee

University of California, Los Angeles

ANTHONY TIEN PHAM

Loma Linda University

STEVEN DEBULGADO, DDS
MILTON VEGA, DDS

University of the Pacific

NEAL ATUL PATEL, DDS
TANNER ZYLSTRA, DDS

Left to right: **Dr. Rob Handysides**, *Dean, LLU;* **Dr. Steven Debulgado,** *Senior Awardee;* **Dr. Milton Vega**, *Senior Awardee;* **Dr. Peter Chung**

 (continued from page 6)

Rebuild or Relocate?...a Gut-Wrenching Question!

FOREVER

INSURANCE COVERAGE A PIVOTAL FACTOR

with payouts falling way short of the cost to rebuild!

"The majority of photos are from an area where friends of ours used to reside. We came to know each other via our 25-year-old disability group; a group of colleagues willing to keep a practice going until it sells or the dentist returns to work post-illness or injury. It took a few days for me to contact them due to much of the cell service not working during the fires. They came to live with us while their insurance company tried to locate a suitable rental for them. Nearly two months later this was accomplished and they resettled in Marin County.

"The property has been cleared and they do plan to rebuild, but this particular area needs to await further testing to determine if benzene is leeching into the water lines. Every week presents potentially new and varied information disseminating from the city, the water company, the electrical company, the insurance company and the state. It's a challenging time for these fire survivors as they negotiate new and unforeseen hurdles with regularity." DB

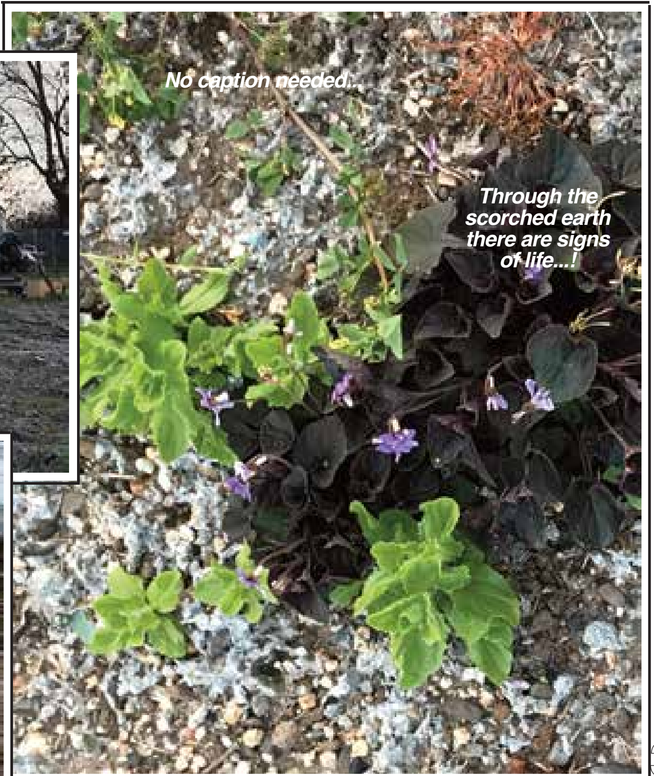
Lots **FOR SALE**
(7,000 structures were lost with most being homes with maybe 30 re-builds underway in the entire area)

There are more **FOR SALE** *signs going up than new foundations...!*

EDITOR'S NOTE: The destruction in Santa Rosa and reading about this tragic occurrence should make all of us think about whether or not our <u>insurance</u> is <u>sufficient to cover the costs involved in a rebuild</u>. The ever-increasing costs of labor and materials has many of the homeowners finding the payouts falling way short of the cost to rebuild. Also check what you have regarding just what <u>your coverage allows for temporary housing</u>. Additionally, <u>consider joining or starting a disability group</u> with like-minded colleagues. There are models out there; colleagues on rotation weekly or even monthly, depending on how many in your group. RJH ◆

Some folks have temporarily gone in this direction

Some re-build is underway. Mostly what is seen is scorched earth.



No caption needed...

Through the scorched earth there are signs of life...!

Dr. Eugene Y. Kim, *San Diego*
CAGD MasterTrack 5

Contemporary Management of Gingival Recession:

PINHOLE SURGICAL TECHNIQUE

More than fifty percent of the American population have receded gum tissue without even being aware because gingival recession is a very gradual process. Unfortunately, over time, an exposed root does not just compromise esthetics, but also can cause tooth sensitivity, be more prone to caries, and can eventually lead to tooth loss. To prevent such damages, subepithelial connective tissue and free gingival grafts were performed to reconstruct the lost soft tissue. However, due to technique sensitivity and increased morbidity, these procedures were often not performed by general dentists. Contemporarily, simpler and less morbid alternative treatment methods, such as the Pinhole Surgical Technique, are available for general dentists to master in order to increase patient acceptance and improve patient care.

Findings and Diagnosis:

A 54-year-old female presented with symptomatic gingival recession on teeth #4 through #8. The probing depths were within normal limits and there was no bleeding on probing or mobility present. The Miller's classification for the recession was Class I since it did not extend to the mucogingival junction and was not associated with alveolar bone loss in the interdental area. *(Figures 1 and 2)*

Treatment Plan:

The most commonly used soft tissue graft is subepithelial connective tissue graft. An incision is made at the donor palatal tissue. The underlying subepithelial connective tissue is then removed and sutured to the gum tissue surrounding the exposed root. This technique has higher morbidity and the pain of two surgical sites. On the other hand, the pinhole surgical technique requires no incision or suturing and has shorter treatment time (one to two hours), and has reduced post-op pain. It was no surprise that the pinhole technique was preferred by the patient over the subepithelial connective tissue graft.

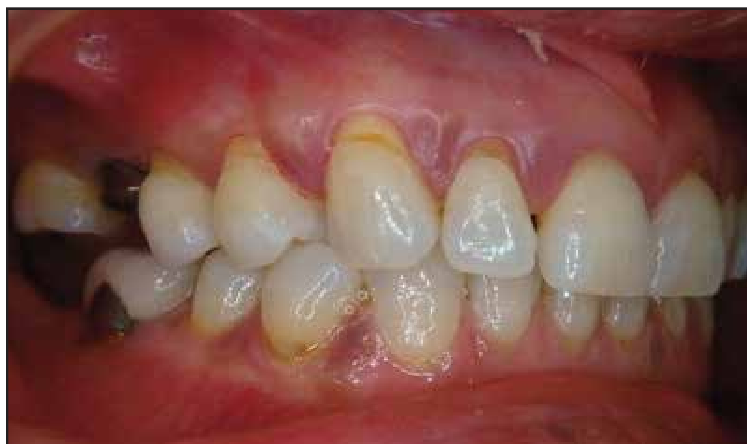


Figure 1: Pre-operative view of gingival recession on teeth #4 thru #8

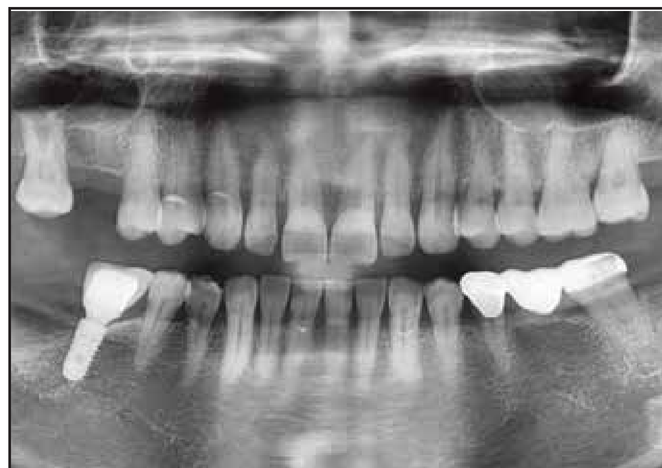


Figure 2: Radiographic examination reveals the absence of interdental bone loss

Surgical Procedure:

The gum tissue is numbed with local anesthetic. The affected root surfaces are cleaned and prepared with EDTA. A small entry point (0.1 inch) is made in the gums above the tooth or teeth to be treated with a 16 gauge needle at 5 mm apical to the mucogingival junction. Then a specialized dental instrument, designed and patented by the Pinhole Surgical Technique inventor, Dr. John Chao, is entered into the pinhole, gently moving the gums down coronally *(Figure 3)*. All the muscular and fibrous adhesions are freed up using this instrument. Supraperiosteal closed blunt dissection is performed and includes the interdental papillae. Complete passive mobilization of the entire muco-gingival tissue is done until the tissues are advanced coronally. Several 2 to 3 mm collagen strips were cut horizontally, then passed through the entry point and placed under the gums by a special small angled instrument to help stabilize the gums. No sutures or periodontal dressing were placed, because the entry point was small and would heal spontaneously within a day.

(continued on the next page...see CASE STUDY)

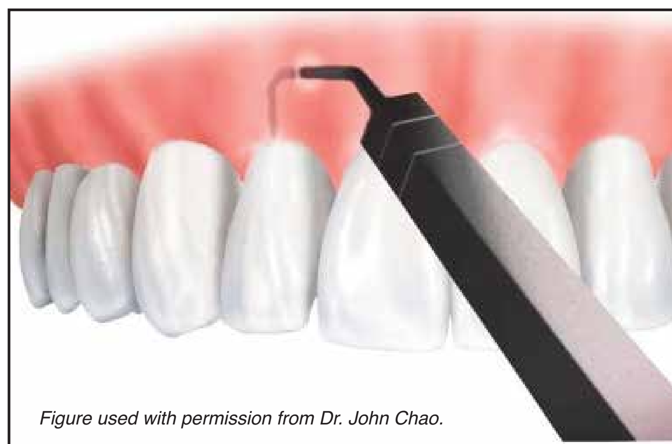


Figure used with permission from Dr. John Chao.

Figure 3: A specialized dental instrument enters the pinhole then gently move the gums down coronally

AGD Fellows and Masters Become Leaders in Dentistry

Dr. Samer Alassaad, *CAGD Vice President, Davis*

AGD Annual Meeting in New Orleans

Dr. Kara Yu of Pleasanton, California and a California AGD MasterTrack 5 participant, presented about "Guided Surgical Implant Placement" in the "Dental Pearls from Our Fellows and Masters" series at the AGD Annual Meeting in June of this year in New Orleans. With dentistry changing constantly, it is important to hear from dentists within the profession who have handled similar obstacles or day-to-day tasks. AGD Fellows and Masters shared their case studies in 10- to 15-minute presentations for the educational benefit of their peers, a format similar to the presentations given on a regular basis during the California AGD MasterTrack 5. ◆

CASE STUDY *(continued from the adjacent page)*

Figure 4: Immediate post-op view of root coverage

The Pinhole Surgical Technique appears to be very promising in the management of Miller's Class I and II recession cases which resulted in highly esthetic root coverage outcome with predictability in this case.

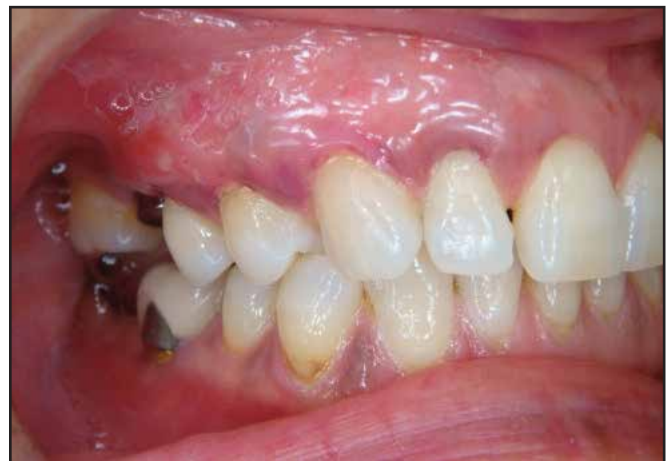


Figure 5: One day post-op view

Post-operatively, the patient was instructed not to brush, floss, or touch the area, but only rinse with lips apart for six weeks. Only Motrin 600 mg., one q 6 h was prescribed.

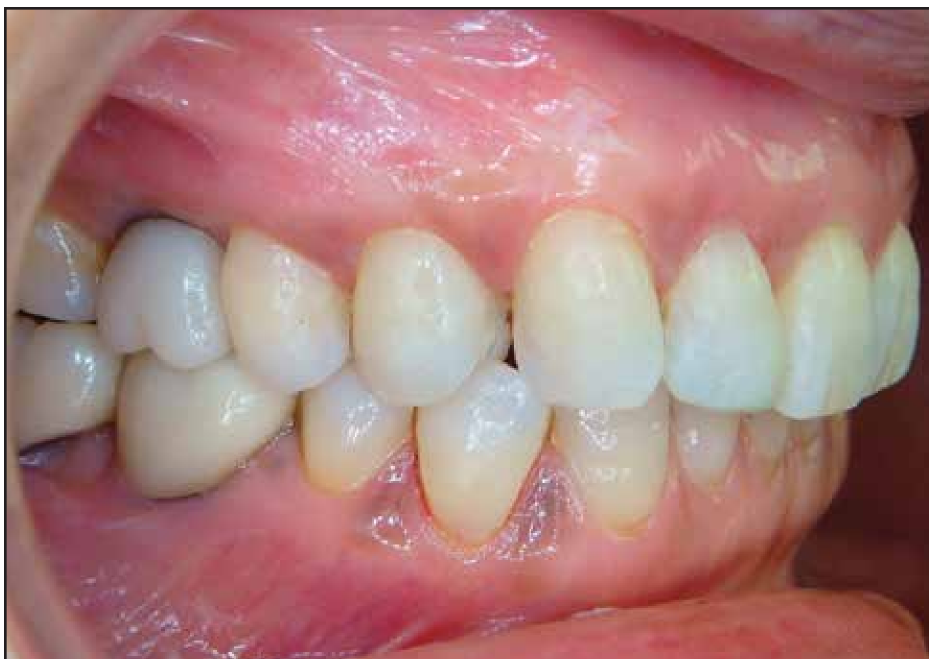


Figure 6: One year post-op view shows stable gingival tissue with 100% root coverage

Follow-up and Conclusion:

The patient was re-evaluated after one day, then at one week, three months and then one year *(Figures 5 and 6)*.

The patient was ecstatic after the procedure, since the results were very obvious to the patient immediately after the surgery. Additionally, the negligible post-operative pain, swelling and discomfort made achieving the overall goal of patient satisfaction far more feasible. ◆

Dr. Eugene Y. Kim
Treating Clinician

Dr. Kim presented this case to his peers at the California AGD MasterTrack 5 as part of the Periodontics participation educational requirements for Mastership in the Academy of General Dentistry (MAGD).

The author reports no conflicts of interest.

A Bit of Our History . . . California AGD Leadership Awardees

DR. VIRGIL BROWN MEMORIAL

Dentist of the Year Award

Past Recipients:

Dr. Tsujio Kato, *1972*
Dr. Duncan Wallace, *1975*
Dr. William Frank, *1977*
Dr. William Molle, *1978*
Dr. John Brown, *1979*
Dr. Judson Klooster, *1981*
Dr. Robert Barrett, *1983*
Dr. Elwood Streeter, 1984
Dr. Bruce Lensch, *1985*
Dr. Terry Tanaka, *1986*
Dr. John Lehman, *1987*
Dr. Eldon Parminter, *1988*
Dr. Eugene Manusov, *1990*
Dr. Deon Carrico, *1991*
Dr. Ted Fortier, *1992*
Dr. Edward Johnson, *1993*
Dr. Bruce Schutte, *1994*
Dr. Robert Garfield, *1997*
Dr. Myron Bromberg, *1998*
Dr. Robert Hubbert, *1999*
Dr. George Davis, *2000*
Dr. Robert Kelly, *2001*
Dr. Richard Sipes, *2002*
Dr. Kevin Anderson, *2003*
Dr. Carol Summerhays, *2004*
Dr. Richard Ringrose, *2005*
Dr. Wai Chan, *2006*
Dr. Jeff Lloyd, *2007*
Dr. Guy Acheson, *2008*
Dr. James H. Thompson, *2009*
Dr. Yolanda Mangrum, *2010*
Dr. Sun Costigan, *2011*
Dr. Michael Lew, *2012*
Dr. Steven Lockwood, *2013*
Dr. John DiPonziano, *2014*
Dr. Cheryl Goldasich, *2015*
Dr. Anita Rathee, *2016*
Dr. Sireesha Penumetcha, *2017*

DR. DEON CARRICO MEMORIAL

Spirit of Leadership Award

Past Recipients:

Dr. Deon M. Carrico, *2002*
Dr. William Frank, *2003*
Dr. Robert E. Garfield, *2004*
Dr. Robert Barrett, *2005*
Dr. Robert Hubbert, *2006*
Dr. Myron Bromberg, *2007*
Dr. John Brown, *2008*
Dr. Victor Diamond, *2009*
Dr. Steve Skurow, *2011*
Dr. Anita Rathee, *2012*
Dr. Richard Ringrose, *2013*
Dr. William Langstaff, *2014*
Dr. James H. Thompson, *2015*
Dr. Eric Wong, *2016*
Dr. Sun Costigan, *2018*

WERHAN *(continued from page 14)*

Here in California, the CDA sued Delta Dental to block the impending fee reductions. Now that a settlement has been reached, Delta will pay a sum to CDA which will be distributed to impacted dentists *(don't spend it all in one place, doctors!).* On the other side of the ledger, Delta is allowed to restructure its Provider Agreements starting in 2018 meaning that lower reimbursements are on the horizon. I am fortunate to be a member of the Academy of Dental CPAs (ADCPA). We are 28 firms strong supporting over 8,000 dentists across the country. In our semi-annual meetings, we hear from top people in organized dentistry, academia, and industry leaders about the impact Delta Dental's lower reimbursements have had on dentists. We also discuss impact on practices in states where Delta has successfully lowered fees. Our colleagues in those states are not telling stories of failing practices and bankruptcies. I believe it will be different in California because of the lawsuit and that Pareto's Principle, which states that 80% of the outcome is affected by only 20% of the input, is out the window.

Dentists should not stand idly by waiting to see what happens. Pulling a few practice management tips out of one's hat, like may have enabled dentists to survive a year-long recession in the past, will not be sufficient. I believe that dentists need to consider lower reimbursements to be like climate change (non-believers, please bear with me). There are not one or two silver bullets that will help practices overcome a permanent reduction in revenue. Rather, I think numerous steps will be required and that dentists need to pull out all the stops and re-invent their practices for an uncertain future. Dentists may need to consider possible alternative business models, and methods to improve dental practices at all levels – from proper procedure coding to optimizing hygiene departments, to overhead control and effective marketing, management and tax reduction strategies.

As a Dental CPA, I feel particularly qualified to discuss solutions to lower revenues as well as other practice, financial and tax issues that can chip away at a dentist's income and ability to create wealth. I am honored to have been asked to join a task force at CDA whose mandate is to study the impact of lower reimbursements on California dentists and to offer possible solutions. I am also honored to have been asked by the California Academy of General Dentistry to present my ideas on re-inventing the dental practice to survive and thrive in the new economic reality facing the profession today.

Thirty-eight years ago, when I started working with dentists and heard the terms PPO and Franchise Dentistry, I ran around like Chicken Little. Today it is the same story, but the names have been changed to IPO and Dental Service Organization (DSO). Plus, I'd like to think I've learned a thing or two over the years. While dentistry has significant challenges ahead, I believe that the profession is one of resilience and creativity. I, for one, have every confidence that, together, we'll do what we must to make the necessary appropriate adjustments to remain the same desirable and honorable profession we've been all along. I look forward to talking about it with you. —J. Haden Werhan, CPA/PFS

2018 AGD MEMBERSHIP APPLICATION

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

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MEMBER'S NAME

CITY, STATE/PROVINCE OR FEDERAL SERVICE BRANCH

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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 license? ❑ 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)*

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PREFERRED BILLING/MAILING ADDRESS: ❑ Business ❑ Home

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

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

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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 | Start Date *(month and year)* to End Date *(month and year)*

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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______

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2015 Graduate	77
2014 Graduate	154
2013 Graduate	231
2012 Graduate	308
Student	17

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

Expiration *(mm/yyyy)* | 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:
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Credit card payments, fax to: 312.335.3443

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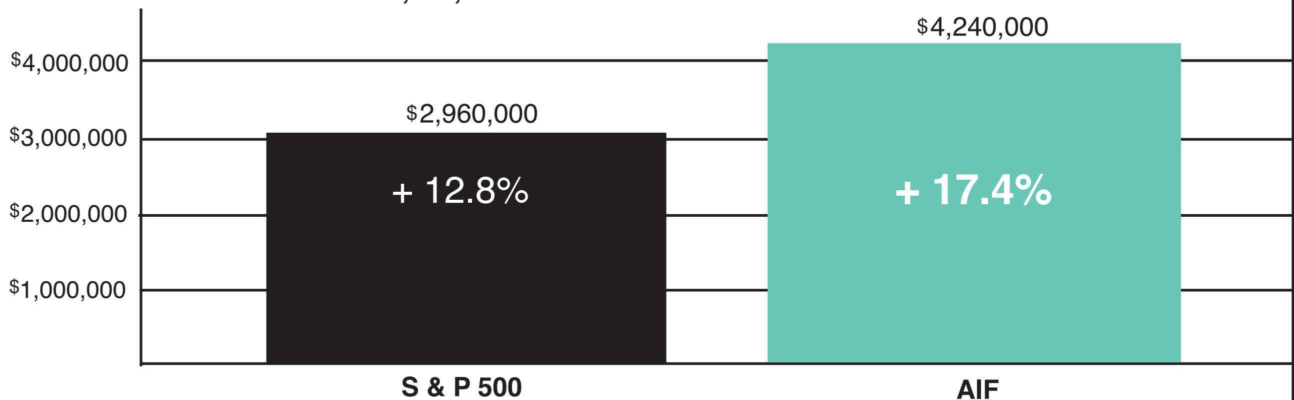

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