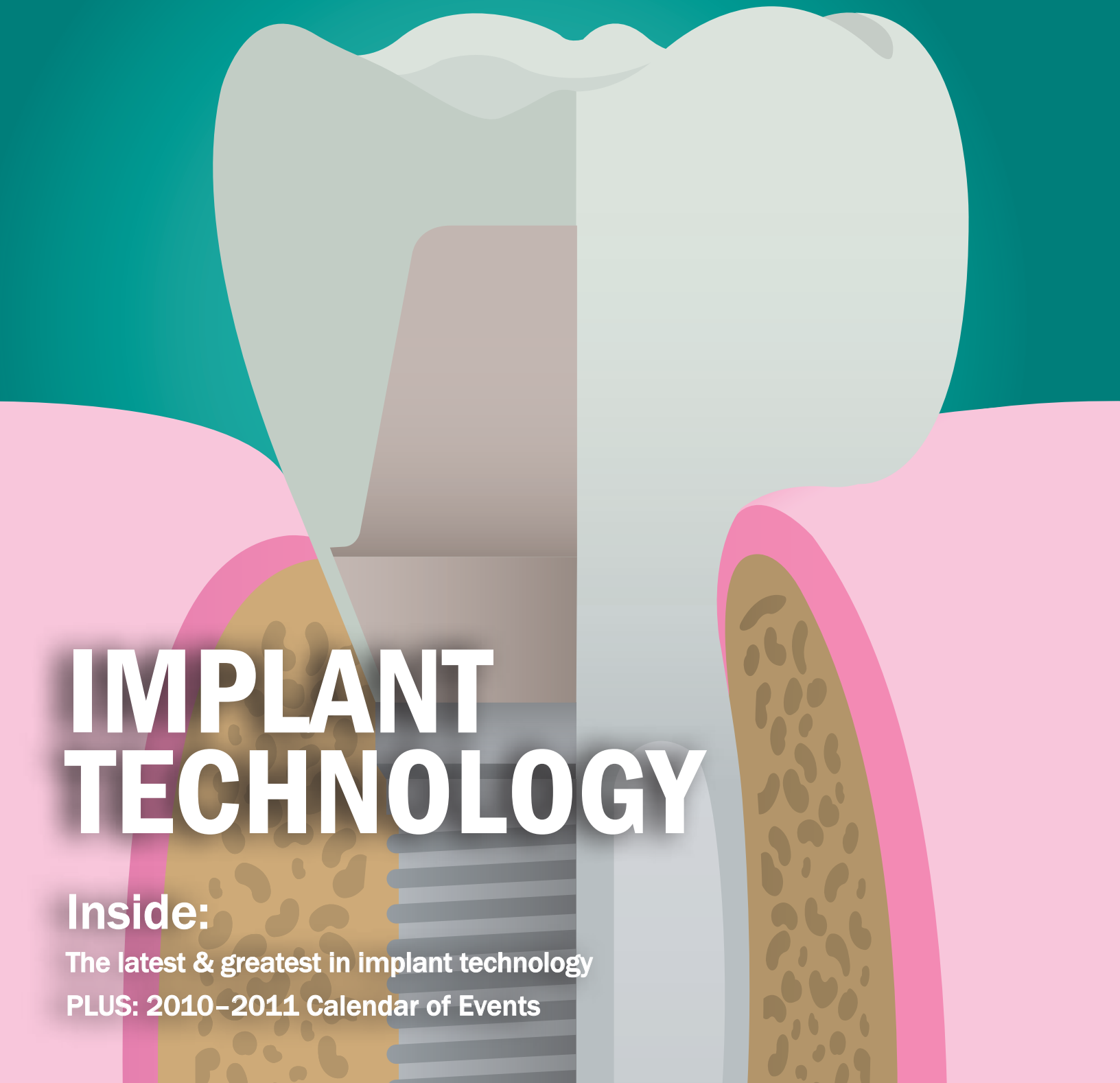
THE NUGGET
A PUBLICATION OF THE SACRAMENTO DISTRICT DENTAL SOCIETY
AUGUST/SEPTEMBER 2010



IMPLANT TECHNOLOGY

Inside:

The latest & greatest in implant technology

PLUS: 2010–2011 Calendar of Events

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AUGUST/SEPTEMBER **2010**

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THE NUGGET **IS A FOUR-TIME INTERNATIONAL COLLEGE OF DENTISTS JOURNALISM AWARD WINNER:**

GOLDEN PEN (HONORABLE MENTION, 2007)

OUTSTANDING COVER (2007)

OVERALL NEWSLETTER (2007)

PLATINUM PENCIL (2010)

** featured on cover*

PRESIDENT'S MESSAGE

THIS NUDGE IS FOR YOU

By **Terrence W. Jones, DDS**

In the middle of these dog days of summer when the temperature is in the triple digits, I'm sure you'll want to give me a high five when I tell you I've got my feet in the water and my Bud in the ice chest. Top this idyllic scene with my grandson and me playing Marco Polo with our makeshift vuvuzelas, (those annoying world cup soccer horns), and we're talking life is good.

Ah, but all good things must come to an end. My grandson heads off for a nap. I toss my makarapa (those world cup team hats), grab my book and vow for the umpteenth time… "no more polish dogs and my exercise program definitely starts tomorrow."

I don't know about you, but nearly every day I have to resist the urge to eat the donuts or cinnamon rolls sitting in the break room. Yeah, I know I said I got them for the staff but I'm the one who wanders back there most often and I'm the one who eats the most. Making the right choice is easy on paper but not so easy in daily life.

How do we improve decision making about healthy behavior? We all know that consistent oral hygiene and wise dietary choices vastly increase the chances for a healthy mouth. Just as getting people to take their medicine correctly or exercise routinely have medical benefits. In general, it does not appear to be a matter of more education but rather behavioral modification. So how do we assist our patients effectively, without being too heavy handed and paternalistic or too soft and wimpy.

My summer reading provided me with some answers. In a new book entitled, Nudge, authors Richard Thaler and Cass Sunstein argue that what's needed to help us make wiser decisions is a dose of libertarian paternalism. People should have the right to choose but society should encourage particular choices. The idea is to use behavioral nudges to influence choices in positive ways.

The authors cite as an example the men's restrooms at JFK Airport. Not the cleanest of places but surprisingly cleaner than many other airport restrooms because of one tiny detail hidden in each of the urinals. Inside each urinal, is a small image of a fly strategically placed to, as they say in the maintenance business, reduce spillage. As mothers are wont to say, boys will be boys, and this single example of choice architecture that encourages that hunter instinct was responsible for as much as an 80% reduction of errant aims and major savings in maintenance costs. That tip alone will pay dividends as we potty train Caleb.

Intentional or not, we can't help nudging people.

Put simply, their research calls into question the rationality of many decisions we make. It seems that we humans error predictably. Whether it involves our systematic tendencies to underestimate the time it takes to complete a job, or our strong bias to stick with the status quo, important lessons can be gleaned from this research.

The authors suggest that most of us have lives that are too busy and complicated to allow us to take the time to analyze every decision we make. Consequently we rely on short cuts. When magazines provide us with automatic subscription renewal, more magazines are renewed. When a food is described as 80 % fat free, we are more likely to purchase it than when we are told that it has 20% fat. In the first case of the "opt in" default setting, inertia comes into play; in the second case, wisely framing the problem produces the desired results. Would "opt in" default settings be considered too coercive for annual dental association renewal?

Social norms also have a great influence on our decision-making. If we believe our neighbors are more energy efficient than we are we are, or are more willing to recycle, chances are we will be motivated to increase our efforts. If more of your dental colleagues attend the General Membership meetings, you are more likely to attend.

The authors have a wealth of examples illustrating clever use of choice architecture for the good. They also pay due respect to the potential to manipulate decisions in a self-serving, venal way. They make a good case that what seems to be unavoidable in many circumstances is the possibility of not influencing behavior. Intentional or not, we can't help nudging people.

If you would permit me a gentle nudge, have fun this summer but, come this fall, join us at the September 14th General Membership meeting. Help us make that meeting, our kick off meeting for the 2010-2011 program year, one of our best attended ever. Better yet "opt in" to our Dedicated Monthly Dentist Program and enjoy the benefits of 14 units of outstanding CE credit. These next few dinner meetings are going to be extra special — so grab your vuvuzela, hold on to your SDDS makarapa and join in the fun. ■

FROM THE EDITOR'S DESK

IMPLANT TECHNOLOGY

By **David J. Crippen, DDS**
Associate Editor

Implant technology is one of the most dynamic and fastest growing areas in dentistry. Just under a decade ago I graduated from dental school with little more than the knowledge that implants existed.

Today's graduates are another story. My own alma mater, The University of the Pacific, has recently revamped its "implant curriculum" to include not only didactic training but also clinical experience for every student. The University estimates 90% of its students will complete an implant case prior to graduating. Student participation in these cases includes case selection and presentation as well as an intimate involvement in the preoperative set-up, the lab work, the surgical placement and the final restoration of the implant. This experience affords today's graduating dentists a basic knowledge of the utilization of implants and their role in modern-day treatment planning — but what about those of us who graduated years (or decades) ago?... enter *The Nugget.*

The following articles provide an overview of the latest types of implants and their various uses. Each author is a specialist who either places, restores, and/or utilizes implants in their daily practice and each of whom will testify not only do implants exist… they are here to stay. ■

Dr. Crippen is a Diplomate of the American Board of Pediatric Dentistry and a clinical professor with the University of California, Davis School of Medicine and the University of the Pacific School of Dentistry. Dr. Crippen maintains a private pediatric dental practice and office-based surgery practice in Midtown Sacramento, California.

CATHY'S CORNER

"BEING SOCIAL..."

By **Cathy B. Levering**
SDDS Executive Director

I never thought I'd admit it. Nope. Never.

"Email is enough. Facebook is not for me… Keep my life simple." I was quoted as saying that just 12 short months ago. Since that time, I have learned so much.

I've learned that websites are becoming more and more NOT what businesses need as their primary source of PR – websites are just an enhancement and an information distribution center. At least websites, as they used to be, are not what small businesses need. Websites today need to be maintained by you, not the webmaster. Those days are over. They need to be interactive and YOU need to monitor them. The click-thrus are so important and increase your online presence. If your website is still html, start investigating the transition to Wordpress and content management systems/platforms. It won't be done overnight, but start now. If you are a client who can't get into your site… yikes!

What are people saying about you online? Do you monitor that? You should. Subscribe to Google Alerts, Facebook alerts, Yahoo, Bing. When someone mentions your name, you are alerted – then make sure that the incorrect information is dispelled.

Then, there's Twitter, Flickr, Facebook, LinkedIn, YouTube and on and on. Did you know that video actually has become the number one source for getting your marketing message out? It's becoming huge.

With all this changing on a daily basis, start reading. To help, *The Nugget* is starting a feature called "Being Social" (and it's not about this weekend's cocktail party). We have many experts who will weigh in on the topic. And, while you are soaking all this information up, please be a fan of SDDS on *www.facebook.com/home.php?#!/pages/Sacramento-District-Dental-Society-SDDS/135050459953!* (Or just search us on Facebook.)

Whether you're social or not… it's time! ■

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Cutting Edge IMPLANT TREATMENT

By **Paul P. Binon, DDS, MSD**

We have come a long way since science based implants were introduced by PI Branemark in 1982 at the Toronto Meeting. Amazing strides have been made over the past 27 years. This year marks the 25th anniversary of the American Academy of Osseointegration, an organization dedicated to the advancements of the science and art of implant dentistry. What an exciting quarter of a century it has been. Research during this time has led to new treatment protocols, materials, and equipment, resulting in breakthroughs only dreamed of, a short time ago.

Ten years ago, I was asked to write an article for JOMI on implant components as we entered into the new millennium. At that time there were approximately 1200 implant varieties and some dozen manufacturer's world wide. Today those numbers have easily doubled and more are added each year.

We definitely live in an immediate gratification society and there are numerous advancements that have allowed us to load the implants much earlier than previous protocols allowed. Implant surface changes, thread designs, thread distribution and implant shapes have all impacted integration by reducing the treatment time line. The advent of the internal connection and different platforms has resulted in predictable abutment and prosthesis stability as well.

Measuring the stability of an implant at the time of insertion is a critical assessment if immediate loading is to be accomplished with predictable success. Clinically, if an implant is inserted and insertion torque values of 45 Ncm are reached or exceeded, the implant can be loaded with security. For those implants that do not reach that heady requirement, the typical 3 months in the lower and five months in the upper jaw arch wait is indicated. For those who want to progress faster, instrumentation is now available that tells you when integration has occurred and the implant can be loaded. The **Ostell Mentor** *(fig. 1, below),* a resonance frequency monitoring instrument can be used to generate accurate technical data that measures bone formation, changes in bone height, degree of osseointegration and bone stiffness. It's a noninvasive test that requires a test peg to be inserted into the implant and takes very little time. It is especially helpful at the second stage to determine if the implant is in fact stable so that you can restore it and avoid costly late failures.

Patients who have been told that they are not candidates for dental implants due to the lack of bone in the maxilla, now have a predictable solution without extensive grafting. Prof. Branemark conducted extensive research on craniofacial bones that had excellent load bearing ability. The zygomatic bone consistently demonstrates dense quality and acceptable quantity of bone volume. It is similar to the dense cortical bone of the mandible that has demonstrated exceptional implant stability for more than 30 years. The first **Zygoma implants** *(fig. 2, below)* were placed in 1989.

In a 10 year follow up study the success rate was 96.8% (N=97). It effectively provides treatment to those patients that cannot be grafted or want to have an immediate fixed upper prosthesis without waiting the typical 12 to 18 month time line. It has been very effective in my practice.

Another immediate load protocol for patients with adequate bone in the maxilla and the mandible involves the concept of **all on 4 implants**. Historically, the lower arch was restored with 5 buried implants that were allowed 4 months to integrate before loading. In the upper arch, a minimum of six implants were placed and allowed to integrate for 6 months. The new protocol calls for 4 implants to be placed and loaded immediately with a fixed prosthesis. Patients have to be carefully selected for adequate bone volume. In marginal cases with advanced atrophy other options should be evaluated. A real concern with this technique is the risk of overload and that if one implants fail, the entire restoration can fails and has to be re-done. Currently there is no five year published data on this protocol and patient should be advised of the risks especially in the maxillary arch. A much more preferred option is to place two additional implants in the molar area to improve load bearing distribution. Using four implants in the lower arch is much more predictable, especially in smaller arch sizes.

In the surgical arena, the frequency modulated **Piezoelectric energy scalpel** *(fig. 3, below)* has made bone cutting preparations extremely simple. Three manufacturers current make units that vary in frequency. **Mectron** (24kHz to 29.5kHz); **Acteon** (28kHz to 36kHz); and **EMS** (24 to 32 kHz). There are multiple uses for the piezoelectric scalpel. It can be used for extractions, calculus removal and implant placement. It simplifies block bone harvesting (lateral ramus and chin) for grafting procedures and if ridge expansion is indicated it makes extremely fine accurate cuts. Since it does not cut soft tissue, it is ideal for sinus window preparations, and lateral nerve repositioning procedures. The only down side is that the units are still very expensive, heat is generated in the handpiece and the diamond cutting blades can break if mishandled.

Soft tissue lasers are increasingly used in second stage implant procedures. The

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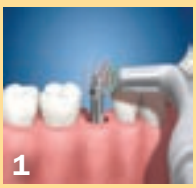
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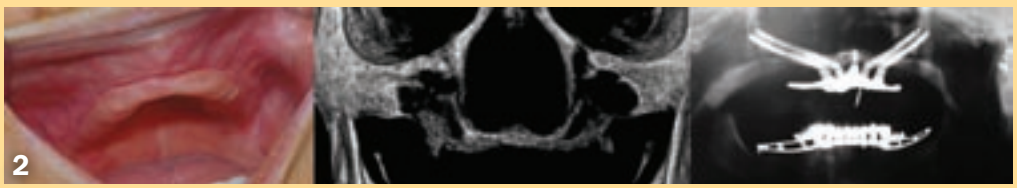
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Minimally Invasive DENTAL IMPLANT SURGERY

By **Ash Vasanthan, DDS, MS**

As we enter a new decade in time, we are also entering an exciting and interesting time in the practice if dentistry. At the present time, most, if not all general practitioners are involved with some form of restorative dentistry with dental implants but only a few are involved with the surgical aspect of implant placement and the reason for this could be the surgical protocol. Minimally invasive surgery, which is a flapless surgical approach, could make it much more simple for more dentists to consider getting on board the surgical part.

Flapless Implant Surgery

As the one stage implant surgery became more predictable, there was an interest in pushing the surgical part another step and placing the implant with a flapless approach. In my opinion flapless surgery can be divided into 3 categories: 1. Traditional Approach, 2. Model Based Approach 3. Computer Fabricated Guide Approach and 4. Real Time Navigation Approach.

Traditional Approach: This approach involves more surgical experience and is generally followed by implant surgeons in the posterior quadrants of the mouth on a relatively common basis on preference. It involves a reasonable understanding of the bone and soft tissue profile of the area and includes use of an initial tissue punch and sequential drilling to widen the osteotomy and placement of the implant[1]. This particular situation is one where the use of a surgical guide may or may not be required based on the location and the number of implants. *(Fig. 1, below)*

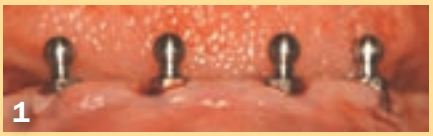
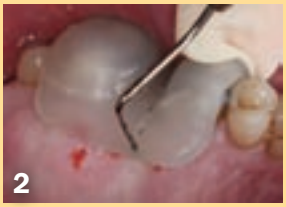


Fig. 1: Four implants placed in a traditional approach



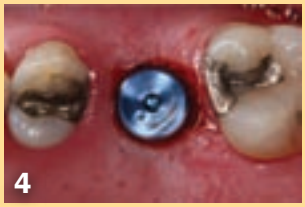


Fig. 2: Ridge Mapping to assess the bone profile and soft tissue thickness
Fig. 3: Implant site preparation through model based guide in place.
Fig. 4: Minimal tissue trauma with the implant in place

Model Based Approach: This approach involves the use of models of the case with ridge mapping information transferred to the model. Ridge mapping involves the use of a calibrated probe with a stopper to measure the thickness of the tissue along the edentulous site on a bucco-lingual manner including the crest. This is done after the patient is anesthetized in the area and a minimum of 4 – 8 areas are measured along the ridge from buccal to lingual. The information of each reading in the location is then transferred to the model in the form of dots on the model corresponding to the same location. It is then sectioned with or without the use of pins (similar to that of sectioning a model for crown and bridge) and the ridge form can be evaluated or assessed. Based on this information, a surgical guide can then be fabricated. The surgical guide is then used to follow the steps of implant site preparation and placement through the flap. *(Fig. 2, 3, 4, above)*

Computer Fabricated Guide Approach: This is the newest method currently used and probably the most efficient approach to placing multiple implants in a flapless way. This method involves the use of a CT scan of the patient with the radiographic guide in his jaw in order to generate a virtual 3D model of the jaw in the computer. Utilizing an implant planning software, a virtual implant is placed within the bone profile of the edentulous site in the scan. The information on the location and size of the implant are sent to the company, which will make a stereolithographic surgical guide milled out of the information obtained from the planning software. Since this majority of this process is automated, there is less room for human error in the transfer of information and fabrication of the surgical guide. The surgical guide generated in this manner, allows the implant surgeon to place the implant with little error[2]. Although the surgical placement has become predictable with the computer generated surgical guide, the restorative aspect being done at the same time can be quite challenging and calls for meticulous steps to be followed in order for it to happen at the same time. The computer generated guide is usually received in the dental office within 1-3 weeks of the software based planning and can vary depending on the company and the lab involved in the process. *(Fig. 5, 6, 7, 8, opposite)*

Real Time Navigation Approach: Image Guided Implantology® is a company based out of Israel which provides implant navigation with motion tracking technology. It tracks the position of the implant drill in the patient's jaw, in real time, as the site is being prepared for implant placement. This technology requires the use of a pre-surgical CT scan to allow the surgeon to navigate through the CT scan in real time as he is preparing the site and placing the implant. Unlike the computer fabricated

surgical guides, this technology allows for direct placement of the implant without a guide and will give real time information on the angle of the implant as the drilling sequence proceeds. The company claims that it is a "GPS for implant dentistry"[3]. At this time, there are a few places in the United States that this technology is being tested and utilized. A friend of mine had the opportunity to use this system for a few months in his practice and said, "The process was laborious with a steep learning curve but the surgical part was exciting and the technology is promising," Over the next few years, we shall see the evidence in peer reviewed journals to facilitate clinicians like us to consider its use if the cost is not prohibitive.

I have listed my recommendations and rationale to consider the use of minimally invasive dental implant surgery and this is an exciting time in dentistry, especially implant dentistry where science and technology is making the surgical part simpler and easier to do and minimally invasive to the patients. ■

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1. Campelo LD, Camara JR; Flapless Implant Surgery: A 10 year clinical retrospective analysis. **Int J Oral Maxillofac Implants.** 2002 Mar-Apr;17(2):271–6.
2. Elian N, Jalbout ZN, Classi AJ, Wexler A, Sarment D, Tarnow DP. Precision of flapless implant placement using real-time surgical navigation: a case series. **Int J Oral Maxillofac Implants.** 2008 Nov–Dec; 23(6):1123-7
3. *http://www.image-navigation.com/IGI/overview*

Dr. Vasanthan completed his Periodontics residency along with a Masters in Dental Biomaterials from the University of Alabama at Birmingham. He is a visiting professor at the Department of Periodontics and Implant Dentistry — University of Missouri Kansas City, where he previously taught for five years. He is currently in private practice at Roseville, California.

RECOMMENDATIONS / INDICATIONS:

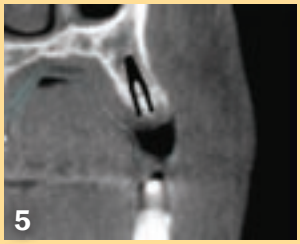
- *4mm of keratinized gingiva from the mid-point of the crest buccal and lingual to the site.*
- *Bone thickness of 6mm as measured or assessed.*
- *Minimal anatomical risks.*
- *Guidance to the path of implant site preparation.*
- *Surgical parameters within restorative requirements.*

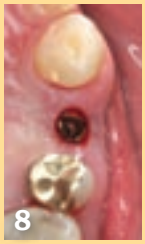
CONTRA-INDICATIONS:

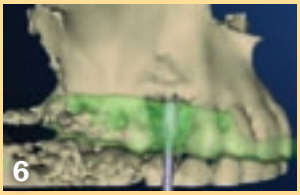
- *Inadequate bone thickness.*
- *Need for bone or soft tissue grafting.*

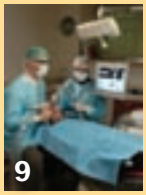
RATIONALE / ADVANTAGES:

- *Minimally invasive*
- *Decreased pain and discomfort*
- *Preserves vascularity*
- *Preserves crestal bone*
- *Less plaque accumulation*
- *Enhanced esthetics for provisionalization*









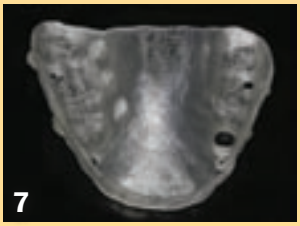


Fig. 5: Software based planning with virtual implant

Fig. 6: Software with radiographic guide showing virtual implant with abutment and guide

Fig. 7: Surgical Guide with metal sleeve along the edentulous spot

Fig. 8: Implant placed as per guide with minimal tissue trauma

Fig. 9: Real time display of the implant drill on computer screen

Fig. 10: Real time display of drill angulation with future location of the implant in that path displayed as the yellow shell with red dot.

WHY KEEP ASPIRIN BY YOUR BEDSIDE?

About Heart Attacks: There are other symptoms of an heart attack besides the pain on the left arm. One must also be aware of an intense pain on the chin, as well as nausea and lots of sweating, however these symptoms may also occur less frequently. Note: There may be NO pain in the chest during a heart attack. The majority of people (about 60%) who had a heart attack during their sleep, did not wake up. However, if it occurs, the chest pain may wake you up from your deep sleep. ■

In the case of a heart attack:

- take two aspirins
- CALL 911
- say "heart attack!"
- say that you have taken two aspirins.
- phone a neighbor or a family member who lives very close by
- take a seat on a chair or sofa near the front door, and wait for their arrival and...
- DO NOT LIE DOWN

Temporary Anchorage Devices: MOVING IN THE RIGHT DIRECTION

By **Damon Szymanowski, DMD**

As dental practitioners, we strive to provide the best treatment options for our patients, offering them the most modern and innovative practices available. Orthodontists are always trying to find innovative ways to reduce treatment time and to improve treatment outcomes and the patient's dental health. The use of Temporary Anchorage Devices (TADs), also known as miniscrews, is a great example of this. With use of TADs, orthodontists can overcome anchorage limitations and predictably move teeth in ways that would have required extra-oral and intra-oral devices, extractions and, in some instances, orthognathic surgery.

The primary benefit of TADs is to gain absolute anchorage and move groups of teeth or individual teeth without the unwanted side effect of anchorage loss, thus reducing treatment time and improving efficiency. Traditionally, these unwanted side effects are minimized with extra-oral devices such as headgear and intra-oral devices such as distalizing appliances, fixed functional appliances and elastics. These devices mainly rely on patient compliance; if poor compliance is a factor, this can result in the lengthening of treatment time.

The use of TADs is not a new concept. Dental practitioners across many specialties have experimented with similar devices over the past fifty years. The TADs that we use today were FDA approved in 2005. Their modern technology, relative ease of use, and low cost has allowed them to gain acceptance into mainstream orthodontics.

TADs are generally fabricated from medical grade titanium alloy and come in several lengths ranging from 6–12 mm and a diameter of 1.2 to 2.0 mms. They also come with a variety of different head designs. These head designs range from hooks, eyelets, ball-shaped, to simple slots, reflecting the various ways to attach the TAD to the teeth or appliance. Currently there are more then two-dozen dental companies that manufacture TADs. Each manufacturer has its own proprietary system that has a unique thread design and head and driver to insert the screws.

Placing TADs is relatively simple. Unlike traditional endosseous implants, TADs do not osseointegrate, but they do rely on cortical bone for stability. This form of stability allows the TAD to be loaded immediately. TADs are most commonly placed between the roots of teeth, both buccally and lingually, and on the palate, however they can also be placed in the retromolar and infrazygoma regions. With the use of topical anesthesia or a simple local infiltration, TADs are easily screwed into the bone. Patients generally tolerate this procedure very well, and bleeding is minimal. Some potential complications are soft tissue irritation and inflammation, root and periodontal ligament trauma, sinus perforation and, lastly, TAD failure. Removal of the TAD is as simple as unscrewing it with the use of topical anesthesia and healing takes place over a few days with little patient discomfort.

Dental practitioners across many specialties have experimented with similar devices over the past 50 years.

The most common uses of TADs are protraction, retraction, distalization and intrusion of teeth. In cases in which the maxillary and mandibular teeth are severely proclined, TADs can be used as an anchor to retract the anterior teeth without allowing the posterior teeth to move forward. This will result in a more favorable profile and a more stable upright incisal tooth position. TADs can also be utilized to predictably distalize teeth without the use of devices such as headgear. One common orthodontic challenge is the treatment of patients with congenitally missing mandibular second premolars. Traditionally, orthodontists would prepare the space for an implant or attempt to protract the first and second mandibular molar forward with elastics and headgear to prevent the anterior teeth from moving distally. Using TADs, orthodontists can now successfully protract the molars forward without disturbing the position of the anterior teeth. Lastly, TADs can be used for intrusion of super-erupted posterior teeth due to tooth loss in the opposing arch. Up until now, with the use of TADs, the intrusion of posterior teeth was extremely difficult, if not impossible. Treatment would most likely consist of prosthetic crown reduction, possible root canal therapy and crown lengthening surgery. Today, with the use of TADs, orthodontists can predictably intrude posterior teeth and re-establish a functional posterior occlusion.

More recently, orthodontists have been using TADs as a temporary approach to maintaining space in cases of congenitally missing lateral incisors. In the past, we would utilize retainers with pontic teeth to maintain the space of the missing incisors; these retainers would be used until skeletal maturity when a final implant fixture would be placed. In contrast, TADs are placed in the lateral incisor location and prepared with a provisional restoration, thus eliminating the need for a retainer to hold the space. Upon skeletal maturity, the TAD is simply removed and the patient is then ready for the placement of an implant and the final restoration.

This is just the beginning. As dental practitioners continue to use TADs, we will undoubtedly find more ways to integrate these useful devices into our treatment plans, ultimately improving treatment efficiency and the dental health of our patients. ■

Dr. Damon Szymanowski completed his dental school at Tufts University School of Dental Medicine and his orthodontic residency at the University of Pennsylvania School of Dental Medicine. He is currently in private practice in Sacramento, California.

CONTINUED FROM PAGE 7

minimally invasive entry limits bleeding, the use of sutures, reduces healing time and postoperative pain and gives the clinician greater overall control.

Although not new, simplification of the harvesting technology to obtain **Platelet Rich Plasma (PRP)** has made grafting more predictable and shortens the time line. Units are more affordable and compact. In bone grafting, autografts are the gold standard because of their osteoinductive nature and the presence of osteogenic cells. The problems associated with autografts are donor site morbidity, unreliable quality and limited quantity of bone. The introduction of **OSTEOCEL** provides a bone grafting product that has living cells required for osteogenesis. Osteocel®, an HTC/P allograft product, has been processed in such a way as to selectively deplete immunogenic cells while maintaining a rich source of live multipotential stem cells delivered in a cancellous bone matrix. It is delivered the day of surgery packed in dry ice to insure viability. It is considerably more expensive than conventional grafting materials. Using PRP and Osteocel in combination has resulted in grafted bone that is considerably denser with a turn over and utilization time that has been reduced significantly.

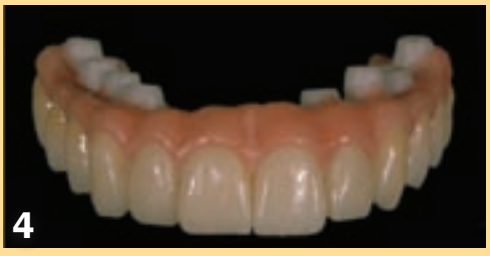
BMP (rhBMP-2) has been used routinely in a variety of orthopedic surgery procedures. It is becoming more available for dental applications as well. BMP is a protein in a pure, freeze-dried powder form. It is naturally occurring in small amounts and stimulates bone formation at the site where it is placed. During the procedure rhBMP-2 is soaked onto and binds with an absorbable collagen sponge (ACS). This is placed in the defect and stimulates the cells to produce new bone. It is commercially available as **INFUSE®** Bone Graft the material. It consists of two main components, the protein powder and the ACS which is made from a material found in bone and tendons. As the graft site heals, the ACS is absorbed and replaced by bone. One of the primary advantages of INFUSE® Bone Graft material is that it is an alternative to harvesting autogenous bone from the hip, leg, jaw or chin. Healing and regeneration also appears to be accelerated. Again this new material is quite expensive.

Cast implant frameworks are increasingly being replaced with **Titanium CAD cam technology** *(fig. 4, below)*. The primary reason is the extreme accuracy of this type of framework. No more distortions from one piece castings or soldering parts together. A variety of bar designs for both removable and fixed prosthesis are possible. Two major players in that technology are **C&M Ceramics** and **Cagenix Inc**. C&M offers both acrylic and combination ceramic /acrylic fixed implant superstructures. Moving the bar even higher are frameworks that are milled completely out of Zirconia. **ZirkonZahn USA Inc.** offers these restorations and they are esthetically superior. Typically in the fixed design, the entire prosthesis is milled from Zirconia and the soft tissue flange portion is veneered with pink porcelain (Prettau Bridge). With the removable option, a bar is milled from Zirconia that is attached to the implants with screws. A gold electroplated sleeve is made over the bar that is then cemented into the removable Zirconia superstructure. The technology is quite new and to date there is no significant data available to evaluate their long term status.

Computer guided implant planning and placement *(fig. 5 and fig. 6, below)* has made a significant impact in completing complex treatment plans with reasonable accuracy. I can well remember the first **Simplant** offering many years ago. It was limited, basic and expensive. During the course of many upgrades it has matured into a more user friendly and accurate software. With a surgical stent derived from the CT scan and proprietary software the patient is transformed into a three dimensionally secure surgical stage that allows the clinician to place implants with acceptable accuracy. The surgery is not only more predictable and accurate, but often flapless, much faster and with less surgical sequelae.

No longer the only player in this technological wonder world, **Simplant** now has multiple competitors. There is **Ident Guides** (all systems); **NobelGuide** (NBC implants); **3i Navigator**; **BlueSky Bio** (all systems); and **EasyGuide** (Keystone). However, there are differences in the accuracy of the various software offerings. Some do not allow transfer of full resolution DICOM scan data and "dumb" down the scan so that their software can handle it. As a consequence high resolution accuracy is lost. **INVIVO 5 (Anatomage Inc.)** implant software uses total DICOM data. After opening the DICOM data software has the ability to do virtual prosthetic setups followed by virtual implant placement and surgical guide fabrication. It is very simple and easy to use. No scan guides are required with this software. *(Typical images below, fig. 7).*

Mini implants *(fig. 8, page 13)* have traveled full circle. From the initial application of providing temporary anchorage during extensive implant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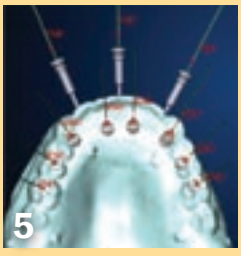
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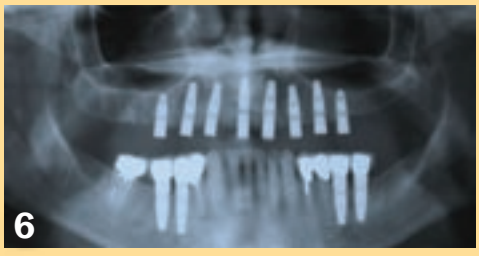
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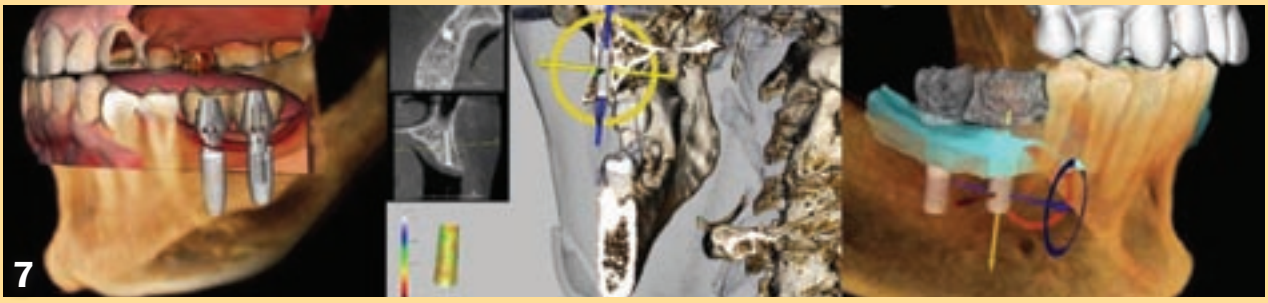
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8

treatment, to currently, providing low cost substitute anchorage for complete and partial denture anchorage in both the maxilla and the mandible. Several competing companies have excellent products available that vary in diameter, application and prosthetic options. Initially implants were 1.8 mm in diameter. Current offering are 2, 2.5 and 3 mm in diameter that vary in length from 11 to 16 mm. IMTEK, has been joined by IntraLock, BT Look and others in the narrow diameter arena.

The three millimeter (IntraLock) implant has application in the restoration of undersized edentulous areas with excellent predictability. No longer the throw away implant of the past, it has now gained respect as a predicatable treatment option in the edentulous arch of the elderly.

Less glamorous than the major advancements noted above, but perhaps of even greater importance to the success of implant procedures is the **SAC Classification in implant dentistry**. This originated in 1999 and was updated as a result of the 2003 ITI conference. The classification is available from Quintessence publishing. In the last issue of the Academy of Osseointegration Newsletter, John Schmitz DDS, MS, PhD states: "knowing how complex an implant case can be can keep you out of trouble or allow you to refer it to someone who can perform…" He goes on to say that **"The SAC classification has applications in esthetics, restorative and surgical situations in implant dentistry**. Even though there is no universal accepted classification system for the difficulty involved in the implant process, the SAC classification can be very helpful." Once you consider some of the SAC specifics and follow them, a clinician who is engaged in implant dentistry can definitely have a greater sense of confidence and security. ■

Dr. Paul Binon is an 36-year SDDS member practicing prosthodontics in Rocklin, California.

IN MEMORIAM

RICHARD G. BROWN, DDS

Dr. Richard Brown passed away on Memorial Day at 85 years old. He grew up in Fair Oaks, graduating from San Juan High School in 1943 and serving in the Navy for three years after that. He graduated from the first full class at Sacramento State, and entered UC San Francisco Dental School, graduating in 1954. While building his practice, he worked at the Youth Authority, and opened his first permanent office in the Campoy Building in Fair Oaks. He continued business there for 42 years, retiring from dentistry at age 72. Dr. Brown was a member of SDDS for 55 years.

ERVIN THOMAS CASSELMAN, DDS

Dr. Casselman was born to Ervin Nolan Casselman and Mae (Connery) Casselman on April 16, 1940 in Santa Maria, CA and passed away on June 17, 2010. After the death of his parents in 1947, he was raised by his Aunt and Uncle, Annabelle and Earl Casselman, and gained four siblings: Bob, Barbara, Don and Doug. On July 23, 1960 he married his high school sweetheart, Jeanne. Dr. Casselman received his DDS from UC San Francisco Dental School in 1968, after which he spent 36 years practicing dentistry in San Jose. After retiring in 2004, he and Jeanne moved to Rocklin. Upon transferring from Santa Clara County Dental Society, Dr. Casselman was a member of SDDS for 2 years.

DOUGLAS W. COFFELT, DDS

Dr. Coffelt passed away at age 51 on July 20, 2010, from a major heart attack while cycling in Eppie's Great Race. For each of the past five years he and Dr. Herman have had teams from their office participate in the race. Dr. Coffelt loved cycling, but most of all he loved the competition with his co-workers. Dr. Coffelt grew up in Carmichael, worked his way through dental school and achieved a Master of Science in Periodontics. He served in the U.S. Navy as a dentist and was chosen to attend graduate dental studies at the school of his choice. Dr. Coffelt was a member of SDDS for 14 years.

PHILLIP M. GIN, DDS

Dr. Gin graduated from UOP Arthur A. Dugoni School of Dentistry in 1995. His general practice was located in Davis, where he also lived with his wife, Marlene. Dr. Gin passed away on October 10, 2009 after a battle with cancer. Dr. Gin was a member of SDDS for 10 years. ■

OUR CONDOLENCES

CYNTHIA A. MORIKONE

Born in 1976, Cyndi (daughter of SDDS member Dr. Abraham Morikone) unexpectedly passed away on April 28, 2010 at the tender age of 33. She will be remembered by her family and friends for her bubbling energy and passion for life. As a Georgetown class of 2004 graduate, she practiced law, focusing on helping those in need. Our thoughts and prayers are with the Morikones and their family.

MARY ROSA

Mary Rosa (mother of SDDS member Dr. Marty Rosa and grandmother of SDDS member Dr. Jeff Rosa) passed away in June 2010. Our thoughts and prayers are with the Rosas and their family. ■

YOU
THE DENTIST, THE BUSINESS OWNER

YOU ARE A DENTIST. You've been to school, taken your Boards and settled into practice. End of story?

Not quite. Are you up to speed on tax laws, potential deductions and other important business issues?

In this monthly column, we will offer information pertinent to you, the dentist as the business owner.

Tax Effects of the PURCHASE & SALE OF A BUSINESS

From **Craig Fechter** (Fechter & Co, CPAs, SDDS Vendor Member)

One of the most confusing issues any business owner will face are the tax consequences of the purchase or sale of a business. A related issue that can cause confusion is what the most advantageous ways to structure the transaction are so that both the buyer and seller benefit. Unfortunately, there are no easy answers as to what is the best way to structure the sale or purchase of a practice because there are so many possibilities that exist and a lot of them may depend on the personal circumstances of the buyer or seller. That being said, we'll present an example of a "routine" practice sale and analyze the tax consequences of the different allocations to the different components of a practice being transferred, and whether or not the buyer or seller are the ones that benefit from the respective allocation.

One of the most important concepts to keep in mind as we analyze a practice sale, is that the Internal Revenue Service (IRS) depends on a natural tension between the buyer and seller to see that items are not allocated to what would effectively be "double dipping" and having the maximum tax advantages go to both the buyer AND seller. A good example of this is the question of allocating the purchase price to goodwill or equipment. Typically, the purchaser of a practice will want to allocate the maximum possible amount to equipment as opposed to goodwill because equipment can usually be written off in the first year (under Internal Revenue Code Section 179), whereas goodwill must be written-off equally over 15 years. In the same scenario, the seller would like to allocate as MUCH as possible to goodwill as opposed to equipment because the sale of an intangible asset (in this case, goodwill) is considered a "capital asset" and as such, upon disposition of the "goodwill" the seller will realize a capital gain. Capital gains are subject to tax rates much lower than regular income tax rates (the maximum capital gains rate is 15% as opposed to a maximum individual tax rate of 35%). The sale of equipment will require that depreciation previously taken (which is usually fully taken) to be "recaptured" as ordinary income, taxable at the higher ordinary income rates! So you can see this natural tension helps to keep components allocated amongst assets at their respective fair market values.

Once a purchase price has been agreed upon, the wrangling of what to allocate to what components of a practice will begin. Without getting too much into the subject, how the purchase price is allocated is dependent on a number of tax and non-tax factors which involve the personal circumstances of the buyer AND seller. But in a typical practice sale, you might see a sales price of $500,000 being allocated amongst the following components as such:

Patient records and x-rays — $100,000

Goodwill — $200,000

Covenant not to compete — $35,000

Supplies — $15,000

Equipment — $90,000

Furniture & Fixtures — $60,000

The tax consequences on the purchase of the patient records, goodwill and covenant not to compete are the same. The purchaser of the business is required to amortize those items equally over a 15 year time period. That means the annual deduction that the purchaser would receive would be $22,333 (sum of the above items, divided by 15). The seller would receive capital gain treatment on the proceeds received from the sale of each of the above, which means the seller would be taxed at a rate of 15% of the gain recognized from the sale of the patient records, goodwill and covenant. Because the purchaser must amortize these "intangible" assets over a 15-year time period, and the buyer receives capital gain treatment, we can say that the seller receives the maximum tax benefit from the sale of the goodwill due to the fact the purchaser must amortize the costs over 15 years while the seller receives the benefit of lower tax rates.

The tax consequences of the sale of the supplies are in general good for the buyer and comparatively bad for the seller. Since supplies are consumable resources, and will have theoretically been used up by the end of the following year, the purchaser can IMMEDIATELY deduct the $15,000 allocated to the supplies. For the seller the answer is much different from the above: since the seller has presumably already expensed the supplies being sold, the seller is taxed at ordinary income rates (typically anywhere from 26–35% for a dentist) on the proceeds from the supplies.

One of the most important concepts to keep in mind as we analyze a practice sale, is that the Internal Revenue Service (IRS) depends on a natural tension between the buyer and seller.

The equipment and furniture being purchased are eligible for immediate expense recognition under Internal Revenue Code Section 179 as the Internal Revenue Code allows for up to $250,000 of immediate expense recognition on equipment and furniture being purchased and placed in service prior to the end of

the year (the State of California limits this amount to $25,000). This provision is particularly helpful to a first-time business owner as this will allow them to keep as much capital as possible by putting off paying taxes on the IRC 179 deduction until a future year while they adjust to life as a business owner. For the seller, however, it is a different story. Even though the assets being sold are "capital" assets, because the value of the assets were presumably already deducted against ordinary income, any depreciation deduction previously taken must be "recaptured" at ordinary income rates. Therefore, the seller here will have $150,000 of ordinary income taxed at ordinary rates on the sale (again, usually anywhere from 26–35%).

Another consideration is TIMING of the sale as well. One of the options a seller has is that of carrying part of the note due from the purchaser and accepting installments over a period of time. If the seller of the business accepts an "installment sale" from the purchaser, even though the purchaser of the business may realize all the tax benefits up front (the depreciation and amortization deductions) the seller may defer recognition on the sale of the business until the funds are actually received from the purchaser. Installment recognition may be preferable to the seller for a number of reasons, whether it be being in a lower tax bracket in a subsequent year, change in tax rates or large deductions in a following year.

As we have inferred before, perhaps the most important part of a practice purchase or sale is how much the practice is valued at and the personal circumstances of both the buyer and seller. However, hopefully we've given enough information so that you can appropriately assess your options when considering the tax consequences of a practice transition. ■

Are You Ready FOR A CHARTLESS FUTURE?

By **Terri Evans, RDA**
Digital Record Storage Solutions

How the dental practice manages dental records will change rapidly in the future. There is currently an initiative to create Electronic Health Records (EHR) for patients that could be accessed by all health care providers. The goal is for patient records to be available to all health care providers electronically, virtually anywhere in the country.

Why do we need a National Health Information Infrastructure? Computerized health care records will be accessible to all health care professionals (with the patients consent). All the patients' information will be in one place for all their health care providers to view. Providers won't have to rely on the patients' memory for important information. Such information includes:

- Allergies the patient may have to medication
- Medications the patient may be currently taking
- Premedication requirements
- Complete dental and medical history

As part of his plan to revive the U.S. economy, President Obama plans to invest billions of federal dollars on health information technology. This is not a new plan; it was initiated by President Bush in 1996. The federal National Health Information Infrastructure (NHII) has been formulating the parameters for this future. Chartless electronic records are not a choice. The year 2015 is only five years away, which can seem far until one remembers 2000, when the Y2K computer update was supposedly going to create computer failure. Computers needed upgrades to insure "00" meant "2000," not 1900. As 2000 approached, finding qualified technicians became a concern for those who waited.

Most corporations, businesses and governments are interconnected with computers. Yet adoption in health care has been slow. Hospitals, physicians' offices and other health–care providers are moving in this direction, yet dentistry is moving much slower. Very few offices are prepared for 2015 deadline. Approximately 25% of practices are using computers chairside and only 1% of dental offices are completely chartless.

"Chartless" is not "paperless." It is not realistic to think that dental offices can operate without paper. Almost all dental offices have paper documents that need to be retained at least as long as state and federal laws dictate, usually seven years. These include the following documents:

- Financial information
- Confidentiality Statements
- Patient treatment information with original patient signatures

With today's digital technology, these documents, including x-rays, can be digitally stored indefinitely. Digital storage is the recommended form of document storage according to the California Dental Association (CDA) guidelines. Items that are stored electronically can also be submitted to the NHII database as needed and required.

2015 is not as far off as it seems. Take steps now to be ready for the change. ■

september

14 **Sleep Disorders, Sleep Medicine & Dentistry**
Peter Chase, DDS
6:00pm–9:00pm • 2 CE, core
New Member Night

21 **Navigating the Wage & Hour Minefield**
California Employers Association
Noon–1:00pm • 1 CE, 20%

23 **Hiring & Firing Bootcamp**
Mari Bradford
(California Employers Association)
6:30pm–8:30pm • 2 CE, 20%

october

8 **Adult Conscious Sedation: Recertification Course**
Michael Silverman, DMD (DOCS)
8:30am–4:30pm • 7 CE, core

12 **Crown Lengthening for Restorability & Esthetics**
William Lundergan, DDS, MA
6:00pm–9:00pm • 2 CE, core
CDA Night

22 **Licensure in a Day**
Infection Control, CA Dental Practice Act, OSHA Update
LaDonna Drury-Klein, RDA, CDA, BS
8:30am–3:30pm • 6 CE, core
LR

28 **Bras, Boyfriends & Tattoos (HR Issues)**
Mari Bradford
(California Employers Association)
6:30pm–8:30pm • 2 CEU, 20%

november

5 **"Esthetics in Action" Clinical Techniques, Materials & Technology**
Ross Nash, DDS
(for doctors & assistants — 4 hours)

Win the Battle Against Biofilm: Leverage the Power of Ultrasonics
Karen Hays, RDH
(for hygienists — 4 hours)

On Target: Creating Systems for Success
Cathy Jameson, CEO
Jameson Management Group
(for all — 1 hour)

8:30am–1:30pm • 4 CE, core / 1 CE, 20%

6 **CPR Renewal: Basic Life Support (BLS)** LR
8:30am–12:30pm • 4 CE, core

9 **Patient First — Maximize Every Interaction**
Debbie Castagna & Virginia Moore
6:00pm–9:00pm • 2 CE, 20%
Staff Night

17 **Investigating Employee Misconduct**
California Employers Association
Noon–1:00pm • 1 CE, 20%

december

7 **Annual Holiday Party, Silent Auction & Installation of Officers**
Del Paso Country Club
6:30pm

january

8 **CPR Renewal: Basic Life Support (BLS)** LR
8:30am–12:30pm • 4 CE, core

11 **Shift Happens: Incorporating New Protocols into Practice**
Kristy Menage Bernie, RDH, BS, RYT
6:00pm–9:00pm • 2 CE, core
Hygiene Night

13 **2011 Labor Law Update**
California Employers Association
Noon–1:00pm • 1 CE, 20%

february

3 & 4 **31st Annual SDDS MidWinter Convention & Expo**
Sacramento Convention Center

LR ***Licensure Renewal Course:*** *The Dental Board of California requires CPR BLS Renewal (AHA or Red Cross approved), two hours of Infection Control and two hours of California Dental Practice Act for each license renewal cycle.*

cale

= General Membership Meeting • = Member Forum *(Business Series)* • = Continuing Educati

2010–2011 Calendar of events

march

4 **Removable Partial Dentures: Clinical Considerations**
Alan Carr, DMD, MS
8:30am–1:30pm • 5 CE, core

8 **Skin Cancer — Diagnosis & Treatment**
Barbara Burrall, MD
6:00pm–9:00pm • 2 CE, core
Spouse Night

18 **Build Your Employee Handbook**
Mari Bradford (California Employers Association)
8:30am–12:30pm • 4 CE, 20%
HANDS-ON COURSE SPACE LIMITED

24 **The Numbers of Your Practice: The Good, The Bad, Avoiding the Ugly**
John Urrutia, CPA (Mann, Urrutia, Nelson, CPAs)
6:30pm–8:30pm • No CE

april

2 **CPR Renewal: Basic Life Support (BLS)**
8:30am–12:30pm • 4 CE, core
LR

8 **Crown Lengthening for the General Practitioner**
Partially Sponsored by Brasseler U.S.A.
Timothy Hempton, DDS
8:30am–1:30pm • 5 CE, core
HANDS-ON COURSE SPACE LIMITED

12 **Turn it On & Off: What's New in Local Anesthesia**
Alan Budenz, MS, DDS, MBA
6:00pm–9:00pm • 2 CE, core
Recruitment Night

19 **Top 10 SDDS Hotline Questions**
California Employers Association
Noon–1:00pm • 1 CE, 20%

21 **Practice Management: Straight Talk About Balancing it All**
Gayle Suarez (Dental Management Solutions)
6:30pm–8:30pm • 2 CE, 20%

may

6 **SDDF Annual Golf Tournament**
Turkey Creek Golf Club

10 **Infant & Early Childhood Care**
Jeffrey Wood, DDS
6:00pm–9:00pm • 2 CE, core
Foundation Night

14 **Right in Your Own Backyard**
Speaker: SDDS Members
8:30am–12:30pm • 4 CE, core

20 **CA Dental Practice Act & Infection Control**
LaDonna Drury-Klein, RDA, CDA, BS
8:30am–12:30pm • 4 CE, core
LR

june

25 **CPR FULL COURSE: Basic Life Support (BLS)**
8:30am–1:30pm • 5 CE

DON'T FORGET! Your 2010–11 Program at a Glance details all the info you see here in a convenient pocket-sized format!

For more information on SDDS events, visit:

www.sdds.org

on • = HR Audio Conference • = CPR • = Special Event • = MidWinter Convention

SACRAMENTO DISTRICT DENTAL SOCIETY FOUNDATION

A CHARITABLE 501-C3 ORGANIZATION

SFK & SFBK FINAL STATISTICS

SMILES FOR KIDS

FINAL STATISTICS

Total screened: **27,679**

Total treated: **1,007**

Total volunteers: **858**

Total $$$ donated: **$1,100,000**

SMILES FOR BIG KIDS

FINAL STATISTICS

Total screened: **286**

Total treated: **135**

Total volunteers: **104**

Total $$$ donated: **$285,657**

ADDITIONAL SDDF MEMBERS

(since May 2010 *Nugget* Listing)

DENTIST MEMBERS

Sean Avera, DDS, MS
Paul Binon, DDS, MSD
Robert Burkhard, DDS
Kevin Chen, DMD, MS
Regina Cheung, DDS
Teresa DeGuzman, DMD
Pamela DiTomasso, DDS
Gordon Douglass, DDS
Timothy Durkin, DDS
James Everhart,
Diana Fat, DDS
Kenneth Fat, DDS
David Feder, DDS
Thomas Fong, DDS
Kenneth Fox, DDS
Jerome Gutterman, DDS
Nicky Hakimi, DDS, MSD
Neelofar Khan, BDS
David Lewis, DMD
Steve Longoria, DDS
Nancy Luu, DDS
Daniel Miyasaki, DDS
Kenneth Moore, DDS
Megan Moyneur, DDS
Gary Newhouse, DMD
Philip Quinley, DDS
Ronald Rott, DDS
Adrian Sarchisian, DDS
William Schaedler, DDS
Kathleen Shanel, DDS
Waleed Soliman, DDS
Victoria Sullivan, DDS
Jun Tanimoto, DDS
Scott Thompson, DDS
Jeffrey Vernon, DDS
Chang Vong, DMD
David Wong, DDS
Dennis Wong, DDS
Peter Worth, DDS
Thomas Yamamoto, DDS

ASSOCIATE MEMBERS

Stephanie Cripe
Paige Moyneur
Elaine Schaedler

FOUNDATION BOARD NOMINATIONS:

SDDF BOARD OF DIRECTORS:

Matthew Campbell, DDS *(2011–2012: 2nd term)*
Adrian Carrington, DDS *(2011–2012: 1st term)*
Kelly Giannetti, DMD, MS *(2011 only)*
Gordon Harris, DDS *(2011–2012: 2nd term)*
Kevin Keating, DDS, MS *(2011–2012: 1st term)*
Dennis Peterson, DDS *(2011–2012: 3rd term)*

ELECTION
September 14, 2010

EXISTING BOARD MEMBERS CONTINUING 2011 TERM:

Robert Daby, DDS (Treasurer) • Robert Gillis, DMD, MSD • Victor Hawkins, DDS
Gayle Peterson (Associate Member) • Damon Szymanowski, DMD (Golf Chair) • Wesley Yee, DDS

SACRAMENTO DISTRICT DENTAL FOUNDATION DOES...

broadway

OCT. 6 2010 — BURN THE FLOOR

NOV. 11 2010 — IN THE HEIGHTS

MAR. 16 2011 — 9 to 5

APR. 20 2011 — YOUNG FRANKENSTEIN

JUNE 2 2011 — MARY POPPINS

BEING SOCIAL

NEW FEATURE! Engage social media marketing to establish branding, build your practice and protect your reputation

Your Practice & Facebook

By Michael Haverhais
Reprinted with permission,
San Mateo County Dental Society

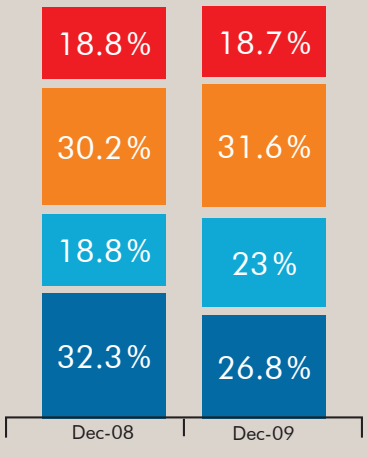
Why you need to care about Facebook...

We've seen a growing response to our posts about Facebook over the past year, and are excited to see doctors beginning to realize what Facebook can do for their practices. Still, the number #1 question we get when we say "Facebook" is something along the lines of "yeah, my kids are on it… but what does it have to do with my practice?" Here's a simple explanation of why you should care about Facebook…

It's not just the 'kids' on Facebook — it's your patients!

The numbers don't lie — the largest group of Facebook users are 35–49 years old:

Also take into account that over 40% of North Americans use Facebook. That's over 120 million patients — some of which are surely your own.



Visitors to Facebook by Demographic Segment

Facebook users refer services

About a month ago, Facebook released their 'like button' to provide a simple way for websites to promote themselves via Facebook. Since then, over 100,000 websites have jumped onboard because they realize the potential for word-of-mouth referrals via Facebook. Here are a few stats from some of the more notable sites:

- ABC News increased Facebook referrals 250%
- IMDB.com has seen it's users create 350,000 word-of-mouth referrals on Facebook
- NHL.com has reported an 80% increase in visits referred from Facebook

Facebook users are loyal

For websites that fully integrate with Facebook via Facebook Connect, patient engagement is even better. Job search engine SimplyHired.com has found that job-seekers logged into Facebook while on SimplyHired.com use the site's services twice as much as a non-Facebook visitor. Plus, when a website integrates fully with Facebook, it allows patients to have their comments distributed to all of their friends on Facebook as a genuine word-of-mouth referral. It's the exact same word-of-mouth marketing you've used for years at your own practice, only scaled 100x via the Internet!

Facebook Features for Your Practice

Earlier this year, Facebook unseated Google as the most visited website in North America this past month. Well, it turns out they have additional plans to take over the entire Internet and make it more social. Here are a few of the features they've released in the past month on their quest for world domination…

Along with basic profile pages for yourself, and fan pages that you've hopefully set up for your practice, Facebook has hinted at 'place pages,' a la Google Places (formerly Google Local). Naturally, this would be a great benefit to any doctor wanting to create a profile for their practice alongside their fan page. While this likely won't be a very effective way of reaching out to new patients, it should serve to help you claim your name on search engines like Google.

A simple feature they have added is the ability to put a 'like button' on any website. This will allow websites that aren't fully integrated with Facebook to still utilize a bit of Facebook's social networking power. By including a 'like button' on your own website, Facebook users can share with their friends that they like your website (and, intuitively, your practice). So, now's a pretty good time to call up that website company you've paying $100 a month to sit around and do nothing, and tell them to get you a 'like button' on your website ASAP!

For any of you wanting to harness the real power of Facebook and its ability to automate your word-of-mouth referrals there's still Facebook Connect, which will also allow for other websites to fully integrate with Facebook. Without getting too technical, it basically allows for any user generated content (i.e. a review of a doctor) posted to a website to be automatically shared with the user's network of Facebook friends.

Instead of a 'place page' that advertises your practice or a 'like button' that leads back to a website that tends to be a bit salesy, Facebook Connect allows for reviews to seamlessly be sent directly from your patients to their friends as genuine word-of-mouth referrals. True word-of-mouth referrals like those you've built your practice on over the years – not just another Internet marketing scheme! Behold the transparent power of Facebook, and why its movement to bring authenticity online will be the greatest thing to happen to your marketing since the water cooler.

Facebook's Privacy Settings & Your Practice

As doctors begin to understand how to put Facebook to work for their practices, we've ▶

started getting more questions about how to manage your privacy on the social networking site. These are great questions since, as a doctor with your name as your brand, you have both a personal and public persona you need to manage online. Here's how to go about it…

Privacy Settings

Facebook's privacy settings have been in the news lately, since they recently introduced a load of new configuration options. The rationale behind this was to give users more granular control over who-could-see-what on their Facebook profiles. Unfortunately, this meant that users had to now go in and configure these options from the default (public) settings to custom (private) settings in order to keep their personal info private.

As you may expect, this caused for a backlash from users that has already led Facebook to agree to making privacy settings simpler in their next update. Still, even with this minor inconvenience, Facebook still enables users to keep everything on their profile private from public eyes — enabling you to have a personal profile invisible to your patients.

Facebook Pages

Now that you've configured the privacy settings on your personal profile to avoid prying eyes, it's time to put Facebook to work for your practice. One way to do this is to create a Facebook Page (aka Fan Page) for your public persona as the rockstar of a doctor you are! Creating a Facebook Page allows you to have a Facebook profile that gives a professional view of you and your practice that patients can view and use to communicate with you.

Because your Facebook Page is public, it also allows search engines like Google to include it in their search results. Now, when patients type your name into Google, the results will also show your Facebook Page — not just another third-party website filled with unverified reviews and ads for other doctors. ■

Michael Haverhais is with DoctorBase (www.DoctorBase.com), an employee owned company in San Francisco that's passionate about creating easy ways for patients and doctors to communicate. They provide educational updates for doctors on how to utilize the Internet to improve practices and patient communication.

DONATIONS NEEDED!

The Effort
The Family Lifeline Since 1953

Children's Dental Clinics Opening!

The Effort's Oak Park Children's Dental Clinic is opening in August with the other two clinics (North Highlands and Rancho Cordova) opening the early part of next year. Dr. Cassie Krupansky, Dental Director and SDDS member, still has some equipment needs and would appreciate donations. It is preferred that items be no older than 10 years and in good working condition.

Wish list for The Effort:

EQUIPMENT & INSTRUMENTS:

- Digital Pano machine
- Patient Chairs
- Doctor and Assistant Stools
- X-ray chair
- Steam Autoclave
- Large Ultrasonic Cleaner
- Vacuum
- Compressor
- Waiting room chairs
- Composite/Amalgam instruments
- Instrument Cassettes
- Extraction instruments
- Curing lights
- Amalgamators
- Cavitron
- Composite guns

MATERIALS:

- 2% Lidocaine with 1:100,000 epi
- Fluoride varnish or gel
- Topical
- Toothbrushes
- Prophy paste
- Stainless steel crowns
- Orthodontic bands

To make a donation or for more information, please contact either of the following:

Dr. Cassie Krupansky (cjkrupan@gmail.com)

The Effort (916.233.4925)

YOU'RE BEING **GOOGLED**

Learn four steps to build and manage your online identity

By **Maren Finzer**, *(Maren Finzer Personal Branding & Creative Marketing)*

In today's new global marketplace, it's essential for you to build and proactively manage your online identity. Whether a potential patient is searching out a new dentist in their area, researching a dentist by specialty, or perhaps they met you at a local event and want to know more, whatever the case, you count on being Googled. Google is used over 200 million times a day by people in virtually every country in the world. People are making decisions and forming impressions about you based on what they find online. And they are people who matter. Google is now the best source for discovering your untold story!

Many studies show that your personal reputation is an important part of your practice's reputation.

So, when you Google yourself, what's revealed about you? Does your online identity accurately represent you the way you want to be known? If you don't show up in Google, do you exist? What if your Google results are unflattering and inconsistent with how you want to be known?

Your online presence is crucial to your successful business and professional success. Here are 4 steps you can take to increase your visibility and credibility, and begin building and managing your personal online identity:

Step 1: Know what's out there

First, you need to Google yourself. Type your name in quotes, like this: "Maren Finzer" to determine where you stand. What comes up?

We've learned that when somebody Googles you, they use two measures to decide what they think about you. One is volume. If there's tons of stuff about you, it makes them believe that you must have something to say.

The second thing they look at is relevance, which is how clearly the results communicate your personal brand and what you want to say.

Ideally, what you want to find are lots of results about you that reinforce your brand. Is it consistent? Is it easily understood? Does it clearly separate you from your competitors and peers?

Fortunately, this is easy to improve by creating the online profile you need to express, in order to bolster your personal brand and target your goals.

Step 2: Know how you want to be known

Before building your online reputation, you need to know what you want your Google results to look like. You must uncover and clearly define your personal brand by being able to answer these questions:

- What do you want people to know you for?
- What makes you stand out?
- What is your area of thought leadership, or expertise?
- What words would people use to describe you?
- Who is the specific target audience that needs to hear your message?

You want your personal brand to be injected in everything you do, and you need to focus on that every step of the way.

Step 3: Clean up the dirt

If there is negative or inappropriate content about you online, which might include photos and comments that conflict with how you want to be known, and hinder your reputation, we call that digital dirt. You need to vacuum it up. Self-posted dirt can easily be removed by you. If you posted it, simply take it off.

If someone else posted it, it can be more difficult to remove. Sometimes you can ask the site-owner to remove it, and they will. But it's not always that easy. If it's in a major high-ranking publication, such as the New York Times, most likely it's there to stay.

One option is to create high-ranking entries that reinforce your brand, and will push the dirt down. Most people won't look past page 3. You can create these entries by following the six P's in the following step.

Step 4: Build your online identity using the 6 P's

You can start with one post, one profile or one article. Take what you're already doing in the real world that communicates how you want to be known, and think about ways you can repurpose it for the online world to increase your visibility. Here are 6 things you can begin to do today:

PUBLISH — Create great content that is interesting and helpful, and showcase your expertise online. Repurpose material that you may already have offline; you've already worked hard to create it, so reuse it by introducing it in the virtual world.

- Build your own website — It's easy to create your own website on typepad.com or wordpress.com. This is the best way to ensure your online brand says what you want it to say. It serves as your home base to all your social networking activities.
- Create a blog — This is a great way to share your expertise, and to connect, engage, and interact with patients while building strong relationships.
- Video — Video is the hottest new trend, and video stands a much better chance than your text pages of being shown on the first page

Google results. You Tube ranks high with Google, so post your "on brand" videos. Keep them short and keep them relevant.

- Presentations — are you already recognized for giving powerful and compelling presentations? If so, upload them to Slideshare.net and let everybody see them.
- White papers and articles — if you've already created lots of content that may not be online, here is an opportunity to simply update them and publish them on websites, or in article banks such as ezinearticles.com. Publish the content that connects with your target audience, and become a thought leader in that area.
- E-book — writing an e-book will take some time, but the rewards are immense. If you enjoy writing, an e-book can be colorful and easy to read, much more so than a white paper. Make sure it has remarkable content and think about giving it away for free; it can go viral almost overnight.

POST — Write reviews of relevant books and post them on amazon.com or barnesandnoble.com. If your area of specialty is 'oral pathology,' don't confuse your brand by writing about something totally unrelated, but try to integrate it into each review.

PONTIFICATE — Go to technorati.com or blogsearch.google.com and search for blogs that align with your area of expertise. Subscribe to them, and when a new post is made you will be notified. Commit to regularly posting comments that are helpful, valuable and interesting, and this will demonstrate your knowledge and become part of your online identity.

PUBLICIZE — Don't wait for someone else to write a press release about you. Companies do it for themselves, and so should you. Announcing your special recognition, a speaking engagement at an event, or a new partner or alliance are just a few ideas.

- pressrelease365.com
- prweb.com
- i-newswire.com
- prleap.com
- free-press-release.com
- prlog.org

PARTNER — Connect and build relationships with others that you share something with, and leverage social networking sites to build your identity. Don't try to do them all, but pick one or two and learn their features and how to use them efficiently.

- Facebook
- Twitter
- YouTube, Viddler, Vimeo
- Flickr, Photobucket
- Slideshare, Squidoo
- LinkedIn

PROFILE – Create a fun, memorable and magnetic bio, and add it to your profile sites to assure people will find the right information about you:

- google.com/profiles
- zoominfo.com
- naymz.com
- businesscard2.com
- ziggs.com
- visualcv.com
- ning.com

Building and managing your online identity is an ongoing process, and you need to commit to being steadfast in maintaining it. You will find your Google results are changing all the time, so be sure to monitor them on a regular basis. Subscribe to Google Alerts for your name (google.com/alerts) and set up a weekly time to Google yourself. This way, you'll be the first to know each time you show up online, and you will remain "on brand" even as the information changes.

Does your online identity accurately represent you the way you want to be known?

It's no longer a luxury; it's essential for you to build and continuously manage your on-line identity. A 2009 study done by Microsoft reveals your positive online reputation matters, although many underestimate the impact it has. Get a step ahead and start to manage it today, before someone else does! ■

Maren Finzer couples her energetic personality and drive for excellence, with over 20 years of business and marketing experience, to help entrepreneurs and mid-sized businesses seize the opportunity to attract, engage and increase customers building their unique online and real world brands. Maren can be reached at ***maren@marenfinzer.com*** *to receive your complimentary online brand assessment. Or connect at* ***www.marenfinzer.com.*** *(Maren is also an OSU Beaver!)*

YOU
THE DENTIST, THE EMPLOYER

YOU ARE A DENTIST. You've been to school, taken your Boards and settled into practice. End of story?

Not quite. Employee evaluations, hiring and firing, labor laws and personnel files are an important part of being an employer. Are you up on the changes that happen nearly EVERY January 1st?

In this monthly column, we will offer information pertinent to you, the dentist as the employer.

Dishing the Dirt
ON FACEBOOK

From **Toni Talbot (Human Resource Management Services)**

Question: *My daughter told me that she was on Facebook and found out one of my employees had made some disparaging comments about my practice, her co-workers, and some of my patients. She must have forgotten that she had "friended" my daughter. These negative comments must have had to be seen by a lot of people, including my patients.*

What, if anything, can I do? I feel a bit violated. It is one thing to complain to your friends or family, even to your co-workers, but she's posted her complaints for all the world to see. What can I do? I can't stop her from using Facebook, but do I have the right to stop her from making these comments against my practice, my staff and especially my patients?

Answer: An attorney once told me that a person may have the right to free speech, but you also have the right to protect your reputation.

What can you do about this employee? You certainly have some options. For starters, as an at-will employer, you have the ability to address her actions through discipline, including termination. But you may first want to consider your other options.

Do you have a policy in place that served notice to your staff that these actions are not acceptable, and that if employees do such things, there will be consequences? While it should be "common sense" that her comments would not be acceptable – you cannot count on the fact that the employee has any concept of the impact of her actions.

Employees need to know, especially in a service position, that they are the face of the practice, and although they are not at work all the time, they represent the practice to the community at all times. While they may see Facebook as something that's private, it really is very public. This particular employee's comments may have caused harm to your practice, and consequently you maintain the right to address this potential harm.

The best way to address this problem is to expand your technology policy (if you have one) to include language that address social networking. This is done through a policy that specifically addresses content in an employee's social networking sites. This policy should address:

- restriction of the content of individual social networking sites — no comments about the practice, co-workers, patients, and vendors;
- restriction of use during the work day — limited to business-related activities;
- no identification of the practice, such as the logo;
- defining the practice's use of the networks for marketing and communication;
- addressing excessive time spent on non-productive activities — including time spend on Facebook and other social media during work time;
- notification of management when employees have knowledge of any aspect of a violation of this policy;
- addressing consequences for failure to comply.

You will certainly get complaints from your staff: *"How can you restrict what I say on my Facebook page?" "You're invading my privacy!"* Just remember, you're not restricting what they say unless they are writing comments about you, your practice, your staff or your patients.

Yes, you can fire her, you can formally discipline her or you may want to consider a documented coaching session, where she is advised of the impact of her actions on the practice. Tell her that this will not be tolerated in the future. If she has been a good employee, this may be an opportunity to learn why she is unhappy, what problems she is having and how these problems can be addressed.

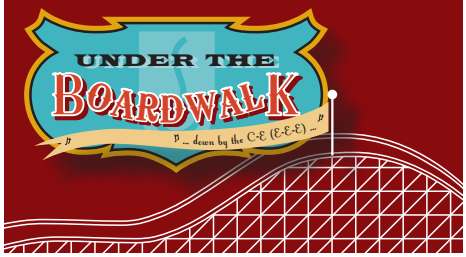
At the end of the day, you should look at the whole picture and then make the decision on how to handle her. No matter what you do with this employee, you will need to make sure that you implement a policy that addresses social networking and that you have a means to administer the policy. ■

Reprinted with permission from Michigan Dental Association. Toni Talbot can be reached at ***tonitalbot@hrmservices.biz.***

Link of the Month

Catch a wave with MidWinter 2011!

www.sdds.org/MW2011.htm



TRUSTEE REPORT

Kevin M. Keating, DDS, MS
Don P. Rollofson, DMD
CDA Trustees

BARRIERS TO CARE

It is anticipated that in the next few years, California likely to be the next arena for legislative attempts to address the needs of those who have access to health care barriers. The Trustees have been studying alternative strategies for oral health care delivery that may serve those in need in our state. Studying educational strategies, the Trustee received a presentation by the Dean of the Arizona School of Dentistry regarding their dental school's educational model that addresses the nurturing and training of new dentists to serve in areas of need. The Arizona model has the senior students spending half of their last year working in Public Heath Dental Care centers around the country.

The Trustees recognize we need to have well prepared strategies for solutions to access to care issues. We have learned from the 8 other states that have preceded us that we need to have answers for how to solve the many and varied aspects of need driven health care delivery that our current models do not address. We have learned that without meaningful answers we could be left out of the debate as occurred in Alaska, Minnesota, and the New England states.

There are two well financed lobbying groups funded by the Kellogg Foundation and Pugh Charitable Trust which have been very effective in achieving their goals of changing work force models in other states. It is their goal to provide better care to those that are underserved by breaking down current barriers to care. Because the ADA Policy prevents the ADA discussing alternative models, they have been excluded from participation in the legislative discussions. Other State Associations had as their only strategy, we don't want or need other models, and consequently were not included in the debate.

Without an extremely well informed association, we as individual dentists are ill prepared to participate in the discussions regarding solutions when the legislature begins considering Barriers to Care. It is the Trustees' position that while we might personally not wish for any changes to our model, we have to be prepared with alternative models for oral health care delivery that maintain the Dentist at the head of a potentially expanded health care delivery system. We know that there are many other interest groups that have models for alternative oral health care delivery that would mean the Dentist would not have oversight of that health care provider. There is not just one aspect to the barriers to care, so there is not just one solution that will need to be provided. CDA is trying to develop a basis of information so we are better informed to represent its members. Other state dental associations have lost the right to control the debate regarding the solutions to the Barriers to Care by their behavior and strategies employed when the legislative solutions were moved through their legislatures. CDA's goal is to have the members' back.

MICRA discussion

MICRA legislation has protected your ability to obtain Malpractice Insurance over the past 30+ years. The MICRA legislation update was given by Lisa Maas, the executive director of Californians Allied for Patient Protection. This organization was established by Health Care organizations in the 1980s to ensure continuation of MICRA's legislative protection of our ability to obtain Malpractice Insurance that is affective and affordable. For those who do not recall, in the mid-1970's there was a Malpractice insurance crisis where the claims experience and escalation of insurance costs drove most malpractice carriers out of business in California.

SAN DIEGO SCHOOL OF DENTISTRY

The Dean of Arizona School of Dentistry spoke about their interest in establishing a new Dental School in San Diego. The educational model would employ the same model used at Arizona. This is in the very early stages of discussion and site selection. If San Diego does not work out, how about Sacramento? ■

ABSTRACTS

THANKS, DR. BONK!

Who is RTB?

Roy T. Bonk, DDS has been submitting material for the Abstracts column since 1987. He says it's just his way of contributing to the continuing education of SDDS.

Dr. Bonk grew up in Waukegan, IL, located on the shores of Lake Michigan. He attended college and dental school at Marquette University in Milwaukee. While at dental school, he became friends with SDDS member Thomas Adamson, with whom he graduated in 1964. At Marquette, Dr. Bonk also met his future wife, Jeri, who was studying hygiene. After graduation, he served as a captain in the Air Force for two years in a dental intern program.

Dr. Bonk and his Jeri moved to Sacramento upon completion of his Air Force internship, and has practiced dentistry in Citrus Heights ever since. In addition to being a 44-year member of SDDS, CDA and ADA, Dr. Bonk is a member of the American Equilibration Society and Society of Dentistry for Children. He is also a diplomat of the American Academy of Dental Orthopedics and the International Association for Orthodontics.

Dr. Bonk and his wife enjoy spending time with their children and grandchildren, sailing, whale watching and golfing.

After 23 years of providing Abstracts for the *Nugget,* Dr. Bonk has retired, and therefore so will the Abstract column.

Thank you, Dr. Bonk, for doing such a fantastic job for so many years. You will be missed! ■

VENDOR MEMBER SPOTLIGHTS

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- **Web-Based Reporting:** STRAINE offers virtual onsite consulting through its unique online service, StraineOnline.

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- Patient education materials
- Children's Dental Health Month materials
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VENDOR MEMBER A

VENDOR MEMBER B

ADVERTISER INDEX

NOTICE OF ANNUAL MEETING & ELECTIONS

Elections to be held at General Meeting September 14, 2010

SDDS EXECUTIVE COMMITTEE

President: Wai Chan, DDS
President Elect: Victor Hawkins, DDS
Treasurer: Gary Ackerman, DDS
Secretary: Kelly Giannetti, DMD, MS
Immediate Past President: Terrence Jones, DDS

BOARD OF DIRECTORS

Jennifer Goss, DDS *(2011–2012: 1st term)*
Wallace Bellamy, DMD *(2011–2012: 1st term)*
Dan Haberman, DDS *(2011–2012: 2nd term)*
Viren Patel, DDS *(2011–2012: 2nd term)*
Kim Wallace, DDS *(2011–2012: 2nd term)*

EXISTING BOARD MEMBERS CONTINUING 2010–11 TERM:
Craig Johnson, DDS • Ken Moore, DDS
Brian Royse, DDS • Carl Hillendahl, DDS

TRUSTEE

Kevin Keating, DDS, MS *(3rd term, 2011–13)*

EXISTING TRUSTEE CONTINUING 2009–11 TERM:
Don Rollofson, DMD

___ *I approve the above slate for SDDS Executive Committee and Board of Directors*
___ *I DO NOT approve the above slate for SDDS Executive Committee and Board of Directors*

DELEGATES TO THE CDA HOUSE OF DELEGATES

(2 year term, 2010–11):
(please vote for 4)
___ Matt Comfort, DDS
___ Craig Johnson, DDS
___ Ken Moore, DDS
___ Kim Wallace, DDS

EXISTING DELEGATES CONTINUING 2009–10 TERM:
Nancy Archibald, DDS • Adrian Carrington, DDS
Viren Patel, DDS • Robert Gillis, DMD, MSD

SDDF BOARD OF DIRECTORS:

Matthew Campbell, DDS *(2011–2012: 2nd term)*
Adrian Carrington, DDS *(2011–2012: 1st term)*
Kelly Giannetti, DMD, MS *(2011 only)*
Terrence Jones, DDS *(2011 only)*
Gordon Harris, DDS *(2011–2012: 2nd term)*
Kevin Keating, DDS, MS *(2011–2012: 1st term)*
Dennis Peterson, DDS *(2011–2012: 3rd term)*

EXISTING BOARD MEMBERS CONTINUING 2011 TERM:
Robert Daby, DDS (Treasurer) • Robert Gillis, DMD, MSD
Victor Hawkins, DDS • Gayle Peterson (Associate Member)
Damon Szymanowski, DMD (Golf Chair) • Wesley Yee, DDS

___ *I approve the above slate for SDDF Board of Directors*
___ *I DO NOT approve the above slate for SDDF Board of Directors*

In accordance with the bylaws…

ADDITIONAL NOMINATIONS: Any active or life Member in good standing who meets the qualifications of the office he/she is seeking may be nominated by filing with the Secretary at least 30 days prior to the annual election a written nomination signed by at least ten (10) active or life Members in good standing.

Deadline: August 14, 2010

SAMPLE BALLOT • SAMPLE BALLOT • SAMPLE BALLOT

COMMITTEE CORNER

YOU ASKED FOR THIS!

Nugget Survey 2009

Dental Health Committee:
1ST TOOTH OR 1ST BIRTHDAY

By **Chester Hsu, DDS** & **Cindy Weideman, DDS**

"Every child should have a dental home by age one."

This is the "across-the-board" recommendation from both dental and medical establishments, yet we are still seeing hundreds of children with ECC (Early Childhood Caries) in the Sacramento region. The SDDS Dental Health Committee formed an Infant/Toddler Oral Health Access subcommittee in recent months to tackle the issue of creating an infrastructure within our collective membership to increase access for age one infants into the oral healthcare system.

The subcommittee has reviewed the barriers faced by GP's, and hopes to overcome them by providing the information, tools and resources necessary to help and encourage any members willing to see infants in their offices, and to persuade those providers that may be "on the fence."

No provider is expected to deliver comprehensive care for these children unless they choose to. Anyone can perform an easy lap exam and then refer the infant with carious lesions to a pediatric dentist or GP who sees kids. The goal is to create a consistent pathway for these young patients to find the dental home they deserve.

Volunteering to take a "peek" inside an infant's mouth and giving caregivers the information they need to prevent ECC is very rewarding. Parents will be grateful that you provide this service for them and will likely form an even closer bond of trust and respect with you. The SDDS wants to add your name to their list of dentists who do infant exams and refer infants and their parents to you. This is a win-win situation. If seeing young children simply isn't your cup of tea; at least refer them out to an appropriate dental home by age one. Too often the public is given the wrong message that a child's first dental visit should be at age three, or even age five. ***This information is outdated and not in the best interest of our patients.***

A child is affected in some way for the rest of their life if they begin with a mouth full of decay. Please join our effort in preventing this from happening to another undeserving infant.

Here are some links that provide some of the basics tools and resources necessary to start doing infant exams in your practice:

Please view the Infant Oral Exam demonstration video on the University of Iowa Department of Pediatric Dentistry — Educational Videos Main Page:

http://www.dentistry.uiowa.edu/pediatric/peds_videos/index.shtml

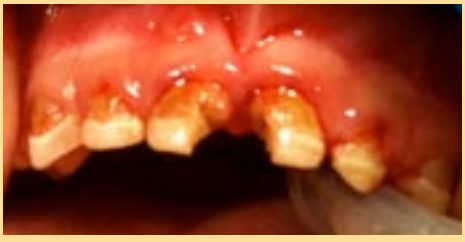
Here is a link to a Caries Risk Assessment form put forth by the First5 Oral Health:

http://www.first5oralhealth.org/library/download.asp?id=1578

Here is a link to an archived *CDA Journal* article from October 2007 with an anticipatory guidance chart, caries risk assessment form, risk-based treatment recommendations chart, and much more:

http://www.cdafoundation.org/library/docs/jour1007/ramos.pdf

There will be more on this topic in the future. Stay tuned! ■



Two-year-old child with severe Early Childhood Caries (ECC)

Ethics Committee:

The Buck Stops Here

Alice Huang DDS
Dental Director
Sacramento Native American Health Center

Does your office give you the authority to treatment plan? Do you get to explain options to your patients? Can your office manager act as if they are a dentist and tell you how to do your dentistry?

In this bad economy, new dentists find themselves challenged by corporate dentistry that insists on teaching only how to make money. How is success measured and at what cost? For some dentists, their success means production. The only thing that matters is the patient signing the treatment plan that your treatment planning coordinator collects and schedules the patient's next appointment.

How wonderful is it when the guilt is out of your equation and your patients potentially may have purchased an unnecessary treatment plan? You may think that you are not involved, but what you forget is you are the dentist who carries out the dentistry. You have a license that you may lose. Is your manager's only objective is to make the company money? Think twice when receiving your next achievement award at corporate parties as top producing dentists while your peers require improvements or are fired. Your corporation may have labeled your peer as practicing below the standards, but what they may actually be doing is punishing them for unwillingness to participate in overtreatment dentistry.

We all like paying off our student loans early but is it worth ruining your reputation as a care provider? If you think that is how everyone is practicing dentistry, you are wrong.

New graduates beware: large corporations aim at recruiting those desperate for jobs in this bad economy. They lure graduates in with promise contracts and money only to mold these new dentists to practice the way they want. After several months of "coaching" under the corporation umbrella, these new dentists often forget about ethics and the true standards of practice.

Do the right thing and present the treatment that is in the best interest of your patient. Too many dentists are aware that there is a plethora of over diagnosing and treatment planning of unnecessary upgrades. It is unfortunate to think that a corporate policy may trump our professional opinion at work. Remember to follow the "Code of Ethics" taught to us in dental school by not letting others decide your treatment plans and dictate how you do your dentistry. ■

WE'RE BLOWING YOUR HORN!

CONGRATULATIONS TO...

Dr. Paul Binon, for his lecture presented at Indiana University on June 13th entitled, "Zygoma Immediate Implant Placement and Restorative Treatment." The focus of the three-day John F. Johnson Advanced Prosthodontic Society meeting, at which this lecture was presented, was "Contemporary Prosthodontics: Merging Science, Art and Evidence."

Dr. Wen-Li Wang and her husband Dr. Richard Pan, on the birth of their second son, Alexander, on June 24th. He weighed 7 lbs, 12 oz and measured 20 inches long. Mom, dad, baby and big brother (William, 4) are at home, happy. *(photo below)*

Dr. John Adams, on his son Nathan's graduation from Loma Linda School of Dentistry on May 30th. Dr. Nathan Adams plans to join his father's practice upon licensing.

Dr. Bev Kodama, recently appointed to the Delta Dental Corporate Membership Board.

Roseville Personalized Dental Care (including **Drs. Tim Herman, Doug Coffelt, Madeline Majer, Abdon Manaloto, Chis Cooper, Flaviane Peterson and Kayla Nguyen** and their office of 22 people), who ran in the Eppie's Great Race this and for the past five years.*

Dr. Kevin McCurry, for his achievement of Mastership from the Academy of General Dentistry (AGD). The Mastership Award is the highest honor available at the AGD and one of the most respected designations within the profession. To accomplish this goal, Dr. McCurry completed 1,100 hours of continuing dental education.

Jesse Manton, former CSUS Pre-Dental Club President and SDDS Student Member, for his outstanding DAT results. His scores place him as one of the top 15 DAT scores in the nation!

Dr. Howard Chi, on his participation in the Taste of San Joaquin 2nd Annual Way Out West BBQ Championship. Unlike many of his competitors who favored very expensive grills, Dr. Chi used a Weber Smokey Mountain grill, costing about $300. Dr. Chi's team, Smok'd Chi, came in 17th overall, out of 40 teams.

Dr. Wai Chan, for his participation as Dental Director at Hiram Johnson School-Based Health Center. *(photo below)*

Dr. Paul Binon, one of the first committed major sponsors for TOUR for a CURE, benefiting breast cancer research and treatment in our community. At the South Placer Art in Public Places inaugural event, a six-foot ribbon, created by artist Karen Dukes, was placed at MAS movement and strength fitness studio in Granite Bay, in honor of Susan Binon's sister, who recently died of cancer. For a map of the location of the other 15 ribbons on display throughout South Placer County until September 20th, visit www.southplacerartinpublicplaces.com. *(photo below)* ■

Have some news you'd like to share with the Society? Please send your information (via email, fax or mail) to SDDS for publication in the *Nugget!*

1. Drs. Wen-Li Wang and Richard Pan welcomed Alexander to the world on June 24th.

2. Nurse Pauline Tracey, Elizabeth Wong, RDHAP and Dr. Wai Chan (volunteer) work tirelessly at Hiram Johnson School-Based Health Center.

3. Rex Owens (Owner of MAS), Karen Dukes (artist), Susan Binon and Dr. Paul Binon celebrate the installation of the first of 16 public art pieces in South Placer County.

** Sadly, Dr. Doug Coffelt passed away during this event.* *(See page 14)*

NEW MEMBERS

AUG/SEPT
2010

WELCOME

to SDDS's new members, transfers and applicants.

IMPORTANT **NUMBERS:**

SDDS *(doctor's line)* . . . . . (916) 446-1227

ADA . . . . . (800) 621-8099

CDA . . . . . (800) 736-8702

CDA Contact Center . . (866) CDA-MEMBER *(866-232-6362)*

CDA Practice Resource Ctr . . *cdacompass.com*

TDIC Insurance Solutions . . (800) 733-0633

Denti-Cal Referral . . . . . (800) 322-6384

Central Valley Well Being Committee . . . . . (559) 359-5631

KEEP US UPDATED!

Moving?
Opening another office?
Offering new services?
Share your information with the Society!

We can only refer you if we know where you are; and we rely on having your current information on file to keep you informed of valuable member events! Give us a call at (916) 446-1227.

The more accurate information we have, the better we can serve you!

Priya Patel, DMD
General Practitioner
3290 Arena Blvd, Ste 610
Sacramento, CA 95834
(916) 574-9400
Dr. Priya Patel graduated from the University of Florida in 2006 with her DMD. She is currently practicing in Sacramento with fellow SDDS member, Dr. Sheila Inalou, and lives in Sacramento with her husband, Mitesh.

Thang Chi Pham, DDS
General Practitioner
5200 Stockton Blvd, Ste 110
Sacramento, CA 95820
(916) 455-6600
Dr. Thang Chi Pham graduated from New York University in 2007 with his DDS. He is currently practicing in Sacramento where he also lives.

NEW TRANSFER MEMBERS:

Eric Grove, DDS
Transferred from Tri-County Dental Society
General Practitioner
9230 Bruceville Rd, Ste 1
Elk Grove, CA 95758
(916) 683-6020
Dr. Eric Grove graduated from Loma Linda University in 2009 with his DDS. He is currently practicing in Elk Grove with fellow SDDS member, Dr. Dan Juarros, and lives in Sacramento.

Paul Luczynski, DDS
Transferred from Tri-County Dental Society
General Practitioner
2821 Eastern Ave, Ste 1
Sacramento, CA 95821
(916) 483-2900
Dr. Paul Luczynski graduated from Loma Linda University in 2010 with his DDS. He is currently practicing in Sacramento with fellow SDDS member, Dr. Dan Juarros, and lives in Sacramento.

Natsuyo Yamamoto, DDS
Transferred from San Francisco Dental Society
General Practitioner
Pending Office Address
Dr. Natsuyo Yamamoto graduated from the UCSF School of Dentistry in 2009 with her DDS and completed a residency at the Lutheran Medical Center in New York in 2010. She is currently seeking employment in the greater Sacramento area and lives in Sacramento.

NEW APPLICANTS:

Ana Maria Antoniu, DMD
Lydia Cam, DDS
Michelle Kucera, DDS
Maria Lopez-Shams, DDS
Darin Lunt, DDS
Phong Ngo, DDS
Nawal Osman, DDS
Gina Salatino, DMD
Adrian Sarchisian, DDS
Trevor Smith, DDS
Pok Teh, DMD
Kirk Youngman, DMD

CORRECTION

WELCOME BACK!

Robert Burkhard, DDS
Transferred from Butte-Sierra District Dental Society
General Practitioner — Retired
Dr. Robert Burkhard graduated from the UCSF School of Dentistry in **1953** with his DDS. He was SDDS President in 1980 and later retired and transferred his membership to BSDDS. After attending this year's Past Presidents Dinner, Dr. Burkhard decided to transfer his membership back to SDDS. He currently lives in Downieville.

NEW SHOW DAYS FOR CDA PRESENTS

In response to attendee feedback, CDA has shifted the *CDA Presents* show days to **Thursday through Saturday.** This change takes effect with the upcoming San Francisco meeting on Sept. 9–11.

Courses and the exhibit hall will be available on all three days. To celebrate the new days, CDA Presents is hosting a happy hour in the exhibit hall from 4:30 to 6 p.m. on Thursday, Sept. 9.

The new day pattern also applies to the Anaheim meetings. *For more convention information, visit cdapresents.com.*

cda

CLIP OUT this handy NEW MEMBER UPDATE and insert it into your DIRECTORY under the "NEW MEMBERS" tab.

TOTAL MEMBERSHIP (AS OF 8/3/10): 1,546

TOTAL ACTIVE MEMBERS: 1,286
TOTAL RETIRED MEMBERS: 195
TOTAL DUAL MEMBERS: 3
TOTAL AFFILIATE MEMBERS: 13
TOTAL STUDENT/PROVISIONAL MEMBERS: 2
TOTAL CURRENT APPLICANTS: 12
TOTAL DHP MEMBERS: 35

TOTAL NEW MEMBERS FOR 2010: 35

EVENT HIGHLIGHTS

RIVERCATS GAME

June 17, 2010 — Dental Day at Raley Field

***1:** It's a beautiful day at the ballpark, as the SDDS crew arrives. **2:** Dr. Scott Grivas settles in with his "gals" and friends. **3:** Drs. Walter and Gary Griffin enjoy some father-son bonding. **4:** Dr. Robert Hays and his staff make some memories at the ball game. **5:** The SDDS section is ready for action as the RiverCats take on the Reno Aces! **6:** Dr. and Mrs. Richard Silva get cozy. **7:** Dr. Frederick Wenck made the trip all the way from South Lake Tahoe to join in on the fun! **8:** Dr. Robert Meaglia takes in the summer sun with his good friend. **9:** Dr. George Mayweather roots for the home team with members of his staff. **10:** Dr. Scott Grivas is FIRED UP!*

Nugget Classifieds

Practices For Sale

DENTISTS SERVING DENTISTS — Western Practice Sales invites you to visit our website, **westernpracticesales.com** to view all of our practices for sale and to see why we are the broker of choice throughout Northern California. **(800) 641-4179.** *03-09*

SACRAMENTO, SAN JOAQUIN & SOLANO COUNTIES — Orthodontic, Pediatric and GP practices available in Sacramento, San Joaquin and Solano Counties! Visit **www.practicetransitions.com** or call **Practice Transition Partners** at **(888) 789-1085** about dental practices throughout California and the U.S. *04-10*

ESTABLISHED FAMILY DENTAL OFFICE for 8 years in Rancho Cordova greater Sacramento area. 3 ops great potential. Cash/PPO/HMO. Asking $150,000. Please call (916) 308-3006. *08/09-10*

Equipment For Sale

GE PANELIPSE II — Very clear panos, nice office upgrade, replaced only because going digital, $1890, ericknutson@surewest.net, 916-622-9929. *04-10*

2 ADEC PRIORITY CHAIRS with new black upholstery, good condition. $3000 total. (916) 929-5544. *08/09-10*

CEREC '07 FOR SALE. Latest MCXL Milling Unit, Acquisition System, Ivoclar Furnace. Sale by original owner. Lightly used. (626) 552-8844. cerec4sale@gmail.com. *08/09-10*

Employment Opportunities

A GREAT OPPORTUNITY! If you are planning or considering opening a practice in El Dorado Hills, give me a call!!! Dr. Linssen (916) 952-1459. *02-09*

BUSY MULTI-SPECIALTY DENTAL GROUP in the Greater Sacramento area is looking for an associate pediatric dentist and orthodontist to join our team 2–4 days/week. Competitive compensation determined on experience and certifications. Our unique office offers an excellent opportunity for a highly skilled individual who is motivated, a team player and dedicated o providing superior patient care. Seeking someone interested in a long term commitment. Please fax resume to (916) 817-4376. *06/07-10*

EXCITING OPPORTUNITY FOR ENDODONTIST — Advanced practice with beautiful, new high tech office in foothills of Jackson, California looking for an endodontist to work one day per week, developing into a full practice with great potential. Please fax resume to (209) 223-2719. *01-10*

ORTHODONTIC OPPORTUNITY — Start an orthodontic practice in an established orthodontic office in Sacramento. For details email bs2bandit@aol.com. *08/09-C1*

Positions Wanted

STOP THE SCREAMING! In-office sedation services by MD anesthesiologist • Pedo/Adults • Medi-Cal Provider • 20 years experience • Call (800) 853-4819 or info@propofolmd.com. *05-07*

LOCUM TENENS — I am an experienced dentist, UOP graduate and I will temporarily maintain and grow your practice if you are ill / maternity leave or on extended vacation. (530) 644-3438. *04-10*

For Lease

DENTAL SPACE $0.95 psf — In an established Carmichael dental building. 1,200 sf. 2–3 exam rooms, waiting room, reception and private office. Nicely appointed and ADA accessible. Call Owner/Agent (916) 443-1500. Lic. #01413910. *02-09*

SUITE FOR LEASE — MIDTOWN: 6 months free rent. 2 operatory. Sacramento Dental Complex. Possible to purchase existing equipment. Great for new practice. Please call (916) 448-5702. *04-09*

OFFICE OF YOUR DREAMS! Open or relocate your practice. Beautiful, state-of-the-art office in Roseville available immediately. Please call (916) 772-6248 or (916) 257-0832. *08/09-10*

YOU ASKED FOR THIS!

Nugget Survey 2009

NEW CLASSIFIED SECTIONS!

Vacation homes • Misc items for sale • Home rentals / sales • Tickets

Contact SDDS at (916) 446-1227 for more information.

SDDS MEMBER DENTISTS CAN PLACE CLASSIFIED ADS FOR FREE!

Selling your practice? Need an associate? Have office space to lease? Place a classified ad in the *Nugget* and see the results! SDDS member dentists get one complimentary, professionally related classified ad per year (30 word maximum; additional words are billed at $.50 per word). Rates for non-members are $45 for the first 30 words and $.60 per word after that. Add color to your ad for just $10! For more information on placing a classified ad, please call the SDDS office (916) 446-1227. Deadlines are the first of the month before the issue in which you'd like to run.

SACRAMENTO
DISTRICT DENTAL
SOCIETY

915 28th Street
Sacramento, CA 95816
916.446.1211
www.sdds.org

ADDRESS SERVICE REQUESTED

SDDS CALENDAR OF EVENTS

YOU ASKED FOR THIS!
Nugget Survey 2009

AUGUST

24 **CE Committee**
6:00pm / SDDS Office

27 **Executive Committee Meeting**
7:00am / Del Paso Country Club

28 **CPR BLS FULL COURSE**
Sutter General Hospital
8:30am–11:30pm

SEPTEMBER

7 **Board of Directors Meeting**
6:00pm / SDDS Office

9 **Peer Review Committee**
6:30pm

13 **Dental Health Committee**
6:30pm / SDDS Office

14 **General Membership Meeting**
Sleep Disorders & Dentistry
Peter Chase, DDS
New Member Night
Sacramento Hilton — Arden West
2200 Harvard Street, Sacramento
6:00pm Social
7:00pm Dinner & Program

20 **Membership Committee**
6:00pm / SDDS Office

21 **Continuing Education**
HR Audio Conference
Navigating the Wage & Hours Minefield
Noon–1:00pm

22 **Foundation Board Meeting**
6:00pm / SDDS Office

23 **Member Forum**
Hiring & Firing Bootcamp
Mari Bradford (CEA)
Sacramento Hilton — Arden West
2200 Harvard Street, Sacramento
6:30pm–8:30pm

28 ***Nugget* Editorial Committee**
6:15pm / SDDS Office

OCTOBER

1 **Executive Committee Meeting**
7:00am / Del Paso Country Club

6 **SDDF Broadway Series**
Burn the Floor
8:00pm / Sac Community Center

8 **Continuing Education**
Adult Conscious Sedation
Recertification Course
LaDonna Drury-Klein, RDA, CDA, BS
Sacramento Hilton — Arden West
2200 Harvard Street, Sacramento
6:30pm–8:30pm

11 ***Columbus Day***
SDDS office closed

CATCH A WAVE AT THE **31ST ANNUAL MIDWINTER CONVENTION**
TONS OF CE & A GREAT TIME! YOU WON'T WANT TO MISS IT! **FEBRUARY 3–4, 2011**

EARN **2** CE UNITS!

September 14, 2010:
Sleep Disorders, Sleep Medicine & Dentistry

Presented by:
Peter Chase, DDS

COURSE OBJECTIVES:

- Overview of sleep medicine
- Explanation of the dentist's role in sleep medicine

6pm: Social & Table Clinics
7pm: Dinner & Program

Sacramento Hilton, Arden West
(2200 Harvard Street, Sac)

SEPTEMBER GENERAL MEMBERSHIP MEETING: **NEW MEMBER NIGHT**