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wisdom

A close-up photograph of a dental procedure. A high-speed dental handpiece is shown grinding a white, curved dental wax or resin block. The grinding surface is covered in a fine, metallic, crystalline dust. The background is dark, making the white material and the bright sparks stand out.

Construction of Surgical Template
for Posterior Implant Prosthesis

Disability Income Insurance:
What Every Dentist Needs to Know

Instant Patient
Presentations

The 21st Century
Digital Dental Practice

Dental Clinic
in New Orleans
Helps Thousands

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In this issue

- 3** President's message
- 4** In my opinion
- 5** The trustee's voice
- 6** Instant Patient Presentations
By Joseph DiDonato III, DDS, MBA, FAGD
- 8** Construction of Surgical Template
for Posterior Implant Prosthesis
By John DiPonziano, DDS, MAGD, FICOI, CDT
- 10** The 21st Century Digital Dental Practice
By Charles D. Samaras DMD
- 14** Disability Income Insurance:
What Every Dentist Needs to Know
By Nathan G. Browning
- 16** NJAGD news
- 17** AIM update
- 18** Dental Clinic in New Orleans
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President's message



Melvin Pierson,
DDS, FAGD

Focus on Continuing Dental Education

The NEW New Jersey Academy of General Dentistry (NJAGD) is focused on Continuing Dental Education (CDE). As the new President of the NJAGD my goal is to expand the CDE opportunities for not only our members, but for the rest of their dental team, non-member dentists, and dental students of New Jersey. As the dental professionals of this State, it is our ethical responsibility and legal duty to remain informed of the increasingly complex and rapidly advancing technologies of our profession. The NJAGD will be there to lead the way.

I am very excited about the CDE schedule that the NJAGD has assembled for this year. Yosh Jefferson, DMD, MAGD, our CE Chair has put a tremendous amount of time and effort into planning a schedule of quality speakers. Of course, since NJAGD operates as a non-profit organization, tuition for these courses is always low, and since they are right here in New Jersey travel expenses and time away from the office is minimal. Even our Bermuda Cruise leaves from right here in Bayonne! This year NJAGD has teamed up with NY-AGD and PA-AGD for several events to keep tuition down. One example is the new Fellowship Exam Review Course-a must for anyone thinking about taking the AGD Fellowship Exam. For those that have already achieved Fellowship NJAGD's AIM program is the logical next step.

This year, the NJAGD journal, *Wisdom*, and our website, www.NJAGD.org, will get a new format thanks to a new Editorial Committee and a new publisher. The Editorial Committee members are Evan Spivack, DDS, FAGD, Editor; Jeff Christopher, DDS, MAGD, Associate Editor/Webmaster; Joseph Sandberg, DMD, MAGD, President-Elect; and Yosh Jefferson, DMD, MAGD, CE Chair. Each of these members brings a unique talent to the Committee and together they will produce a journal and website that will keep our members informed and promote the NJAGD.

In August, the AGD held the 54th Annual Meeting in Denver, Colorado. There was a strong contingent from New Jersey on hand to welcome our new Masters and Fellows. Please see all the photos from the meeting in the center of this journal. Dr. Bruce DeGinder was installed as President and has promised a new, leaner, more nimble Academy. We look forward to strengthening the relationship between the NJAGD and our National Organization. Next year, our own Dr. Vinny Mayher of Haddonfield, NJ will take the helm as National President. Please make plans to join us in San Diego, California to help cheer him on.

I would like to personally thank Dr. Scott Dubowsky, NJAGD Immediate Past President, for making my transition extremely smooth. I would also like to thank Dr. Manny Cordero (our National Trustee) and Dr. Beth Clemente (our Regional Director). They provide a vital link between the NJAGD and the National AGD. Finally, I would also like to extend a very personal thank you to Mr. Art Meisel, Executive Director of the NJDA. He has been instrumental in helping NJAGD transition from one year into the next. Thanks Art!





*Evan Spivack,
DDS, FAGD*

Doing it the Right Way

Not long ago, I was speaking with the dentist who had given me my first opportunity as an associate in private practice. As we conversed, I mentioned how grateful I was to have had the chance to learn “real world” dentistry in an atmosphere where the primary objective of the practice was to do things “the right way”.

I stayed with that practice, a small neighborhood dental office in a predominantly blue-collar Bronx neighborhood, for nearly four years. Every now and again, I would hear how important it was to “do it the right way”, and that “we have to do the right thing”. They seemed to be throwaway comments at the time, but their impact, in combination with the ever-present examples of *how* to do it the right way, were important guides that have stayed with me through my career. Our office provided a high quality of care at a reasonable fee, and all of us — dentists and staff alike — cared for our patients as we would for our own families.

As we spoke, the topic of dental overtreatment arose. My friend was concerned by the increasing number of patients who were coming into his office having received full mouths of crowns, or those who had “smile makeovers” with veneers from molar to molar. The problem, he felt, was more than just some dentists pursuing aggressive treatment plans. He mentioned a shift in patient mindset influenced by the media, and in dentists’ education coming more from throwaway publications than from sound, science-backed journals. His view of dentistry’s future as a respected and trusted profession was not a hopeful one.

Recent years have seen tremendous strides in dental materials and techniques, with the possibility of dentists now able to do more than ever to improve patients’ function and appearance. Our patients have benefited from this, as have we. I cannot imagine anyone wanting to turn back the clock to a time before choices in porcelain crowns and veneers were plentiful, when implants were commonplace and when composite restorations were ubiquitous. We truly are living in a golden age of dentistry, but the question must be asked: have our eyes been blinded by the dazzle from all of this gold?

Dentistry is both science and art. For almost any clinical situation there will be several treatment alternatives available, many of which will lead to a desirable outcome. Which alternative is chosen depends on a number of factors, not the least of which is the practice philosophy of the treating dentist. We have a responsibility to help our patients make informed choices, and in doing so must follow the medical dictum “first, do no harm” that is central to the Hippocratic oath. Does this principle conflict with the “extreme makeover” philosophy that seems to dominate lay and professional thought? In some cases it does and we, as educated and experienced professionals, must know when and where to draw the line.

In looking at articles, particularly those in nonrefereed journals, it is important to be critical of what is presented. How many times have you thought to yourself that the “before” picture really wasn’t so bad in the first place? In listening to a lecturer present, remember that the images shown are almost always that dentist’s successes. No one wants to show off his or her failures. We must be critical of what we read, see and hear, and we must be willing to step back from time to time to reevaluate how we provide care to our patients. Whatever you do, do it the right way.

The trustee's voice



*Manuel Cordero,
DDS, MAGD*

So, what is new at the AGD? Plenty!

I was elected to the position of AGD trustee last year during our Annual Meeting in Washington DC. At that time I was serving as New Jersey's regional Director and as campaign manager for AGD President-elect Dr. Vincent Mayher. When I assumed the position of AGD Trustee, my focus turned from leadership and development at the component level to fiduciary and managerial responsibilities at a national level. My duties are management of the AGD while acting as a mentor and support to our new Regional Director, Dr. Elizabeth Clemente.

Beth has been a consistent and contributing member of NJAGD since I have been on this board and it is refreshing to see someone recognized for the hard work that they have performed. I have no doubt that we will see NJ continue to develop its leadership base under her direction.

New leadership, new direction

During this past year we have made meaningful changes at the national level that will affect our AGD for years to come. To bring our organization to a model in tune with today's reality, we needed to evaluate and refine our goals, objectives and strategies..

Jay Donohue replaced our old Executive Director, and we benefited greatly from his updated managerial perspective. We were placed on a positive and constructive path, while self evaluating our roles as leaders. Mr. Donohue served as an agent of change who implemented numerous new strategies, with AGD 2010 identifying a new core purpose and goals, with a revamped financial process. AGD became more of a positive resource for general dentistry and its team members. Over the last 24 months AGD has become more strategic, efficient and fluid, with increasing benefit, value, and services for all members.

For a number of reasons, the decision was made to replace Jay Donohue, and Ms. Christie Tarantino was named Executive Director at the April Board of Trustees meeting. It was obvious to us that Ms. Tarantino had the skills, qualifications and commitment to best serve our organization and its members, and the atmosphere in Chicago is one of camaraderie and cooperation. Ms. Tarantino named Kelly Fox as associate executive Director, and she has been performing the functions necessary to make our AGD more nimble and responsive.

AGD.org: resource and member benefit

Please visit our website and experience the unprecedented wealth of information and resources available to our members. There is an incredible amount of material readily customizable for our patients, such as the Dental Facts sheets and others. You may also develop your own website with the outline provided to our members. Visit our website, you will not regret it!

AGD Membership Directory

The new AGD members directory was previewed in Denver this August. Members can order a CD or printed copy of the directory, and it will also be available in downloadable form at the AGD website. Contact the Director of membership services at ext. 4085 for more information.

CE Processing

In June, the decision was made to use all staff — over fifty people — to ensure that the AGD catch up on the backlog of CE entry. It is a staggering job, with the AGD receiving as much as 15,000 CE entries from the membership each month via the AGD Web site, e-mail, regular mail, and fax!

The primary goal of this initiative is to provide AGD members with more valuable benefits that not only report their continuing education, but also to identify, record and report CE in a format acceptable by their state or province for verification of mandatory continuing education requirements.

All members should have received their 2006 AGD Membership Card. In conjunction with the new membership cards, we have launched a new Electronic Roster Submission initiative which will allow some PACE-approved providers to scan the card for CE recording. The providers will in turn submit their electronic rosters to the AGD, and those credits will be applied in a more timely fashion.

Instant



Joseph DiDonato III,
DDS, MBA, FAGD

Patient Presentations

Can you imagine the ideal patient presentation technique? What would it be like? It would probably work on its own, without any staff or doctor involvement. It would completely educate patients about their condition. It would prove that you have adroitly restored cases just like theirs. It would be instantaneously ready when patients are making a decision to seek treatment. It would cost you nothing. It would be reusable. Oh and its success rate would be 100%.

Is there anything like this available? Yes, except that it is slightly less than 100% successful. But hey, its free, or at least is comes bundled with stuff you already paid for, what more can you ask?

In my office I can create complete video presentations for my patients in as little as ten minutes. These videos show the patient's current condition, similar cases that I have restored and some information about me and my office. And I do it all in the time it takes to see a patient for their first exam and oral hygiene visit. With training any staff can do the same.

This process is as simple as a 'drag and drop' exercise with your favorite patient images. Video editing software allows you to create high quality movies that have a compelling message for patient care.

Video editing software, like Windows MovieMaker II, can assemble photos, video and sound to create a custom presentation in minutes. Impressive presentations can be as simple as a series of patient photos showcasing your best work or a movie that explains patient options and outcomes using still images, video, music and narration. The sky's the limit for demonstrating practice philosophy and clinical results using images to tell the story.

For new patients, one of the many hurdles to treatment is choosing a new dentist. It is time consuming and filled with many unknowns.

Experience with technology, such as intraoral cameras, has demonstrated that the path to treatment can be faster when patients can see problems and are given immediate answers to their questions. Additionally, patients prefer to see problems and solutions rather than hear or read about them.

Helping patients to understand the cause of dental disease is one part of the patient presentation. Allowing patients to choose treatment options among a complex menu is another. Making that choice can be a significant hurdle for patients who don't understand the options. Three to five minute movies can deliver patient specific answers and be constructed in as little as ten minutes. In the hands of an experienced staff member these presentations can be produced for every patient throughout the day just as rapidly as patient registration is done on the computer.

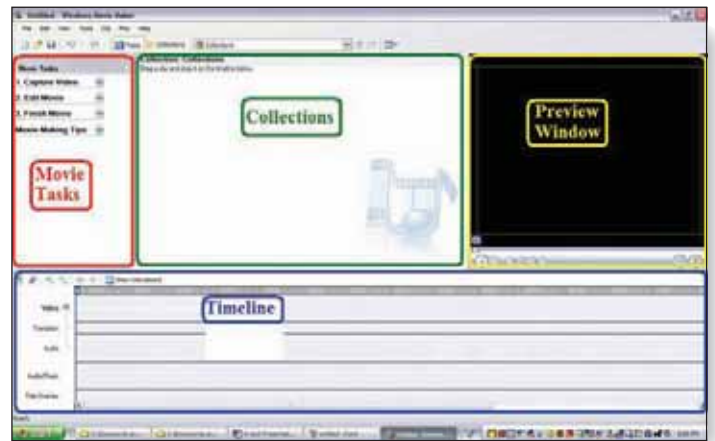


Figure 1

Creating a patient presentation allows practitioners or staff to view the movie with the patient and supply added narrative, answer questions and provide patients with a personally tailored initial experience with the office. Patients come away with a clear understanding of their case and complete documentation on the condition of their oral health. This provides patients with a solid position in which to make treatment choices, thus it speeds access to care.

To create a patient presentation one must have a movie making program such as Windows MovieMaker II and the ability to capture intraoral images (preferably digital.) It is also useful to have a library of before and after images (with patient consent to publish) and video of you and your staff interacting with patients and providing routine care.

Most movie making software has the same layout. You will find a desktop with four components; a tasks menu, a collections area for resources, a preview screen and a timeline. (Figure 1) A presentation consists of video and still images that you place on a timeline which when played back will be the content of your movie. This project is a work in progress to which you will add the content for the movie.

Next, import before and after images of cosmetic cases you have preformed, images of you, your staff, the physical facilities of your practice and any other images you may wish to include. (Figure 2) These become the resources from which you will construct your patient presentation.

A movie project is now made by taking resources that I want in all the movies and drag-n-drop on the timeline. I create a generic



Figure 2



Figure 3

movie and for each patient add patient specific resources like digital intraoral images or digital radiographs. (Figure 3)

A typical presentation consists of the following components. An introduction to the practice, a picture of the practice from the street and then inside, and a picture of me with my staff. This is followed by pictures of the patient with some introductory remarks that were taken when the patient presented, "I don't like my smile. I want to have it fixed."

This is followed by quadrant images of the patient. I then use before and after images of patients with similar problems that I have treated.

The presentation is concluded with a case write-up that includes a complete review of the case condition and treatment recommendations.

Indeed, you may decide to make templates that cover specific disciplines and then join those templates together to cover a complex treatment plan. Such a treatment plan might include initial caries control, periodontal intervention, orthodontic treatment, implant surgery and finally restoration. Each template may include before and after images, explanatory segments on the problem, treatment options and doctor recommendations and video of the procedure being accomplished.

In review the steps in creating a movie are:

- Capture resources (images, video, music, narration) to a file.
- Create a new project in a movie making application.
- Import resources.
- Drag and drop resources from collections to the timeline to create content.
- Save the project as a movie presentation with the patient's name.
- Burn the movie to a disc.
- Present to the patient.

I like to add narration and music to bring the presentation to life. I also add action by adding video scenes of me and my staff performing treatment chair side.

To add a professional look to the production I also look for royalty free animations with transitions provided by the movie maker software.

Finally, you can add an assortment of titles and text throughout the movie which can personalize and enhance the patient's understanding and experience.

There are many benefits in providing patients with a custom video presentation. It will demonstrate your commitment to

patient care, your ability to manage the technology of your craft and raise the bar on quality treatment.

Windows MovieMakerII is bundled with Windows XP and all you add is the content to create patient presentations that are fast and effective. There are many other programs that allow you to make a slide show from a series of pictures. However, the benefit of using video presentation software is that you can combine motion video with text, animations and background music.

Mac users will find that iMovie HD along with Final Cut Express HD will allow capturing, editing and authoring of movies using Apple's easy interface.

The technology behind video editing has become more accessible to us professionals who want the latest technology in patient presentation.

About the author

Dr DiDonato graduated from NYU Dental in 1981 and completed a GPR at Univ of Rochester Strong Memorial Hospital. For more than 25 years he continues to attend and teach at the Eastman Dept of Dentistry. In 2001, he completed an MBA at the Rochester Institute of Technology. He is a Fellow of AGD and President of the NYSAGD. Dr D is the developer of Dental Decide, a computer simulation used to teach dental practice management. He maintains a practice focusing on adult reconstruction in addition to consulting with healthcare providers on how to integrate technology into their practices. Dr D is an experienced technology user who employs lasers, radiovisiography, digital photography and wireless technology in his practice, as well as, a consultant to local law enforcement, insurance companies & investigators in forensic dentistry. Dr D will share with you the latest in patient presentation techniques. He is also an avid amateur paleontologist and has collected dinosaur fossils on four continents.

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Construction of Surgical Template for Posterior Implant Prosthesis



John DiPonziano,
DDS, MAGD, FICOI, CDT



Figure 1



Figure 2

One of the biggest challenges in implant dentistry is the correct surgical positioning of the implant body to allow an esthetic fixed prosthesis — with good emergence profile — which is also easily maintained by the patient.

This article illustrates a simple laboratory fabricated surgical template for posterior prostheses that can be constructed in a short time, and provides a stable, rigid device that exhibits excellent visibility at the surgical site.

The template can be easily made using a light-cured urethane dimethacrylate material (Triad).

As with any surgical guide, the key to aligning the implant fixture in the proper mesial-distal/buccal-lingual position in the bone is based on the visualization of where the final prosthesis will emerge from the edentulous area.

The laboratory will provide this visualization of the prosthesis by first waxing denture teeth in the edentulous areas on an articulated study model. (Figure 1)

After the teeth are luted in position, a duplicate model is made using reversible or irreversible hydrocolloid.

The model that results will have teeth in the proper position that represents the final prosthesis that is desired.

A pencil line is drawn through the central fossa area of the teeth to be included in the prosthesis. (Figure 2) All the stone that is lingual to this line is removed down to the gingival level. This leaves only the facial aspect of the teeth remaining on the model. (Figure 3)

A wafer of light curable Triad is adapted over well-lubricated lingual, incisal, and occlusal surfaces of the remaining teeth on the model. In addition, the areas of the model where the lingual aspects of the stone teeth were cut away are built back to the proper occlusal width with Triad.

After light curing, the hardened material is carefully pried off of the model. The outlines of the lingual contours of the missing teeth are drawn in with the thin permanent marker on the Triad to get an indication of the mesial-distal dimension of the teeth to be replaced. (Figure 4)

A 2mm wide trough is prepared with a heatless stone at the central fossa area of the proposed implant sites and carried down to the gingival aspect.



Figure 3



Figure 4



Figure 5



Figure 6



Figure 7

This trough represents the angulation and position of the implant osteotomy drills that will align the implant body directly below the prosthetic tooth.

Drawing a line down the center of the trough with the fine-tipped permanent marker further enhances the visualization of the drill position. (Figure 5)

This template design is especially useful in a case that has a fully edentulous posterior area since it is more rigid than a vacuum-formed type surgical template.

In addition, the open facial aspect provides a clear sight of the drills — as well good access for coolant irrigation — during the preparation of the osteotomy sites. (Figure 6 and 7)

About the author

Dr. Diponziano has been performing the surgical placement and prosthetic restoration of dental implants since the mid-eighties. A 1983 graduate of Temple University School of Dentistry, he also completed a three-year didactic and participatory program in Implantology at the University of Pennsylvania in 1989. Prior to attending dental school, Dr. DiPonziano was a full-time dental Technician and earned CDT (Certified Dental Technician) status, which he still maintains today. He is past President of the New Jersey Academy of General Dentistry. He is in private general practice in Columbus, NJ, and also provides surgical placement and implant case treatment planning on referral from other practitioners.



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The 21st Century Digital Dental Practice



Charles D. Samaras, DMD

Digital technology has had a profound effect on dentistry in the 21st century. Diagnosis, documentation, patient records, and patient education have all been enhanced through digital practice, management software, digital radiography, and intraoral cameras (IOC). While some dentists have made the transition to digital dentistry, the majority of dentists in the U.S. have not, even though they may want to, and/or they know it will be inevitable. The reasons many dentists have not transitioned to digital technology are because they do not know where to start, do not know how to go about it, and do not know what to look for. I felt the same way ten years ago.

The first two reasons are easy to explain. The first place to start is to identify what digital technology you want to purchase. Clinical practice management software and hardware for the entire office, digital radiography, and intraoral cameras (IOC's) are the cornerstones of today's 21st century digital practice. They *should* be in *every* dental practice. Now that you know what technology to purchase, identify how you are going to go about it. The process will consist of reading the dental publications that describe and compare the technology, examine the technology at local, state, and national dental conventions, in office demonstrations, and speaking with dentists who have the technology in their practices. The hardest part of purchasing digital technology is to know what features to look for. In this article, I will provide some thoughts on what to look for when purchasing clinical practice management software and hardware, digital radiography, and IOC's from a practicing dentist's perspective.

Your First Purchase — Clinical Practice Management Software

In my opinion, the foundation of the 21st century practice is practice management software and hardware for the entire office. This technology is the nexus for incorporating all additional digital technology, such as digital radiography and IOC's. This technology will not only enable you to do accounts, billing, recare management, reports, and the appointment schedule, it will also empower your team to do the charting, patient education, image taking, cosmetic imaging, treatment planning, case note documentation, and scheduling, all *chairside*, through the creation of the virtual patient record. Imagine the benefits of the virtual patient record: the elimination of the paper chart. Nothing gets lost, misplaced, or misfiled. The virtual record contains all patient information (including clinical) on one or multiple screens, resulting in increased efficiency, productivity, and team empowerment. In addition, you can email any chart, document, or digital image to another doctor, insurance company, or dental specialist without sending the original copy. Also, you will be able to *back up* and store your entire practice on CDs or cassettes. So, even if your office is destroyed, you will still have all the patient records.

How do you *back up* paper? Finally, the virtual record provides the ultimate in risk management, as you will not only be able to document in words, but also in pictures.

What Features to Look For in Clinical Practice Management Software

I suggest eight criteria, and several other features to consider or look for when purchasing your clinical practice management software technology.

#1 What is the reputation and longevity of the company? Are they here today, and possibly gone tomorrow? This is very important, because the last thing you want is either a brand new company that has no track record and may not be in business in the very near future. You need to know that you will be able to have a long-term relationship with this company, as well as the ability to speak with dentists who currently utilize this system.

#2 Do they sell and support their own hardware as well as the software? This is critical, because you want the proper setup of your new system. Equally important, is that if you have a problem with your practice management system, how do you know if the problem is software or hardware, and who do you call? If your software and hardware are provided and serviced by the same company, you only need to make *one* phone call. Presently, there are very few companies who can provide this service. I cannot stress enough how important this feature can be.

#3 involves the *conversion process*. The company from which you purchase the technology must have an experienced, qualified conversion team to successfully transfer your current information into the new software program. You do not want to lose important information. Many new companies, or companies that have merged with several other practice management software companies may not have the experienced personnel to ensure a successful conversion process.

#4 Is the system easy to use by your team, including you? Also, does it *have a means of back up (CD, cassettes) to store the saved information*? To me, there is no sense in purchasing a system that is too complicated to use, and cannot store (back up) the information. The simple fact is that some practice management software systems are very easy to understand and use with minimal training. It doesn't have to be complicated!

#5 Service. Is there vendor support? Is there on site support as well as by telephone? Is there a fee for vendor support? And, what is the warranty on the equipment? Make sure you have the answers to these questions in *writing*. And again, what you must be concerned about is your relationship with the company from whom you purchase the system and equipment, with respect to service. Are they here today and possibly gone tomorrow?

#6 Can the clinical practice management software system make a *seamless transition* with other technologies such as

IOC's and digital radiography? Or, does it require the purchase, in addition, of a bridge or a link? Seamless integration will enable you to add digital radiography and IOC's without a bridge, link, or added steps and expense. In addition, some software contains advanced imaging programs that allow you to seamlessly add cosmetic imaging, digital photography, virtual patient education, and voice activation software for clinical and periodontal charting, and case note documentation. The fact is that there are practice management software systems that have seamless integration with many digital technologies, and there are systems that offer no seamless integration whatsoever.

#7 Will updates to the software be provided in a timely fashion, and are there additional costs for those updates? Another question is, will you have support during the update process? Again, the answers to these questions lie in the relationship you have with a long-standing company.

#8 Training! The knowledge and communications skills of a trainer are crucial to the success and expedient transition to the new clinical practice management software system. Also, a good trainer will have a command of how to integrate *any* existing or new technology into the system. Truth be told, there are companies that have excellent, experienced trainers, and companies whose trainers have no experience with the product. Another factor to consider is if there will be a follow-up to the initial training, as well as additional training courses available. You will also want to inquire if training is included in the purchase price of the practice management software system.

Finally, some other features to look for, which are unique in practice management software are: fingerprint recognition instead of password login, a signature pad that will enable you to have a virtual patient signature of every document, letter, treatment plan, financial plan, medical history, referral letter, and store it virtually. In addition, you may have the ability to download ("hot sink") information onto your Palm Pilot in order to access practice information when you are not in the office.

What to Look For in Digital Radiography

In my opinion, it is not a question of IF you will transition to digital radiography, it is WHEN! More and more dental practices are utilizing digital radiography because of the many benefits, which include: expediency, ability to enlarge the radiographic image to the full size of the computer screen, a more thorough diagnosis, better patient education, less radiation, a creation of the virtual record, email capability, and the fact that digital radiographs will not get lost, misplaced, or misfiled.

Initially, you must identify which type of digital radiography system you want for your practice, direct or indirect. Indirect digital radiography utilizes a series of charged phosphor plates that look like conventional x-ray film. A plate is required for every digital image you want to capture. The plates are available in sizes 0, 1, 2, and 3. These plates capture the image in the patient's mouth when exposed to the proper radiation dosage. Then, the plates are placed in a scanning device, where they are scanned and then sent to the computer screen for observation. The plates are reusable by erasing the image.

Direct digital radiography utilizes *chip* technology in the form of a sensor. The sensors come in size 0, 1, and 2. When the sensor is placed in the patient's mouth, the digital x-ray image directly appears on the computer screen in approximately three seconds. And thus, the term

direct digital radiography. Both systems will provide excellent quality digital radiographs, both can utilize your existing x-ray equipment for the most part, and just about every digital radiography system has compatibility with most practice management software systems that contain advanced imaging software. However, at this time, I will state that regardless of whether you choose *direct* or *indirect* digital radiography, I would strongly recommend you consider if it has seamless integration with your existing clinical practice management software system. The reason I say this is because without seamless integration, you *will* require a bridge or a link, and thus introduce a number of unnecessary issues, like separate systems, separate back up, and service issues.

Now, there are fewer indirect systems available than direct. Features that should be considered with indirect are whether the system is a total digital solution. In other words, does the system have Pan and Ceph capabilities as well as intraoral? Another consideration is if the scanner will automatically erase and eject the plates after they are scanned? Also, what are the maintenance and service requirements? Is there training and follow-up included in the purchase price? Can you get onsite service? What is the warranty? How much does it cost to replace a phosphor plate, and how often do they require replacement? Lastly, you want to consider the fact that utilizing indirect digital radiography may be slightly faster than using conventional x-ray film, it is no way near as fast as utilizing direct digital radiography via a sensor.

When investigating direct digital radiography, I believe again, that one of the first features to look for is if the sensor you choose has seamless integration with your existing clinical practice management software, for the same reasons I mentioned when choosing indirect. Next, you will want to consider whether you desire a *wire* versus *wireless* sensor system. There are systems available that do not utilize a wire from the sensor into a USB portal to your hardware. There really is no difference between a wire and wireless sensor. There are numerous sensors available today. Other factors to look for are thickness, comfort; ability to use with currently used x-ray holders, image quality on YOUR practice management software system, warranty, serviceability, track record, and the company from which you purchase the sensors. The reason I mention that last factor is that if for some reason, you have a problem with a sensor, your ability to get a replacement or "loaner" sensor will be much better with a company that has a dental supply branch in your area, as apposed to a stand-alone company located in a different part of the country. Also, you will hear that sensors have a certain "line pair" capacity. In an easy to understand explanation, line pair capacity is a dark and light line, side-by-side in a pair. The capacity refers to how many of these pairs can be present in a certain space or distance. The digital radiography community, in reference to image quality, uses the term line pair capacity. So, you will hear that a sensor has a certain numerical "line pair capacity". For instance, you may hear that a sensor has a line pair capacity of 11, or 18, or 24. The fact is, that from my research of digital radiography sensors, the consensus is that human eyes really cannot distinguish beyond 11 to 13 line pairs anyway. So, no matter what the "line pair" capacity is, if the digital image looks good on your computer screen, so be it! You do not have to worry about "line pairs". Finally, as I mentioned with the indirect digital radiography systems, I believe you want to purchase a system that includes training and follow-up from an experienced, qualified, digital radiography trainer.

Images in Clinical Practice

submitted by: *Evan Spivack, DDS, FAGD*

Case presentation

A 48-year-old Caucasian female presented for routine dental examination. Her medical history was significant for neurofibromatosis. Lesions similar to those noted on the patient's face and neck were also found on the patient's arms and hands, and were reported to be widespread on her body.



Discussion

Neurofibromatosis, or Von Recklinghausen's disease, is characterized by pigmented lesions and tumorous growths of various sizes and shapes as seen in this patient. It is inherited as an autosomal dominant trait, but many cases arise from gene mutation.

Peripheral nerve tumors may occasionally become malignant, and dysplastic changes may be seen in bone, endocrine organs and blood vessels as well as on the skin. Pressure damage to nearby nerves may result in tinnitus, hearing loss, headache, facial pain and paresthesia. There is no treatment for this disorder.

Do you have any cases of clinical interest that you would like to share with your colleagues? If so, please e-mail the editor, including the image and related clinical information, at spivacev@umdnj.edu

What to Look For in Intraoral Cameras (IOC's)

I have stated many times in my writings and lectures that the IOC is the most undervalued and underutilized technology in dentistry. I believe the IOC should be used at every patient visit, one every tooth, every time. A captured IOC image on a computer screen will enhance the practitioner's diagnostic ability, increase patient education, and will provide the ultimate in risk management, virtual documentation.

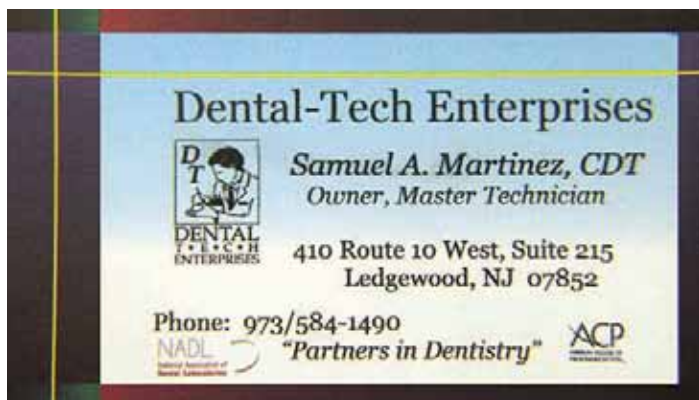
However, there are some features to consider when choosing an IOC, such as, if the camera **wireless** or does it have a **wire** connection? A wireless camera may have more maneuverability. **Portability.** How easy is it to take the camera from operator to operator? Is the final image a **correct** image, or a **mirror** image? Another feature is the **focusing mechanism** of the IOC. Some IOC's have a fixed focus, some have an adjusting focus, and some have automatic focus. What is the **depth of field**? How much of the image can you actually view? With some IOC's, you can capture an image of a quadrant of teeth, while with others you can barely view a large molar. What about the **freeze frame control** that captures the image? Is it by foot, or by hand? Does the camera require you to purchase new and **advanced imaging software**, or is it already compatible (seamless integration) with your existing software? What is the **warranty**? Some IOC's have a two-year warranty, but most only have one year. In many cases, it really **does** matter from which company you purchase your IOC when it comes to service of that technology. A national company, with many local branches, will be more likely to service that IOC onsite, if possible. This will not be possible if you purchased an IOC from a stand-alone company located in a different region than where you are located. In that case, you will have to ship the IOC to the company for repair. Also, you are more likely to get a replacement (loaner) IOC more expeditiously from a national dental supply company, versus a stand-alone company. Finally, as you investigate IOC's, make sure that you view the images at **your** office, on **your** computer technology, with **your** team. That is the only way you can make an accurate evaluation.

Conclusion

Bringing your practice into the 21st century requires the digital technology of clinical practice management software, digital radiography, and intraoral cameras. The process of determining which technology products to purchase is to consider all the features of the respective technologies, through product reports and comparisons, personal demonstrations at dental meetings and conventions, and then, "hands on" demonstrations in your office with your team. The key, I believe, is to get into the game. After all, the 21st century is already 6 1/2 years old.

About the author

Dr. Samaras, a 1982 graduate of Tufts University of Dental Medicine has practiced esthetic and restorative dentistry since 1982. He is Director of Practice Management at Tufts University School of Dental Medicine in 1999. He lectured on practice management at Boston University School of Dentistry in 1997 and was associate clinical professor at Tufts Dental Clinic at Middlesex Community College, Lowell, MA, in 1998. He was a guest lecturer for Harvard Dental School and Forsyth School for dental hygienists. He is a member of the International College of Dentists as well as Academy of Computerized Dentistry. He is a national and international lecturer and is an AGD approved speaker. He has been published in CERP, DMD, MENTOR, Compendium, RDH, and the Advancing Dentist. To learn more, please log on to: www.samarasondentistry.com



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Dr. Donald DeFonce Memorial Lecture

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Transitions to Technology for the Everyday Dentist and Team
"Enjoy dentistry through greater efficiency, productivity, profitability and FUN!"

Date: Friday January 19, 2007

Location: Marriott Hotel, 915 Route 73, Mount Laurel, NJ. Phone: 856-234-7300

Registration 8:00 am. Lecture 8:30 am to 4:30 pm. 6 CE credit hours.

Presentation by

Dr. Charles Samaras

Dr. Samaras, a 1982 graduate of Tufts University of Dental Medicine has practiced esthetic and restorative dentistry since 1982. He is Director of Practice Management at Tufts University School of Dental Medicine in 1999. He lectured on practice management at Boston University School of Dentistry in 1997 and was associate clinical professor at Tufts Dental Clinic at Middlesex Community College, Lowell, MA, in 1998. He was a guest lecturer for Harvard Dental School and Forsyth School for dental hygienists. He is a member of the International College of Dentists as well as Academy of Computerized Dentistry. He is a national and international lecturer and is an AGD approved speaker. He has been published in CERP, DMD, MENTOR, Compendium, RDH, and the Advancing Dentist. To learn more, please log on to: www.samarasdentistry.com



Course Description:

This is a six-hour program that enlightens and excites dentists and teams to integrate dental technology into their practices and understand the personal, professional and financial (ROI) benefits of these technologies. Topics include: Practice Management Software (Front end and clinical), Digital Radiography (direct and indirect systems), Intra oral cameras, laser caries detectors, CAD/CAM (Cerec 3-D) dentistry and the paperless practice. Additionally, he will talk about Patient education systems and Dental Lasers

Course hours: 6 CE credit hours

Course fee: AGD and ADA members – \$195.00 / Non-members – \$295.00 /
Staff/Auxillary/Spouse – \$99.00

Course code: 550

Registration and payment information: Dr. Donald DeFonce Memorial Lecture – Dr. Charles Samaras

Name: _____

Phone: _____ Fax: _____ Email: _____

Address _____ City/State _____ Zip _____

Payment Method: Enclosed is my check for \$ _____ or Credit Card (check one) Visa MasterCard AmEx Discover

Card No.: _____ Exp. Date: _____ Security Code: _____

Name on Card: _____ Signature: _____

Mail registration and payment to: NJAGD/CE, 1 Dental Plaza, PO Box 6020, North Brunswick, NJ 08902-6020, Toll Free: 1-866-GO-NJAGD Fax no.: 1-732-821-1082



Nathan G.
Browning

Disability Income Insurance: What Every Dentist Needs to Know

Are you prepared for your financial future? What if, for example, you suddenly become disabled — through an accident...an injury...or an illness — and are unable to work? Are you fully prepared for such a scenario?

According to a recent study, although most people believe they have only a 16% chance of becoming disabled during their working years,¹ the startling reality is that:

- If you're under age 35, chances are one in three that you will be disabled for at least six months during the course of your career.²
- Men have a 43% chance of becoming seriously disabled during their working years.² Women have a 54% chance.²
- At age 42, it is four times more likely that you will become seriously disabled than that you will die during your working years.²

Want to be better prepared? Consider the following:

Learning to speak the lingo

Before you go shopping for a DI policy, you need to know what features to look for — and the language the insurance industry uses to describe them. The following terms are part of the language describing high-quality policies, and are what you should look for to get coverage you can count on:

- **Non-cancellable:** To avoid the possibility of losing your coverage just when you need it most, choose a policy that's non-cancellable and guaranteed renewable to age 65 — with premiums also guaranteed until age 65. With a group policy, you run the risk of being dropped and left unprotected at a time in your life when, due to your age or to a change in your medical condition, it could be very difficult to qualify for coverage with another provider.
- **Guaranteed renewable for life:** Although premiums may increase after age 65, your policy should be conditionally renewable for life, as long as you are at work full time.
- **Own-Occupation definition of disability:** Own occupation coverage defines “totally disabled” — and therefore eligible for benefits — as not able to work in your own occupation *even if you are at work in some other capacity*. As a highly skilled professional, who has invested so much into your education and training, you want to make sure you have genuine own-occupation coverage...so that even if you can teach, for example, in your field — but cannot practice dentistry — you are still eligible for benefits. A few companies even consider your ADA-recognized specialty your own occupation. Group coverage is almost never *true* own-occupation coverage.
- **Residual Disability coverage:** Through a rider, a good individual DI plan can provide you with protection against the income loss you may suffer as a result of *partial* disability — *even if you have never suffered a period of total disability*. This kind of residual coverage is not available with most group plans.
- A choice of “Riders”: Riders offer optional additional coverage

such as *annual* Future Increase Option, Automatic Increase and Cost of Living Adjustments, or “COLA.”

Protecting your practice, as well as yourself

As a dental professional, you must also protect the source of your income. Special policies, available from the same DI providers who offer high-quality individual coverage, offer your practice protection while you recover from a disability.

To help meet the expenses of running the office while you are disabled, consider a separate type of disability coverage known as Overhead Expense (OE). OE benefits reimburse your practice for expenses such as rent for your office, electricity, heat, telephone and utilities, as well as interest on debts and lease payments on furniture and equipment.

Overhead expense insurance specifically designed for professionals reimburses some additional costs not included in regular business overhead expense policies — including the salaries of all regular employees *except* those who are members of your profession. In a practice such as yours, for example, salaries for your receptionist and assistant would be covered, but not the salary of your dental professional partner(s) or employee(s).

In addition...

Dentists who are partners in a group practice will want to consider a policy known as a Disability Buy-Out (DBO). In much the same way that life insurance benefits can be set aside to fund a buy-out by the remaining partner if the other partner dies, this type of policy is designed to fund the healthy partner's purchase of the disabled partner's share of the practice. With the proper agreement in place before disability occurs, hard feelings and the conflicts of interest that can result from a partner's disability can be avoided. Furthermore, in combination with the disabled partner's individual Disability Income coverage, a DBO policy can provide the funding for the healthy partners to pursue the buyout without potentially crippling the practice — while the disabled partner is supported by the benefits from his or her individual DI policy.

The fact is, as part of your overall planning, you owe it to yourself to look into protection for the one thing that makes all the other planning possible: your ability to earn an income.

1 Gallup survey conducted for UNUM Corporation (508 respondents ages 30 to 65), reported by *Best's Review*.

2 “Why Disability” booklet, published by *National Underwriter*.

About the author

Nate is an advisor with Park Avenue Securities, LLC with 15 years experience working with dental and physicians practices. His firm focuses on personal planning and business planning issues for professionals and executives. Nate advises clients on complex and simple retirement planning, pension planning, profit sharing, investment performance and insurance planning.



Implant Prosthetics — Taking the Mystery out of Implant Parts and Troubleshooting

Date: Friday October 13, 2006

Location: Jefferson Dental Center, 737 Holly Lane,
Westampton Twp, NJ 08060 (Off Exit 5 of NJ Turnpike)

Registration: 8:00 am. Lecture: 9:00 am to 4:30 pm

“Hands On” Participation course, 7 MCE credit hours. Limited to 30 Participants.
Program includes Luncheon and all breaks

Presentation by

John DiPonziano, DDS, MAGD

Dr. Diponziano has been performing the surgical placement and prosthetic restoration of dental implants since the mid-eighties. A 1983 graduate of Temple University School of Dentistry, he also completed a three-year didactic and participatory program in Implantology at the University of Pennsylvania in 1989. Prior to attending dental school, Dr. DiPonziano was a full-time dental Technician and earned CDT (Certified Dental Technician) status, which he still maintains today. He is past President of the New Jersey Academy of General Dentistry. He is in private general practice in Columbus, NJ, and also provides surgical placement and implant case treatment planning on referral from other practitioners.



Course Description:

This course consists of a morning lecture and an afternoon participation session. Indications for the various prosthetic and implant components will be clearly explained and illustrated in the morning presentation. Participants will then have the opportunity to assemble the actual components later in the day. There will also be a review of radiographic and surgical stent design, which will illustrate the proper pre-surgical planning necessary for a successful prosthetic result. In addition, a portion of the lecture will be devoted to the NobelBiocare “Teeth-in-an-Hour” concept. The indications and techniques for the surgical and prosthetic elements of this modality using CT scan and model-based bone mapping protocol will be discussed. Troubleshooting of common implant prosthetic problems will be discussed. Course participants are asked to email Dr. DiPonziano before the course for any trouble shooting questions they would like answered at the course. His email is Jdiponz@hotmail.com.

Comments from past attendees:

- “Best implant course that was geared for the restorative general dentist”
- “Excellent course — nice to have a course on the ‘pieces’”
- “Good material I could use tomorrow without wowing me to death”
- “Well presented course — hands-on very useful, excellent handouts”

Course hours: 7 MCE credit hours

Course fee: AGD members – \$295.00 / Non-members – \$365.00 / Staff/Auxillary/Spouse – \$125.00

Course code: 692

Registration and payment information: Implant Prosthetics—Taking the Mystery out of Implant Parts and Troubleshooting – John DiPonziano, DDS,

MAGD

Name: _____

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Address _____ City/State _____ Zip _____

Payment Method: Enclosed is my check for \$ _____ or Credit Card (check one) Visa MasterCard AmEx Discover

Card No.: _____ Exp. Date: _____ Security Code: _____

Name on Card: _____ Signature: _____

Mail registration and payment to: NJAGD/CE, 1 Dental Plaza, PO Box 6020, North Brunswick, NJ 08902-6020, Toll Free: 1-866-GO-NJAGD Fax no.: 1-732-821-1082

Congratulations to our new Masters and Fellows

On Saturday, August 5th, in Denver Colorado at the Academy of General Dentistry's annual meeting we gathered at Convocation 2006 to honor a new class of Masters and Fellows. New Jersey was well represented. Five Masters and Twenty one new Fellows gathered to receive their awards.

This was the culmination of years of education, commitment, time and effort on the part of these individuals. Each of the following awardees is to be commended for their personal achievement.

Masters: William M. Lane, DMD, Haddonfield
 Lee M. Maisel, DMD, Clark
 Michael J. Maser, DMD, Middlesex
 David W. Pauiussen, DMD, Long Valley
 Gary G. Vander Vliet, DMD, Hackettstown

Fellows: Francis Barbieri, Jr. DDS, Somerville
 Warren E. Boardman, DDS, Ridgewood
 Robert A. Borny, DMD, Sparta
 Yvonne Callas, DMD, Cresskill
 David L. Castellano, DMD, Warren
 Howard Epstein, DMD, Linwood
 Fariba Farrokhi, DMD, West Orange
 Jordan Goldberg, DMD, Barrington
 William M. Kaplan, DMD, Lincoln Park
 Roy E. Lee, DDS, West New York
 Elkan E. Linn, DDS, Cherry Hill
 Lawrence S. Lizzack, DMD, Fair Lawn
 John Mamoun, DMD, Green Villager
 Robert A. Mermet, DDS, Pennington
 Mindy Ok, DMD, Mountain Lakes
 John A. Robina, DMD, Summit
 Gary G. Sapienza, DMD, Merchantville
 Bennett H. Sideman, DDS, Merchantville
 Louis J. Theodorou, Jr. DMD, Ramsey
 Lin Zhu, DDS, North Brunswick

For the first time recipients of the Lifelong Learning and Service Recognition were honored. This is formal recognition for AGD Masters who have continued to serve through continuing education, dental related community service and service to organized dentistry. We are proud to announce New Jersey was represented in this first class by two recipients, Dr. Allyson K. Hurley, Chatham and Dr. Daniel B. Krantz, Somerset

I would like to take this opportunity to thank the members of the 2005-2006 New Jersey Board of the AGD for their tireless commitment to this organization. Without them this journal, continuing education, recognition of awardees, this organization itself would not exist in New Jersey. We do not have a large staff to run this organization. The letters you receive, your CE brochure, your awards are written and designed by these board members.

This is a wonderful group of doctors dedicated to their profession and the Academy of General Dentistry. We are always looking for more members who would like to contribute by joining this board.

If you are interested and/or feel you have something to offer feel free join us at one of this year's meetings. Please contact NJAGD for a schedule.

National Foundation of Dentistry for the Handicapped

Thousands of Americans have developed serious dental complications because they cannot afford to see a dentist. Many of these individuals are elderly or disabled, or have been diagnosed with a life threatening disease. For some, there is hope. Donated Dental Services (DDS) is a direct care service program of the National Foundation of Dentistry for the Handicapped.



DDS connects volunteer dentists and laboratories across the nation with our nation's most vulnerable individuals. The DDS program is very simple. When an application is submitted, a DDS coordinator evaluates how extensive the applicant's dental needs are. The primary goal of the DDS program is to return patients to good oral health, enabling them to reach an affordable maintenance level.

The DDS program is different from other volunteer dental programs. Rather than providing minimal care to many, dentists provide comprehensive care to a few. Volunteer dentists are asked to treat one patient at a time, as it is convenient with their schedule.

Dentists treat patients in the comfort of their own offices. This allows dentists to work with their own equipment and staff. Patients referred through DDS must arrive on time for all appointments, and may be disqualified if appointments are missed without prior notice to the office staff.

Dr. M, a DDS volunteer in Aberdeen, met with Mrs. H. and recommended that her bottom teeth be extracted. An oral surgeon in Old Bridge completed the seven extractions at no charge. Mrs. M was fitted for a full lower denture complements of a local dental laboratory. Mrs. M received \$4,205 in pro bono dental care, something that she could have never afforded herself. Mrs. H. stated the following, "May God bless you and your organization and all the wonderful people who made me smile again and can now seen in public without embarrassment. You made it all possible. Thank you!"

The rewards for participating in the DDS program are immeasurable. Please consider helping someone regain their smile by volunteering today. For more information about the DDS program, please contact south New Jersey coordinator Shanda Bell at 732-549-8090 or north New Jersey coordinator Gerri Baffuto at 732-549-8506.



Navin Boggavarapu
Mastertrack chair NJAGD

Excellence in Dentistry

Dear Fellow of the Academy of General Dentistry:

CONGRATULATIONS!

Now that you have received your fellowship, the next step is the mastership. The prestigious Master of Academy of General Dentistry (MAGD) award requires a total of 600 hours of CE with 400 of those hours being participation type credits in specified areas of dentistry. Trying to meet these requirements can be difficult since courses offering participation credits in some subject areas may be hard to find. This is why the NJ Academy of General Dentistry has developed its **AIM (Accelerate in Mastership)** program.

AIM provides a timely, cost-effective means of accumulating your participation credits in all required areas. It consists of a small group forum, encouraging interaction between participants and instructors which makes for a stimulating and enjoyable experience. After each session, you will receive a challenging in-office assignment which will qualify for participation credits towards your Mastership.

Here are the details. Each meeting is 3 1/2 days in length, from Thursday to Sunday. Each Friday, Saturday, and Sunday (Sunday's session ends approximately 12:30 p.m.); new topics are presented by the instructors. Participants will return to their offices and complete an assignment over the following 6-month period, prior to the next AIM meeting. The assignment usually consists of case presentations and write-ups which are to be presented to the class on Thursday of the next AIM weekend. On Friday, the new topic would begin. This format awards 52 credit hours for each of the meetings, which will be presented twice a year. Continuous enrollment in AIM will allow you to accumulate all the required participation credits in as little as 4 years.

The best part about AIM is the camaraderie. On Friday night, there is a social get together, usually at the home of an AIM participant who lives near the course site. There is also a banquet dinner on Saturday night held at a local restaurant.

Tuition for the AIM weekend is \$ 1,050.00 and includes continental breakfasts, lunches, the Friday social and the Saturday banquet.

Here are some comments about the AIM program:

"Great courses. Quality courses with quality people"

— Howard Lassin

"It took me 15 years to get my mastership in the AGD... Now when you sign up for the New Jersey AGD's AIM (accelerate into mastership) program you can do it in four years!. Going through the process of achieving mastership in the AGD was one of the most outstanding periods in my professional career."

— Bruce W. Small DMD MAGD

The AIM program is a positive and wonderful program that has helped me to grow professionally and expand my paradigms in the various disciplines of General Dentistry. The camaraderie, friendship and interactions with my AIM colleagues has been extremely rewarding and gratifying.

— David Paulussen

AIM is a program tailored to the working dentist who wants to improve their clinical skills to a higher level. The hands-on approach of AIM has increased the clinical options I can offer to my patients.

— Tim Campagna

The NJ AIM group has an excellent learning environment. The non-judgemental attitude of the group allows for the free exchange of ideas. The friendship that have formed is priceless.

— Tom Friscia

I have been to different MAGD courses in NY, NE and Ontario. By far, NJ is the best one, people are friendly, course content is informative. Administration is great.

— Daniel Chow

If you have any more questions, please e mail me and put AIM in the subject and I will get back to you as soon as I can. If you are a dinosaur and want to speak to me instead of e mail, please call me at 732 668 1657 and leave a message with a number and time that I can call you back at.

Dental Clinic in New Orleans Helps Thousands

Dr. Samuel H. Taller

I recently saw an article in the ADA news about a “Mission of Mercy” project set up to assist victims of Hurricane Katrina in New Orleans. My son Barry, a high school senior interested in a career in dentistry, immediately suggested we join the mission to help out. He has previously volunteered in hospitals and charities and felt these people needed our help. I readily agreed, believing that this would not only help the victims but also be a valuable learning experience for his future.

Since the September 11 terrorist attacks I felt that it was important for us to give back to the community. Many volunteers came to NY to help us in 2001 and I was left with a strong belief that it is our responsibility to help others faced with tragedy during their time of need. I have been active in volunteer work and I am a member of the Medical Relief Corps in New York City and also Bergen County. The Medical Relief Corps are staffed with volunteer doctors available for civic emergencies.

Many hospitals, medical and dental facilities were flooded, severely damaged and unable to reopen. L.S.U. Dental School was heavily damaged and had to relocate to Baton Rouge.

When we arrived, it had been almost six months since the hurricane and there were still people without homes, jobs and dental care and various State Dental Societies wanted to help. The Virginia, Kansas and the Texas Dental Associations with the support of the ADA and Louisiana Dental Associations organized a special free dental clinic from Feb.5-12, 2006 at the New Orleans’ Audubon Zoo. The Dental Associations worked very hard to gather enough equipment but needed Dentists, hygienists and support staff to volunteer to treat the thousands of expected patients.

Most of the Dental Clinic was set up outside in tents. Over 70 chairs were set up for patient care. In the small building provided by the zoo areas were set up for x-ray, sterilization, hygiene and



about ten chairs. There were other areas for triage, operative, oral surgery and even denture repairs. Officials report that 425 volunteers from 38 states came with 239 dentists treating nearly 4000 patients. Most dentists came from the Louisiana area, but there were a few from NJ.

Thousands of people arrived each day for the free dental care. They lined up for treatment waiting 5-6 hours to be seen. The clinic operated from 6:00 AM-5:00 PM. Everyone worked together to make sure as many patients were treated as possible. Surprisingly there were times that there were more dentists than chairs. The patients were very appreciative for the help we gave despite the long wait and less than ideal conditions. At one point I was preparing an amalgam while the rain was dripping on my shoulder.

Many people we treated spoke about their individual ordeals. One person reported that her entire neighborhood was flooded and that they were still not allowed to return. She gave us directions there so we later drove there to see. The houses were still standing and the streets were clear but there were piles of debris in front of each house and no power was available. One person reported that their store was not damaged by the flooding but looters came daily till there was nothing left to take.

When Barry was asked how the experience affected him he said, “I saw how important the need for dentistry is and how one by one we could help raise their spirits.” In all, thousands of people were helped, but more needs to be done to restore their lives.

About the author

Dr. Taller has practiced in Riverdale, NY for over 20 years. He has been a member of AGD over 20 years and obtained his F.A.G.D. Dr. Taller has a Masters of Human Anatomy from FDU Dental School and graduated at the top of his class from NJDS in 1982. He is also the treasurer of the Uptown Dental Study Club.



AGD Annual Session 2006, Denver & Fellows/Masters Recipients



Power UP your dental practice



Give your practice the boost you've been seeking by hiring the dentist's coach - we're Coaching Solutions. Our team is comprised of highly skilled professionals working together with some of the most respected and proven specialists dentistry has to offer. Unlike many other coaching programs, we have a proven dentist-focused approach aimed at enhancing the leadership in your practice, laying the foundation for the success of your team.

We use an in-office coaching team, seminars and doctor/owner coaching continuums in a series of short and comprehensive programs customized to fit your needs and goals, to deliver you the means to build your dream practice.

We're right here in New Jersey, so we're able to follow through on our program. We know the North, South and Central Jersey cultures from living here and working with hundreds of offices.

Our short programs include:

- Assistance in hiring, including Internet assessments and evaluations for prospective employees
- Office manual development with custom policy and job descriptions
- In-office team building and case presentation workshops
- Marketing assistance including brochures, websites and collateral materials

Our comprehensive programs include:

- Upleveling patient service
- Analysis of fees, teams and profitability
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