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- For balances of $250 to $2,499 take 2% off your statement balance if you pay by check.

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Pennsylvania Dental Journal

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The mission of the Pennsylvania Dental Journal is to serve PDA members by providing information about topics and issues that affect dentists practicing in Pennsylvania. The Journal also will report membership-related activities of the leadership of the association, proceedings of the House of Delegates at the annual session and status of PDA programs.

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LOL

I don’t remember getting old. Maybe that’s the first sign of old age. This year marks two important milestones in my life. In January I turned 50. No need to congratulate me, as I fully expected to reach this age and beyond. In May of this year I will celebrate my 25th class reunion at the Kornberg School of Dentistry, formerly known as “Temple.” Also not a surprise, as I love the science of the teeth and gums!

Age is obviously relative. If you are young it’s relatively good and if you are old... well you can complete the rest of the sentence. At a recent executive meeting for our local dental society a discussion about the new dentists committee revolved around the age of new dentists. The ADA and PDA consider new dentists to be graduates 10 years out or less. The committee was asking if they could include those out 15 years to increase the pool of invitees to an upcoming event. It took me a moment, also a sign of age, to realize that I would not be invited under the current limit, nor would I receive an invitation under the proposed change. I am simply too old.

That got me thinking, and that is never a good thing. Where did the time go? Again, an early sign of dementia. Just yesterday, or more accurately about 25 years ago, I was the new kid in town. I would go to visit the dentists in my area and they would call me “kid.” One dentist told me that he had underwear older than me and that I had a lot to learn. Now my underwear is old but I still have a lot to learn.

In 25 years I have made many good dentist friends. I have met thousands of dental patients who I see around town, in restaurants, movie theaters and even on vacation. I have also taught at the same dental school that I graduated from for nearly 22 years. Even there I am now the “old guy.” So what gives?

Some say that age is a state of mind. The saying goes, “You are only as old as you feel.” Some days I feel pretty old. Most days I feel like one of the new dentists, but I’m not allowed to attend any of their functions. I guess you could now call me a “Dentweener.” Too old to be a new dentist and too young to retire and play golf. In fact I don’t really fit the profile of an old dentist:

I only complain sometimes rather than all of the time.

I don’t stand up and grunt “Oy.”

I don’t say things like “Remember when gutta percha cost 25 cents a package?”

I don’t wake up at 5 a.m. and I don’t go to bed at 9 p.m.

I don’t care for prunes, nor do I need them.

What I can tell you is that age does have its privileges. When I graduated from my residency my patients would look at me with some trepidation because I was so young. I can remember wishing that I was older so that both patients and referring doctors would not question my abilities. Well, my wish has come true. I am older, but as for the respect I have found that it comes with what I have done and not how old I am.

When I was a younger dentist I was a pushover for my patients. I once had a call at 2:00 a.m. on Christmas Eve from a patient who insisted that I come to the office because he had a toothache. I was young and felt that I could help, even though I had never seen this patient. Stupidly I agreed. At the office I took a radiograph only to discover the pain was from an impacted wisdom tooth and there was nothing I could do. Today if I got a call at 2:00 a.m. I would tell the patient that I could see them first thing in the morning.

So, would I rather be the dentist I was 25 years ago or the dentist I am today? I would say that I will keep what I have. I have witnessed 25 years of marvels. A wonderful marriage and two beautiful children. A dental practice that has grown. A record of more than 35,000 root canals and still going strong. I have witnessed the marvels of technology, including dental office computers and digital radiography and email communication with patients and colleagues. I have seen the increased use of dental implants, lasers, resins and ceramic restorations. I am reading about the coming of pulpal regeneration and stem cell harvesting from extracted teeth.

(continued on page 6)
After 25 years I still anticipate each day with excitement rather than dread. I would never wish to go back in time just to have more hair and fewer advances in dental innovation. And I would never want to lose a family that is so important to me.

Getting older may not seem like much fun, but there are things you can do to disguise the damage.

- Hang out with people who are younger than you
- Say things like, “Cool” and text “LOL” (laugh out loud) or “NMJCLA” (not much just chilling like always)
- Eat dinner later than 5:30 p.m.
- Buy new underwear

I will get through this tough time in my life. Writing has always been my therapy. Writing this has really helped me to understand what I was feeling. I’m definitely feeling better.

TFL (Thanks for listening)

—BRT
One of Governor Tom Corbett’s first orders of business was to introduce his proposed budget for FY 2011-2012. Now the General Assembly is immersed in the daily grind of appropriation hearings with all the executive agencies. With a new governor, 33 new legislators (30 House freshmen and 3 new Senators) and a shift in power in the House of Representatives, the challenge will be to pass a balanced budget by the constitutionally-mandated date of June 30.

This year, the Government Relations Committee voted to present awards to Rep. Eddie Day Pashinski (D-Luzerne) and Sen. Jane Orie (R-Allegheny) for introducing and championing PDA’s legislation expanding EFDA scope of practice to include coronal polishing, fluoride applications and taking impressions of teeth for athletic appliances. HB 602, now Act 19, passed the General Assembly and was signed into law in 2010.

State Issues

PDA Lobby for Legislation Prohibiting Insurers from Capping Non-Covered Services

At PDA’s request, Sen. Kim Ward (R-Westmoreland) is once again introducing legislation that would prohibit insurance companies from capping dental services they do not cover under their plans. In an effort to gain momentum in both chambers, Rep. Thomas Murt (R-Montgomery) will introduce a companion (identical) bill in the House of Representatives.

Dentists who participate with insurance companies are being asked to sign contracts that will prohibit them from charging patients their usual and customary fees for non-covered services. The impact of this contractual change for dental practices could be significant if the reimbursement for non-covered services is too low for dentists to cover their overhead expenses, pay their employees, etc. Dentists may have to choose between economic hardship and disrupting relationships with patients if they need to drop out of network.

This is a business decision on the carriers’ part, with full awareness of the implications for their provider networks. In down economic times, this is a calculated risk they may be willing to take to reduce costs and shift risk to provider networks to remain competitive in the marketplace.

PDA has made passage of this legislation its priority for the 2011-2012 legislative session. Understanding the financial impact this policy has on those members participating with insurance companies, PDA’s lobbyists, staff and volunteers continue to meet with members of the Senate Banking and Insurance Committee and House Insurance Committee, to which the bills will be assigned for first consideration once they are introduced.

PDA Lobby for Assignment-of-Benefits Legislation

At PDA’s request, Rep. Thomas Murt (R-Montgomery) will reintroduce legislation that would require insurance companies to assign benefits to the treating dentist when he or she is not a participating provider with a patient’s insurance plan.

We believe that this is an issue of protecting patients’ ability to choose their dentist, regardless of whether he or she participates in insurers’ plans. Patients should have the right to choose their dentist and their health insurance plans should be required to respect that choice by paying the dentist directly. This legislation does not change the amount insurers would pay for the services. It only changes to whom they write the check.

We also believe that without assignment-of-benefits, divorced parents with children are less protected if one parent pays for the dentist’s bill covered by the other parent’s insurance, and the second parent does not send the reimbursement check to the dentist.

PDA is meeting with members of the House Insurance Committee to educate them about the issue and is lobbying the committee chair to place this bill on the agenda for consideration once it is introduced.

Fighting for Insurance Coverage for General Anesthesia to At-Risk Patients

PDA supports HB 532, legislation reintroduced by Rep. Stan Saylor (R-York), which would require all insurers to cover the costs associated with administering general anesthesia to children seven years of age and younger and special needs patients. Twenty-nine states require that medical plans pay for related medical expenses, such as the administration of general anesthesia, when needed to provide dental care. Not providing this coverage limits access to care for those patients who require extensive dental work or need general anesthesia because of behavior management issues. These patients simply do not get the care they need because they cannot afford the significant costs associated with the administration of general anesthesia.

Our lobbyists and staff are working with key members of (continued on page 8)
Government Relations

the House Democratic and Republican caucuses to advance this legislation. We will also work with organizations that advocate on behalf of Pennsylvanians with special needs to better educate the legislature about how providing this coverage is necessary in order to provide quality care to the most vulnerable dental patients.

HB 532 has been assigned to the House Insurance Committee for consideration.

**PDA Supports More Funding in the Health Practitioner Loan Forgiveness Program**

PDA continues its strong support for increased funding in the Department of Health’s student loan forgiveness program. Sen. Edwin Erickson (R-Chester, Delaware) introduced SB 278, legislation to reimburse physicians and dentists enrolled in the state’s Health Practitioner Loan Forgiveness Program to serve in designated health professional shortage areas (HPSAs). Dentists may be reimbursed up to 100 percent of their dental student loans, or no more than $75,000, whichever is less, depending on the length of service in a HPSA area.

We support this as an essential piece of legislation that will improve access-to-care in underserved areas of the state, by placing dentists in the communities themselves, rather that have patients seek care far from their homes. However, PDA expressed our concern to Sen. Erickson that the required length of service may deter some dentists from applying to the program. We are also determining whether there is any support for broadening the existing statute to allow specialists to apply. This bill is assigned to the Senate Education Committee, where it has not received any consideration to date. With dire budgetary shortfalls for fiscal year 2011-2012, we expect an uphill battle in passing legislation to secure additional funding for this program.

**PDA Weighs in on Push to Require Malpractice Insurance**

Due to a pending lawsuit against a dentist without liability insurance, there is momentum in the General Assembly to pass legislation requiring all dentists to carry liability insurance. A deluge of media attention brought to many legislators’ attention the fact that dentists are one of the few health care providers not required to purchase this coverage.

Sen. Patricia Vance (R-Cumberland) introduced SB 388, legislation that would require all actively practicing licensees to carry a specified amount of coverage. The bill requires all licensees to maintain liability insurance in the minimum of $1,000,000 per occurrence or claims and $3,000,000 per annual aggregate. Licensees must show proof of having purchased insurance to the State Board of Dentistry within 60 days of the bill’s enactment. PDA met with Sen. Vance to discuss an amendment to her bill exempting volunteer licensees from this requirement. Most volunteer dentists carry insurance through the facility where they donate care.

**PDA Monitoring the Proposed Volunteer Health Services Act**

PDA is developing a position on Sen. John Pippy’s (R-Allegheny) legislation that would give retired dentists and other retired health care professionals immunity from civil damages for the care they provide without remuneration in a clinic that offers free or discounted care. Those health care providers who carry volunteer licenses often purchase liability insurance because they may still be sued. However, the bill’s provisions may need to be strengthened to fully protect the volunteer dentist.

Some providers who may wish to volunteer after retirement view having to purchase malpractice insurance as a disincentive. Sen. Pippy introduced SB 569 in an effort to increase the number of providers volunteering in free or reduced-cost clinics, particularly those in underserved areas.

**National Issues**

**ADA Works to Repeal McCarron-Ferguson Act**

ADA continues to lobby to repeal parts of the McCarron-Ferguson Act, which allows states to regulate and tax insurers while giving the insurance industry a limited exemption from federal antitrust laws. This gives insurers an unfair advantage over health care providers and patients by limiting competition and the ability for collective action. ADA’s legislation to repeal certain parts of this Act would level the playing field and force insurers to comply with the same rules governing providers. Repealing McCarron-Ferguson would also benefit patients by creating a more competitive atmosphere among insurers for a subscriber’s business.

**ADA Weighs in on Health Care Reform Law**

As efforts continue by some in Congress to repeal parts of President Obama’s health care reform package, ADA is again focusing its efforts to ensure funding for federal dental programs. These programs include residencies in general, pediatric and public health dentistry and dental hygiene training programs. Additional funds are allocated to the National Institute of Dental and Craniofacial Research, maternal and oral health programs under the Special Programs of Regional and National Significance and The Ryan White CARE Act for AIDS dental services.

The Senate Appropriations Committee did pass legislation to provide additional funding for dental programs in FY 2011; however, this bill has not yet passed the full Senate.
SAVE THE DATES!

You can see from all the issues mentioned above that now more than ever your participation in dentistry’s advocacy efforts is needed. Please consider joining with other colleagues to speak with members of Congress and the Pennsylvania General Assembly on important oral health care topics. How else can dentistry make such a huge impact than by collectively converging at our state and national Capitols to speak with those in a position to impact your profession?

All members are invited to the ADA Washington Leadership Conference, scheduled for May 9-11, at the Hyatt Regency Capitol Hill hotel in Washington D.C. Participants have the opportunity to hear from legislators, political pundits and others impacting the political scene in Washington. There is also a day at the Capitol, where we meet with members of Pennsylvania’s Congressional delegation.

All members, spouses and dental students are encouraged to attend PDA’s Day on the Hill, scheduled for June 14, in Harrisburg. PDA forms teams to visit with members in the General Assembly who are in positions of leadership, particularly those who serve as chairs of committees that vote on PDA’s legislation. We arrange these meeting in advance, send you background information and talking points on our issues and arrange for your transportation to the Capitol.

For more information or to register, contact Marisa Swarney at (800) 223-0016, or mss@padental.org. You may also register online at www.padental.org.
PAC Trends — How Do We Stack Up?

Over the years, the Pennsylvania Dental Association’s Political Action Committee (PAD PAC) has faced many tough challenges. Decisions are being made on a daily basis to combat those challenges by our PAC board, along with the help of your contributions. Because of your support, we have managed to step up our efforts to prohibit insurers from regulating the fee a dentist can charge for non-covered services. And in the past, we have stopped the legislature from passing a bill prohibiting dentists from administering general anesthesia and deep sedation in their offices.

While the challenges we face are important, we must remember we are not alone. Other state dental association PACs feel the same effects we do on a day-to-day basis and work daily to insure their goals are met. It is important to recognize how other states are using their PACs to gain a competitive edge, and we can learn from each other by sharing ideas, stories and methods of success.

By first learning a bit about ourselves, it will help us better understand others. Looking into our past, we can see how trends in our PAC will better prepare us for the future. Take these key lessons and combine them with viewpoints from others, and more times than not you get a successful foundation to build upon.

By comparing PAD PAC over a five-year period to PACs in four states with similar membership numbers (New Jersey, Washington, Illinois and Massachusetts), we can learn a thing or two about others, but most importantly ourselves.

A Look at PAD PAC

The following graphs represent PAD PAC numbers from 2006-2010. This includes total dollars collected, percentage of members who contributed, along with total contributions. The numbers are based on contributions from active, dues paying members.

Total Dollars Collected:

<table>
<thead>
<tr>
<th>Year</th>
<th>Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>$211,534</td>
</tr>
<tr>
<td>2007</td>
<td>$209,332</td>
</tr>
<tr>
<td>2008</td>
<td>$168,420</td>
</tr>
<tr>
<td>2009</td>
<td>$160,693</td>
</tr>
<tr>
<td>2010</td>
<td>$158,655</td>
</tr>
</tbody>
</table>

*Note: Due to our dues statement being mailed in November, the bulk of our contributions come in November and December. Contributions for 2010 run from November 1, 2009-October 31, 2010.

Total Percentage of Members Contributed:

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>37.51%</td>
</tr>
<tr>
<td>2007</td>
<td>37.20%</td>
</tr>
<tr>
<td>2008</td>
<td>29.54%</td>
</tr>
<tr>
<td>2009</td>
<td>26.02%</td>
</tr>
<tr>
<td>2010</td>
<td>31.00%</td>
</tr>
</tbody>
</table>

*Note: Due to our dues statement being mailed in November, the bulk of our contributions come in November and December. The 2010 percentage is based on November 1, 2009-October 31, 2010.

Total Contributors:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>1,722</td>
</tr>
<tr>
<td>2007</td>
<td>1,691</td>
</tr>
<tr>
<td>2008</td>
<td>1,328</td>
</tr>
<tr>
<td>2009</td>
<td>1,168</td>
</tr>
<tr>
<td>2010</td>
<td>1,229</td>
</tr>
</tbody>
</table>

*Note: Due to our dues statement being mailed in November, the bulk of our contributions come in November and December. The 2010 contributor numbers are based upon figures from November 1, 2009-October 31, 2010.

As we take a look at how PACs in other states operate, it is important to remember that the methods one state uses may not be the best for others. The key is to identify other PACs’ methods and thoroughly review and research them before considering any change in our PAC structure.

New Jersey

Jim Schulz, director of government affairs, explained contribution levels for the New Jersey Dental Association’s PAC. “We have several contribution levels,” he said. Those contribution levels are as follows: Sustaining Member $150, Diamond Club $350, Platinum Club $500, Executive Club $1,000, Chairman’s Club $1,500, and Governor’s Circle...
$2,000 and above. Mr. Schulz went on to say, “We were the largest health PAC in New Jersey for the last five years.”

“We raised about $210,000 to date this year and have approximately 27 percent of our 4,700 members contributing. We typically raise between $225,000 and $275,000 annually, and our contributor level is between 28 and 31 percent over the last five years.”

Washington

The Washington State Dental Association’s PAC, known as DentPAC, is a state-level PAC formed to fund candidates and political causes that support organized dentistry.

“DentPAC operates on a 2-year fiscal period to better match the 2-year cycle for campaign contributions,” says David Hermion, director of government affairs. Instead of budgeting annually, the DentPAC operates its cycle based on an election year.

On each dues statement, there is a mandatory $75/year allocation to their PAC. This is similar to what a few other states do, including California and Oregon.

Mr. Hermion went on to say, “Voluntary contributions are still coming in at about $90,000/year, but dropping some. That $90,000 represents about 700 members; 22 percent who are actively practicing.”

Illinois

Pam Cuffie, government relations assistant at the Illinois State Dental Society, provided key figures and information regarding Illinois DENT-IL-PAC.

“DENT-IL-PAC is the basic level of our political action committee,” Ms. Cuffie said.

Their contribution levels are DENT-IL-PAC $100 and Governor’s Club $200, which is their second level.

“Beginning next year, our contribution levels will change to $125, $250 and we are adding a new level of $500,” Ms. Cuffie said. An automatic $49 is taken out of each member’s contribution and sent to ADPAC.

To date, $212,208 has been contributed to the Governor’s Club, and $114,715 for DENT-IL-PAC. The following chart shows a few statistics concerning PAC membership:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois State Dental Society Total Members</td>
<td>6,334</td>
</tr>
<tr>
<td>Active ISDS Members</td>
<td>5,273</td>
</tr>
<tr>
<td>DENT-IL-PAC Members</td>
<td>1,144</td>
</tr>
<tr>
<td>Governor’s Club Members</td>
<td>1,046</td>
</tr>
<tr>
<td>Total PAC Membership</td>
<td>2,190</td>
</tr>
<tr>
<td>% of ISDS members who are PAC Members</td>
<td>35%</td>
</tr>
</tbody>
</table>

Massachusetts

Dave White from the Massachusetts Dental Society discussed his organization’s PAC numbers.

“As of June 30, 2010, MDS-PAC/MDS-People’s Committee had received 697 contributions, which is roughly 14.33 percent of the MDS membership,” Mr. White said.

“We have been as high as 20 percent in recent years, but unfortunately the economy seems to have impacted our organization.”

The MDS-PAC has raised $115,293 so far this year, with $30,881.74 being sent to ADPAC. The MDS-PAC is limited to receiving $500 per person per calendar year only, accepts personal contributions and cannot accept corporate monies.

What does this all mean?

The most important number to look at is the percentage of those who voluntarily contribute to their PACs. While each organization has their own way of promoting their PAC, we all can agree on the need to encourage better participation among our members. Suffice it to say, the ways we do this may all be different. However, it cannot be stressed enough that the more dentists “speak up” by contributing to PACs, the closer we get to uniting as one.

If you already contribute to PAPAC or are considering contributing, remember that the more you contribute and get the word out the better chance you have to access the right legislators who will influence the legislative process on our behalf. Speak with your colleagues and become informed about the issues that affect your profession. And if possible, considering stepping up your contribution amount.

For more information about PAPAC and how you can contribute, please feel free to contact Don Smith, government relations coordinator, at dls@padental.org. To donate to PAPAC online, go to www.padental.org/papac and click “Join Now.”

<table>
<thead>
<tr>
<th>State</th>
<th>PAC Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>31%</td>
</tr>
<tr>
<td>NJ</td>
<td>27%</td>
</tr>
<tr>
<td>WA</td>
<td>22%</td>
</tr>
<tr>
<td>IL</td>
<td>35%</td>
</tr>
<tr>
<td>MA</td>
<td>14%</td>
</tr>
</tbody>
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Note: These percentages reflect voluntary contributions for the 2010-year. The Pennsylvania percentage reflects November 1, 2009 – October 31, 2010, with the bulk of contributors contributing in November and December as our annual dues billing occurs at that time.
Achieve personal and professional success

Attend the ADA 25th New Dentist Conference: Sweet Home Chicago, Silver Anniversary

Don’t miss...
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- Full day of leadership development
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Chicago – Your kind of town with your kind of Conference.

For 25 years the ADA New Dentist Committee has been hosting this spectacular conference, which focuses on the unique needs of new dentists — dentists who have been out of dental school less than 10 years.

Speakers include:
- Ms. Marsha Rhea, keynote, Dentistry 2036
- Dr. William Carpenter, The Oral Cavity, Gateway to Health or Disease?
- Dr. Gregg Liberatore, Ms. Judy Jennings, Dr. Michael Unthank, Ms. Geri True, Mr. Jim Boltz, Preparing for Practice Ownership
- Dr. Harold Crossley, Street Drugs Exposed — What Your Patients Are Not Telling You
- Dr. Joseph Massad, Spice Up Your Practice with Dentures and Implants — A Great Way to Ease the Economic Tensions in Your Practice Today
- Dr. Mark Murphy, The Art, Science and Business of Dentistry — Growth and Planning Strategies for the New Dentist
- Dr. David Ahearn, Going Green — It’s Not Just for the Environment

Friends, CE and live blues in Chicago — this is your kind of Conference.

Visit ada.org/newdentistconf for information and to register.
PDA is proud to re-introduce the Leadership Symposium, May 20-21, at the Holiday Inn Harrisburg East. This informative, motivational conference is a great way to jump-start your summer planning for the 2011-2012 association year! Register at www.padental.org/leadership by April 29.

Who should attend?
• District & Local Society Leaders, Volunteers & Staff
• PDA & ADA Committee members
• Members interested in jump-starting their leadership talents

Why should I attend?
• Meet PDA Leaders & Staff
• Learn valuable leadership techniques that can be applied in your volunteer work and in your practice
• Network with colleagues
• Share insight and feedback

What are the costs?
The only cost you incur is travel to and from Harrisburg. PDA will reserve an overnight accommodation for you at the Holiday Inn Harrisburg East or a comparable hotel nearby. One night’s accommodations (room and tax only) will be billed directly to PDA. Complimentary rooms are limited so register early!

Do I have to take time out of my office?
We have conveniently scheduled the first program to begin at 4 p.m. on Friday, May 20, which we’ve found interferes significantly less with our member’s schedules than a different day of the week. The conference will wrap up by 4 p.m. on Saturday, May 21, so you will still have half of your weekend remaining for friend/family obligations.

Please note: some PDA committee members will have their regularly scheduled committee meetings the morning of Friday, May 20 and therefore, may require more time out of the office.

Testimonials
“This symposium is a great opportunity for everyone to both enhance and refresh your leadership skills. In addition to being a great networking opportunity, I’ve always found this symposium to be motivating, full of great ideas and worthwhile!”
— Dr. Karin Brian, Chair, PDA Membership Committee President Elect, Second District Dental Society

<table>
<thead>
<tr>
<th>Full Schedule</th>
</tr>
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<tbody>
<tr>
<td><strong>Friday, May 20</strong></td>
</tr>
<tr>
<td>3:30 p.m.</td>
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<tr>
<td>4:00 p.m.</td>
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<tr>
<td>5:00 p.m.</td>
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<tr>
<td>6:00 p.m.</td>
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<tr>
<td><strong>Saturday, May 21</strong></td>
</tr>
<tr>
<td>7:30 a.m.</td>
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<tr>
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“The PDA Leadership Symposium provided me with great networking opportunities, as well as great leadership lessons that I’ve applied in my position as a representative to the New Dentist Committee and within my practice.”
— Dr. O. Basil Aboosi, PDA New Dentist Committee Dental Society of Western Pennsylvania

How do I Register?
Visit www.padental.org/leadership for more information on any of the programs being offered or to register. If you have questions or concerns about participating in the conference, please contact Rebecca Von Nieda at (800) 223-0016, ext. 117 or Jessica Forte at (800) 223-0016, ext. 134.

We look forward to your attendance!
Welcome New Members!

Following is a listing of members who have recently joined PDA, along with the dental schools from which they graduated and their hometowns.

Jason Alabakoff, DDS, MD
University of Detroit Mercy
Lewistown

Phillip K. Brinton, DDS
Columbia University
Havertown

Christopher Carle, DDS
University of Tennessee
Moon Township

Derek J. Conover, DMD
University of Pennsylvania
Philadelphia

Claire Gallagher, DMD
Boston University
Philadelphia

Jeffrey B. Gregerson, DMD
Temple University
Havertown

Harry Yu He, DDS
University of South California
Philadelphia

Sonia Kahlon, DMD
Tufts University
Philadelphia

Peter Kyuchang Kim, DMD
University of Pennsylvania
Philadelphia

Brian I. Lee, DMD
University of Pennsylvania
Morrisville

Philip E. Mason, DMD
University of Pittsburgh
York

Kathiravan Mohan, DMD
University of Pennsylvania
Bethlehem

John G. Rippy, DMD
University of Tennessee
Chambersburg

Khurram M. Siddiqui, DMD
University of Medicine and Dentistry of New Jersey
Hillsborough

Durga Talla, DDS
New York University
Yardley

Dominic C. Tam, DMD
Boston University
Allison Park

Richard B. Thatcher, DMD
University of Pennsylvania
Northumberland

Derick Wang, DMD
University of Pennsylvania
Pittsburgh
On December 15, 2010, the Pennsylvania Department of Insurance (PDI) submitted new Children’s Health Insurance Program (CHIP) benefits to the Centers for Medicare & Medicaid Services (CMS). PDA is concerned with some of the more significant changes to the CHIP benefit package.

For example, CHIP no longer covers composite resins on anterior primary teeth, which may result in many families foregoing treatment rather than paying additional costs for composites. Also, there is no longer coverage for nitrous oxide and conscious sedation on non-emergency cases, even though these forms of sedation are common and helpful when treating children. There is a new maximum plan allowance of $1,500 where previously there was none. Bitewing X-rays are only covered once a year, and in some cases multiple bitewings are required to monitor ongoing problems.

On February 2, PDA attended the PDI CHIP advisory board meeting. Peter J. Adams, Deputy Insurance Commissioner, CHIP and Adult Basic, hosted the meeting and presented PDI’s marketing, outreach and enrollment plans. The purpose of these plans is to attract more people to the CHIP program and make it easier to enroll. Mr. Adams then broke down the new benefit package for CHIP.

Dr. Mark Goldstein, a PDA member representing the 30 pediatric dentists in the Philadelphia area as well as Temple Health Pediatric Dental system, first complimented the CHIP program for providing high quality insurance to children whose families could not previously afford dental care. Dr. Goldstein went on to state his concerns regarding the lack of coverage for composite fillings on primary teeth, the new $1,500 maximum on all dental benefits and the lack of coverage for conscious sedation on non-emergency procedures. Several others expressed concern that the new CHIP benefits may cause parents to cancel appointments if they cannot afford the care. Mr. Adams agreed that there was much debate on the new benefit package and that there should be meetings in the future to discuss the plan.

PDA sent a letter to PDI questioning some of the new provisions in the CHIP benefit package, and looks forward to working with the PDI to discuss possible reform to portions of the CHIP plan. PDA also requested a meeting and offered the assistance of member pediatric dentists who are in the trenches treating CHIP patients. Following is a summary that explains the CHIP benefit changes from the previous two years to the 2011 program. If you have any questions regarding PDA’s ongoing advocacy or changes to the new benefits, please call Ivan Orlovic at (800) 223-0016 or e-mail him at iio@padental.org.

### 2009-2010 CHIP Benefits Program

**Yearly Maximum:** Unlimited yearly maximum

**Ortho Lifetime:** No orthodontic benefits

**Temporomandibular joint disorder (TMJ):** Not covered

**Deductible:** N/A

**100 percent Preventive:**
- Cleanings allowed every six months and fluoride treatments are allowed every six months for individuals ages 16 and under.
- Oral hygiene instruction is allowed every six months with an unlimited frequency.
- Sealants are allowed on the first and second permanent molars when eruption allows once per tooth per lifetime.
- Space maintainers are allowed when premature loss of primary molars occurs.

**100 percent Basic Restorative:**
- No limits on amalgams or composite resins on posterior or anterior teeth.

**100 percent Major Restorative:**
- Stainless steel crowns are allowed once every five years per tooth with prior approval.
- Metal crowns are allowed once every five years per tooth with prior approval.
- Metal/Porcelain crowns are allowed once every five years per tooth with prior approval.
- Porcelain crowns are allowed once every five years with prior approval.
100 percent Oral Surgery:
- Simple extractions are allowed with no limit.
- Surgical extractions, cancer treatment, cleft palate, care of abscesses and treatment of fractures are covered under the medical portion of CHIP with prior approval.

100 percent Endodontics:
- Root canals on baby teeth (Pulpotomies) are considered a dental necessity.
- Root canals on permanent teeth have no limits with prior approval.

100 percent Periodontics:
- Gum therapies are allowed four treatments per 12-month period. Prior approval for treatment is not required.

100 percent Prosthodontics:
- Bridges except for vertical dimension require prior approval.
- Implants are not covered.
- Dentures and partial dentures require prior approval.

100 percent Orthodontics:
- Braces (Orthodontia) and retainers (orthodontic) are not covered.

100 percent Sealants:
- Placed on first and second permanent molars when eruption allows.
- Only allowed one per tooth per lifetime.

Riders

Emergency Room Services
- Treatment and diagnostic tests may be covered under the medical portion of CHIP, depending on the type of service rendered and the type of injury sustained.
- Treatment and tests provided must be considered necessary.

In-patient Hospital Services
- Covered under the Medical portion of CHIP if considered necessary.

Special Anesthesia
- Some services may be covered under the Medical portion of CHIP.

2011 CHIP Benefits Program

When applicable, the dental benefit package outlined here has been designed to be consistent with the periodicity schedule utilized by Pennsylvania’s Department of Public Welfare (DPW) in the administration of their Medical Assistance Program. DPW’s periodicity schedule was adapted from the recommendations made by the American Pediatric Association, the American Dental Association and the American Academy of Pediatric Dentistry. This schedule is routinely reviewed in order to assure that its standards are consistent with the current recommendations of accredited organizations involved in children’s healthcare.

The following is an abbreviated list of current services and limits that are payable under the dental plan of the Pennsylvania Children’s Health Insurance Program (CHIP).

The list includes services most commonly provided to covered individuals, but other services may be covered for an individual member. Individual members may qualify if it is determined that the requested service is medically necessary and one of the services identified below is insufficient to meet their dental needs.

Yearly Maximum: $1,500

Orthodontic Lifetime Maximum: $5,200

Temporomandibular joint disorder (TMJ): Not covered

Deductible: N/A

100 percent Diagnostic:
- Exams are allowed twice in a benefit year. A full mouth X-ray or panoramic X-ray are allowed once every five years.
- Bitewing X-rays are allowed once a year, vertical bite wing series are allowed every three years
- Intraoral periapical X-rays are only allowed in conjunction with full mouth series (210),

100 percent Preventive:
- Adult and child Prophys are allowed twice in a calendar year. Fluoride is allowed twice per calendar year, based on the American Dental Association’s Caries Risk Assessment tool or an approved Contractor tool.
• High-risk patients are allowed three treatments per year and in some cases four. Space maintainers are covered once per lifetime. High-risk patients signify pregnant individuals and those who are determined such by the American Dental Association’s Caries Risk Assessment tool or an approved Contractor tool.

100 percent Basic Restorative:
• One, two, three and four surface amalgams for primary or permanent teeth are covered with no limitations.
• One, two, three and four surface resin-based composites are limited to permanent anterior teeth.
• One, two, three and four surface resin-based composites are limited to permanent teeth only where amalgams are not possible.
• Resin-based composite crown anterior teeth are not covered with the construction of a permanent crown for teeth 6-11 and 22-27.
• Limited to permanent teeth and primary teeth with no permanent successors.

100 percent Major Restorative:
• Crowns are standard per contract benefits

100 percent Oral Surgery:
• Some oral surgery procedures are covered under patient’s medical benefits.
• Removal of asymptomatic teeth is not covered.
• Surgical access of a ruptured tooth is covered if the member has been approved for a medical necessary orthodontics.

100 percent Endodontic:
• Therapeutic pulpotomy is covered within 45 days of a root canal.
• Anterior bicuspid and molar root canals can be performed on permanent teeth only once per lifetime.

100 percent Periodontics:
• Periodontal scaling is limited once per quadrant every 24 months and to no more than two quadrants done on the same date of service.
• Full mouth debridement is limited to one per lifetime after three years since a dental cleaning.
• Periodontal maintenance is limited twice a year to members that have health conditions which impact periodontal health.

100 percent Prosthodontics:
• Standard benefits per contract

100 percent Orthodontics:
• Lifetime maximum of $5,200 with prior approval using procedure code 8080 & 8090.
• Orthodontic benefits are rarely applied towards the individual yearly dental maximum of $1500.
• Orthodontic treatment must be considered “medically necessary”, with pre-approval of orthodontic benefits authorized in one lump sum at the beginning of treatment.

100 percent Sealants:
• Covered up to and not including the age of 18.
• Limited to permanent teeth with no caries.
• Allowed once per tooth every three years.
Fluoride should hold a prime position in the contemporary approach to managing primary and secondary caries. This article will review basic fluoride formulations as well as advantages and disadvantages of each type. It will conclude with a discussion of fluoride as a central agent in a biochemical approach to maintaining intact dentition, with an eye toward recognizing risk factors and tailoring an individualized, evidence based approach to mitigating risk of caries.

For 60 years, dentists have touted the beneficial effect of fluoride. We have sufficient evidence to claim efficacy and safety. An added benefit to the public is that fluoride has saved a substantial amount of money and time that would have been spent on restorations prevented by topical exposure to fluoride.

For most of this time dentists have focused on the beneficial effects of fluoride for children and adolescents. That effort was (and remains) appropriate. The positive effect is this cohort requires few restorative services. Today, dental practitioners face different needs from the fastest growing demographic cohort…seniors. This group is retaining more teeth with more restorations that wear and, with time, require re-restoration. This cohort has access to excellent medical care and survives with chronic illnesses that would have been fatal 10 years ago. As a result, many patients take multiple medications. Most of these medications alter character, rate and flow of saliva and contribute to xerostomia which, in turn, contributes to increased rates of primary and secondary caries.

Fluoride should hold a prime position in the contemporary approach to managing primary and secondary caries. This article will review basic fluoride formulations as well as advantages and disadvantages of each type. It will conclude with a discussion of fluoride as a central agent in a biochemical approach to maintaining intact dentition, with an eye toward recognizing risk factors and tailoring an individualized, evidence based approach to mitigating risk of caries.

Practitioners are familiar with the three basic types of fluoride: Acidulated Phosphofluoride, Stanous Fluoride and Neutral Sodium Fluoride.

**Acidulated Phosphofluoride (APF), 1.23% (12,300 PPM, pH 3-4)** is probably the most common formulation used in practice. Patients are usually exposed to APF for one to four minutes twice a year during recall appointments. Interestingly, all the studies that measure the anticaries effect of APF use a four-minute protocol. Of the two formulations available (foam and gel), foam is preferred. APF foam is low density and a smaller amount is required to fill the tray. A smaller volume of material decreases the amount of fluoride available if the patient swallows prior to expectorating after a fluoride treatment.

The pH of this formulation (gel and foam) is the factor that makes this formulation least desirable for aging patients. As stated, many of these patients take one or more medications. The more medications (prescribed or over the counter) the patient takes, the more likely they are to have xerostomia. Exposing a patient with decreased salivary flow (which, among other things, is responsible for buffering acids) to a highly acidic formulation of fluoride can be problematic for the patient. While some patients can tolerate APF, others respond with a range of responses from mild discomfort (usually from a mild burn) to mucositis.

**Stannous Fluoride (pH 3.5 to 5.1 depending on manufacturer)** is a well-known, effective fluoride formulation that facilitates remineralization. Stannous fluoride is also known to reduce dentin hypersensitivity. It acts in a similar fashion as that of sodium fluoride, i.e., formation of calcium fluoride precipitates inside dentine tubules. Additionally, scanning electron microscope studies have shown that stannous fluoride itself can form insoluble precipitates over the exposed dentine further reducing dentinal
hypersensitivity. It is known to cause surface roughness and stain. The roughness is attributed to the pH of the material. Over time, the acid etches the surface of tooth colored restorations (and can etch the surface of polished or glazed porcelain). The tin contained in the stannous formulation then collects on the etched surfaces and produces stain. The stain can be problematic for some patients, however others derive significant benefit from stannous fluoride and tolerate the stain. Stannous fluoride is available in over the counter (OTC) toothpaste. Most patients who buy stannous fluoride toothpastes are concerned with thermal sensitivity.

The third common formulation is Neutral Sodium Fluoride (pH 7.0). Neutral sodium fluoride does not have any of the negative side effects described above. As its name implies, is has a neutral pH, it is not known to stain restorations and does not effect surface texture (of tooth colored or porcelain restorations). It, therefore, appears to be the preferred formulation for aging patients. Practitioners should evaluate each patient and prescribe the appropriate formulation based on need. There are obviously times when the benefits of any one formulation outweigh the risks of staining or surface roughness.

OTC toothpastes generally have 1,000 ppm of monofluorophosphate available for uptake by demineralized enamel. The current philosophy regarding toothpaste is that multiple exposures are necessary to remineralize early carious lesions. When OTC toothpastes are not successful at remineralizing incipient lesions or new caries is detected, practitioners should consider high fluoride concentration prescription toothpastes. Prevident 5000 is a popular and available brand. Gel and plus forms are available. Gel contains no silica abrasive, plus contains some abrasive. These toothpastes (generic brands are available but still require a prescription in the Commonwealth) contain 5,000 ppm of neutral sodium fluoride or 5 times the available exposure to fluoride than OTC toothpaste. Prescribing 5,000 ppm fluoride toothpaste has proven effective in reversing incipient lesions in dentin.

There is no evidence regarding specific exposure schedules and times, but there is a consensus among practitioners who focus their practices on managing geriatric patients. The suggestions are: have the patient brush with high concentration fluoride toothpaste immediately before bed, brush for two minutes (by the clock, patients generally underestimate...
Fluoride: It’s Not Just for Kids.

brushing time), if possible, hold the toothpaste and any saliva that collects during the brushing process in the mouth for an additional minute, expectorate (as often as necessary until the patient is comfortable), don’t rinse, go to bed. Not rinsing allows more of the fluoride to collect in plaque and biofilm for slow release over time. Since patients generally produce less saliva during sleep, and therefore don’t swallow as often, more fluoride is available for remineralization. Some patients object to the feel of the silica abrasive when left in the mouth overnight and prefer the gel version. Sample prescription: Rx: Prevident 5000 Gel, Disp: 1 tube, Sig: As Directed (instruct the patient to use the toothpaste as above), Refill: PRN X 12 months. There is no abuse potential for fluoride toothpaste and pharmacists in the Commonwealth will refill the prescription as the patient needs it. The only caveat is that the prescription must be rewritten after one year. Another commonly prescribed high concentration fluoride is Gel Kam® (0.4% stannous fluoride, 1000 ppm, pH 3.5). As discussed, stannous fluoride is well absorbed by dentin. The RX and instructions for use of Gel Kam is similar to Prevident.

Commercially available OTC fluoride mouthwash generally contains .05% sodium fluoride, (500 ppm or approximately one half the fluoride exposure of toothpaste). Fluoride containing mouthwash can be beneficial for patients and practitioners should consider using it where appropriate.

Routine tray-based fluoride applications (delivered at recall appointments) are not the only way practitioners can help patients manage dental decay and surface demineralization. Fluoride varnishes (22,600 ppm) have become popular and effective modalities. Practitioners should consider “shelf life” when deciding which type of varnish to use. When tubes of fluoride varnish sit undisturbed for periods of time, the fluoride can precipitate out of the varnish. This issue is unnoticed by practitioners who dispense varnish from a tube. One way to avoid this is “single use” formulations available from various manufacturers. When removing the cover from the single use well, practitioners often see a whitish precipitate on the top of the liquid. This is the fluoride that has precipitated out of the matrix over time. It is easy to use a disposable brush to stir the varnish and redistribute the fluoride into the solution. In this manner, all the varnish has a therapeutic dose of fluoride available.

Fluoride varnish has proved effective in preventing root caries. It is a simple matter to brush the varnish on all exposed root surfaces. Fluoride varnish will adhere and dry in the oral environment, even if the surface is moist, making application simple. Many varnishes are colored, therefore it is advisable to inform the patient that the color is present while the varnish is present, and will disappear in a couple of hours or with repeated toothbrushing. The ADA Guidelines recommend, two or more applications of fluoride varnish per year as effective in preventing caries in high-risk populations. Other evidence suggests practitioners should assess individual risk and apply varnish at more frequent intervals if appropriate.

Interestingly, fluoride uptake occurs at significant rates only at sites covered or immediately adjacent to the fluoride varnish. This means that the fluoride released by the varnish is not well absorbed at distant sites in the oral environment. As an interesting aside, a recent article evaluated the use of Thymol/Chlorhexidine Varnish (Cervetic®) in managing root caries. This randomized, double blind study showed promise and practitioners should look for evidence that confirms (or refutes) the positive findings.

For patients who are at significantly increased risk for caries (cancer chemotherapy or radiation, Sjogren’s Syndrome, Autoimmune Diseases with connective tissue disorders, etc), practitioners should consider high concentration, prescription fluoride delivered in custom trays. A popular type of fluoride for this application is Thera-Flur-N (Colgate). This material provides 11,000 ppm of neutral sodium fluoride. Rx: Neutral NaF gel (Thera-Flur-N) 1.1% neutral NaF.
Disp: 24 mL, Sig: Place 1 drop per tooth in custom tray; apply for 5 minutes daily. Avoid rinsing or eating for 30 minutes after treatment. FDA regulations have limited the size of bottles of fluoride because of toxicity if ingested by infants. Because most preparations do not come in childhood bottles, the sizes of topical fluoride preparations vary; 24 mL is approximately a two-week supply for application to full dentition in custom carriers.

We have restorative materials at our disposal that leach fluoride into surrounding tooth structure (Glass Ionomer Cements and Co Polymers). Glass ionomer cements (GIC) leach fluoride at a statistically higher rate than Co Polymers. These materials can be “recharged” with fluoride. A recent study determined that as the oral environment moves to become more acidic (as with plaque accumulation) more fluoride is absorbed and subsequently released from the GIC.11 It would be appropriate to cite that leaching and recharging of fluoride contributes to decreased incidence of root caries. Unfortunately, the literature on this subject does not warrant this claim at this time.12

Surely, fluoride will continue to play an important role in remineralization of incipient lesions now and in the future. How will the role of fluoride change as we face an aging patient pool, many of whom are aging with chronic illness, multiple medications, xerostomia and declining cognitive skills that make toothbrushing and flossing difficult or impossible to accomplish? The first area that shows potential is slow releasing fluoride devices. These devices, usually beads or copolymer membranes, are bonded to the buccal surface of posterior teeth,13, 14 The devices release low levels of fluoride (usually over a 3-4 month period) into the oral environment. Interestingly, the slow release devices have proven effective in reducing caries on occlusal surfaces where conventional office fluoride treatments are minimally successful. The difficulty with these types of devices is retention.

In summary, dental practitioners today, are facing difficult challenges from a rapidly aging and diverse patient pool. Maintaining restorations and controlling caries becomes more complex as patients’ medical histories become more complex. Fluoride will continue to play a pivotal role in oral health maintenance. Selecting the type of fluoride, the concentration and the delivery system must be determined based on an individual assessment of risk of caries, ability of the patient to comply with complex oral hygiene instructions and medical prognosis. Using evidence-based practice protocols can go a long way to guiding practitioners as they help patients maintain their dentition, oral function, proper nutrition and self esteem.

About The Author
Alan M Stark, DDS, PhD is an Associate Professor in the Department of Oral and Maxillofacial Pathology, Medicine and Surgery at Temple University’s Kornberg School of Dentistry. Dr. Stark is a Diplomat of the American Board of Special Care Dentistry and Immediate Past President of the American Society for Geriatric Dentistry. You can reach him at alan.stark@temple.edu.

REFERENCES
A More Intellectually, Medically and Physically Disabled Society: The Case of the United States

By H. Barry Waldman, DDS, MPH, PhD, Dolores Cannella PhD, Steven P. Perlman, DDS, MScD, DHL and Mary Rose Truhlar, DDS, MS

Abstract

To bring attention to the fact that repeated emphasis on the worldwide increasing number of elderly, with only a passing reference to the magnitude and consequences of the hundreds of millions of elderly with disabilities, neglects to consider the associated burgeoning human and financial costs.

Introduction

The world’s population is aging. During the next decade, the number of elderly people (over 65 years of age) in the world will exceed the number of children less than five years of age, placing greater demands on a shrinking number of young caregivers and taxing social insurance programs.\(^1\)

In Italy, Greece and Sweden, greater than 17 percent of the population is 65 years and over, compared to about 13 percent in the United States. Between 2002 and 2025, the total number of people 65 years and over is expected to increase by 11 percent to 70 percent in European countries and up to 170 percent in some developing countries (e.g. Indonesia an increase of 150 percent, a 160 percent increase in Egypt, a 165 percent increase in Columbia, and a 170 percent increase in Venezuela). By 2025 the countries with the highest percentage of people 65 years and over are expected to be Japan (with 28 percent), Italy (with 24.7 percent) and Germany (with 24.6 percent).

The most rapid increase in the elderly population is taking place in developing countries, where the increase in the numbers of seniors is more than double the rate in developed nations. However, because developing countries such as China and India have the largest total populations, they have and will continue to have the largest absolute number of elderly people. In 2002, there were almost 49,000,000 elderly in India and almost 96,000,000 elderly in China; projections are that these numbers of elderly will double in these two countries by 2025. In 2025, the world’s population over 65 years of age is expected to reach 830 million people.\(^2\)
Of significance is the fact that most of the population 70 years of age and older will be women. Women live longer than men in almost all areas of the world. United Nations projections indicate that, in the developing world, between 1985 and 2025 the number of women 70 years and older will increase by 317 million individuals, compared to an increase of 284 million males. “Women who have experienced cumulative disadvantages over the years are thus more likely to be poor and suffer disabilities in old age than men… It is thought that women’s traditional role as caregivers may contribute to their increased poverty and ill health in older age.”

Compounding predicament

Emphasizing “just” the sheer number of elderly, with only a passing reference to the realities of the magnitude and consequences of the millions of elderly with disabilities, neglects to consider adequately the prevalence of disabilities and associated burgeoning human and financial costs that will increase dramatically in an “older age” population. At the present time, there are more than a half a billion people in the world who are disabled as a consequence of mental, physical and sensory impairment. In some countries more than half of the older elderly have one or more disabilities (e.g. In the United States, 51.5 percent of the individuals 75 and over age group has at least one disability).

“Credit analysts at Standard & Poor’s (indicated) that the cost of caring for the world’s aging populations would be ‘on an explosive path’ and could swamp the budgets of many countries in the next forty year…”

Changes in family structure and social organization will compound the problems of caring for the elderly, including: 1) fewer caregivers: fewer children, 2) inaccessibility of caregivers: in many developing countries extended family members have moved away because of political and economic crises, and 3) loss of caregivers: in areas that have been hit hard by the AIDS epidemic, deaths have been centered among young and middle-aged people limiting the care for the elderly.

“Worldwide, the ratio of working age people for every person in the older age group is expected to decline to four to one, from nine to one now.”

There will be a significant increase in the need for and use of health services by the elderly, along with the demand for increased numbers of health providers and the latest technology to repair and replace body components and maintain life, as well as the associated personal and government financial investment. As the number of older adults increases, the global burden of associated chronic medical disorders (e.g. cardiovascular disease, hip fractures, Alzheimer’s disease, cancer and the full range of disabilities) will compete with the demands of a younger populations wanting “a fair share” of services. This replaces an historical balance and results in an emphasis on an increasing and demanding population of elderly that “contributes minimally to society and which already had its chance.”

The United States

A review of United States government reports (2000-2010) was used to detail the potential enormity of increasing number of elderly with disabilities in a developed country that has a long history of maintaining support for all age groups of individuals with complex ranges of disabilities. For example, average lifetime costs per person in the U.S. have been estimated at $1,014,000 for persons with intellectual disabilities, $921,000 for persons with cerebral palsy, $417,000 for persons with hearing loss, and $566,000 for persons with vision impairment. Total direct costs (i.e., direct medical plus direct nonmedical) amounted to approximately $12.3 billion for persons with intellectual disabilities, $2.2 billion for persons with cerebral palsy, $770 million for persons with hearing loss, and $570 million for persons with vision impairment. An estimated $300 billion is spent annually on care for Americans with disabilities. These estimates are for the period at the end the last decade, prior to the prodigious increase in the number of elderly expected in the next two decades.

A prediction of the numbers of elderly individuals with disabilities in the year 2030 was developed by using Census

| Table 1. | Prevalence and number of individuals with disabilities among non-institutionalized persons in the US by age: 2008, 2030 |
|---|---|---|
| Age | Prevalence | Number + |
| | | 2008 | 2030 |
| All ages | 12.1% | | |
| Age 4 and under | 0.7 | .2 | .2 |
| 5-15 years | 5.1 | 2.3 | na |
| 16-20 years | 5.6 | 1.2 | na |
| 21-64 years | 10.4 | 18.3 | na |
| 65-74 years | 26.6 | 5.3 | 6.9 |
| 75 years and over | 51.5 | 8.9 | 15.9 |

Note: Census Bureau projections used different age cohorts between 4 and 64 years for the year 2030.

+ Numbers are rounded and in millions
A Bureau population projections for that period, under the assumption that the Census Bureau reported prevalence rates for the various demographic groups in 2008 would remain reasonably constant over the next two decades. Assuming the prevalence of disabilities remains constant in the future, reflecting an increase to 71 million residents 65 years and over by the year 2030, the number of senior U.S. residents with:

- Any disability will increase by 80 percent, from 14.2 million to 25.5 million individuals. (Table 1)
- Ambulatory disabilities will affect 16.5 million individuals.
- Independent living limitations will affect 11.6 million individuals.
- Intellectual disabilities will affect 6.5 million individuals.
- Visual and hearing disabilities will affect 15.6 million individuals. (Table 2)

There will be:

- More than 10 million women 75 years and over with disabilities.
- About 25 million white residents 65 years and over with disabilities. (Table 3)

**Closer to home**

Between 2000 and 2030 the number of elderly in the Commonwealth of Pennsylvania is projected to increase from 1.9 million to almost 2.9 million individuals. Based on Census Bureau estimates that 37.7 percent of Pennsylvania seniors have one or more disabilities, we project that the number of elderly with disabilities will increase from 713,000 to 1.2 million individuals.

**Discussion**

At the present time, less than 8 percent of the world’s population is 65 years and older. In 2030, the senior population is expected to reach 12 percent, and by 2050 that share is expected to grow to 16 percent, or 1.5 billion people. In 2030, 55 countries are expected to have at least one-in-five of their total population 65 years and older. 15,16

While it may be beyond our ability to contemplate the worldwide impact of these developments, a review of the projected increasing numbers of older individuals with disabilities in one country helps translate these “just numbers” into the magnitude of the dilemma that will face individuals, their families and nations as younger generations will be called upon to support and care for the burgeoning population of elderly.

For example, in the U.S., the old age dependency ratio (i.e. population aged 65 years and over divided by the population aged 20 to 64 years) will increase between 2010 and 2030, from 22 to 37 elderly per 100 individuals 20-to-64 years.17 Now add the compounding effects of the disabilities, which will afflict many (most?) of these elderly and their families.

Whether it is the United States or any other country, the effort to balance the demands for services between the young, the employed and the elderly is intensified by our ability to maintain individuals with disabilities into advanced years. Acute and long-term chronic care; institutional vs. nursing home; community and private residential facilities; limited geriatric trained physicians, dentists, and full range of ancillary personnel; family abandonment and conflicts; increasing expenses depleting family resources and inheritances; inadequate government programming and funding; and end of life and associated legal decisions are only a

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**Table 2.**
Prevalence and number of particular disabilities among non-institutionalized people 65-74 and 75 years and over in the US: 2008, 2030¹

<table>
<thead>
<tr>
<th>Type of disability</th>
<th>65-74 years</th>
<th>75 years and over</th>
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<td>Percent 2008</td>
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<td>Any disability</td>
<td>26.6%</td>
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<td>1.0</td>
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<tr>
<td>Independent living</td>
<td>8.7</td>
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+ Numbers are rounded and in millions
prologue to the issues facing efforts to come to terms with the escalating number of the elderly; omitting the specific intergenerational conflict between the uses of taxes, resources and personnel. The litany of issues faced by and for the elderly with disabilities is comparable, but given the type and extent of the disabilities, they potentially are more demanding on the families, the health providers and the economics needed to sustain the individual.

It is not beyond the realm of the imagination that without adequate planning and preparation, the time may come when the burden upon younger generations of the tens of millions of elderly with disabilities could affect adversely the social fabric of communities with unfortunate consequences. A continuing emphasis on the worldwide increasing number of elderly, with only a passing reference to the magnitude and consequences of the hundreds of millions of elderly with disabilities, provides an incomplete appreciation of the affects of our evolving demographics.

“Worldwide, the ratio of working age for people for every person in older age group is expected to decline to four to one, from nine to one now.”

Now add the proportion of elderly with disabilities.

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### Table 3.

| Prevalence and number of disabilities among non-institutionalized people 65 years and over by gender and race in the US: 2000, 2008, 2030 |
|------------------|------------------|------------------|
| **65-74 years** | **75 years and over** |
| **Gender** | **2008** | **2030** | **2008** | **2030** |
| Male | 27.1% | 2.5 | 49.1% | 3.3 |
| Female | 26.1 | 2.8 | 53.1 | 5.6 |
| **Race/Ethnicity** | **2008** | **2030** | **2008** | **2030** |
| White | 40.6% | 12.4 | 23.4 |
| Black | 52.6 | 1.5 | 3.6 |
| Asian | 40.8 | .4 | 1.3 |
| Native American | 57.6 | .2 | .3 |
| Hispanic | 48.5 | 2.8 | 3.7 |
| + Numbers are rounded and in millions |

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### References


About The Authors

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There is a new technology being promoted to dentists for imaging studies in their offices, Cone Beam CT Scan (CBCT).

In the current literature, the vast majority of articles are published by the manufacturers or by individuals paid by those manufacturers. In a recent New York Times expose (November 23, 2010), they reviewed this new technology that has been promoted to dentistry over the past three to five years. The article reviews its promotion and the integration of this new technology into dental practice and its risks and benefits.

Myself, having also responded to our own Pennsylvania Dental Journal approximately a year and a half ago after an article appeared in our journal, stated that I basically felt that it was below the standard of care to place any dental implants without a CT scan of the jaws. My criticism of that article was it was written by an individual that had 11 imaging centers with CBCT technology, and that certainly, there are many of us that have been placing dental implants for many years without CT technology. At this point, I should say that I have used CT scanning technology for many, many years and have found it to be very useful for more complex implant cases, complex facial tumors or for skeletal facial deformities. That being said, it is clearly apparent that we need some guidelines because not every case needs this imaging technology. So, we have to decide whether this new technology is “Much ado about nothing,” as Shakespeare would say, or is it a case of the “Emperor’s New Clothes.”

The dilemma we are currently facing is that the preponderance of information provided to practitioners is all sourced from the manufacturers themselves; there has been little peer reviewed literature on this topic insofar as radiation dosage and indications for use of this technology. Some of the concerns expressed by the New York Times involved orthodontic practices where patients are having multiple CBCT scans to shorten treatment times, and that these young patients who are actively growing are more susceptible to radiation dosages. In addition, there are proponents in oral and maxillofacial surgery who feel that virtually every removal of an impacted wisdom tooth would require a Cone Beam CT due to the concerns with the neurovascular bundle and the maxillary sinus; structures located in those areas. Again, the vast majority of patients having their impacted wisdom teeth removed tend to fall in the age bracket of 16 to 25 years old. It is clear that patients at the lower end of this age bracket are still actively growing and are more sensitive to radiation dosage.

Another factor weighing in on this matter is that there are attorneys who get lecturing fees from the various imaging companies who state that it is below the standard of care and therefore negligent not to have a CBCT prior to removal of impacted wisdom teeth. In the current uproar on X-ray screening of individuals boarding aircraft in the United States, the New York Times presented a dosing chart for that: with an airport full body scanner being 1, the various cone beam devices being sold for offices would be equal to 68 to as much as 498 scans. This is certainly significant in that we are seeing reports on patients having more and more imaging studies throughout their life and as we are all aware of from our very first courses in dental radiology, X-ray dosage is cumulative.

In the New York Times article it states that a child faces up to a 1 in 10,000 chance of getting cancer from a single cone beam scan. I’m not sure that many parents would feel comfortable about that, having their children’s orthodontic treatment shortened by approximately a year or so, to put their child at risk; I think most parents would probably opt for a more conventional treatment. In fact the company that provides the software to
do this, Metrix, which owns SureSmile, can also perform the same orthodontic treatment utilizing regular digital photography. The problem is that digital photography takes up to 30 minutes as opposed to a cone beam that could be done in less than a minute. The attorneys need to also take into consideration that parents need to be informed of the implications of these new technologies and what alternatives are available. In light of what was previously mentioned of the dosage of the Cone Beam CT, Dr. James Ma, who recently lectured at the greater Philadelphia Society of Orthodontists, refused to allow the New York Times reporter into his lecture saying there was patient confidentiality because they would be showing specific cases and this would violate patient privacy laws. In his lecture, “Why Dentists Can’t Wait For Cone Beam CT,” he stated that cone beam scans produced no more radiation than a whole body scan at the airport, which according to the few reviews that are out there, is completely incorrect. This is documented in the British Journal of Radiology, which last year stated CBCT scans “produce significantly higher levels of radiation than conventional dental imaging.”

In the November 2010 Journal of the American Dental Association, there was a separate section on cone beam technology that said it accepted somewhere under $100,000 from Imaging Sciences, to put that supplement in the JADA. Part of that showed Dr. Edward Y. Lin using an I-CAT unit for his orthodontic practice. He bases that his office time is worth $5 per minute and using a cone beam, because it’s faster than a digital camera, therefore cuts the appointment by 30 minutes per patient, representing $150,000 in savings, for 1,000 appointments for braces that year.

That raises another question: in my experience of more than 30 years of practice as an oral and maxillofacial surgeon, dentists and physicians, for the most part, are some of the worst business practitioners I’ve ever met. These 3-D scanners, clearly when I look at the technology that they are promoting, are a radiation source. A gantry which houses a scanner, whether a person sits or stands, and the software to process it, with the larger units like Dr. Lin is promoting, costs about $200,000 to purchase and install in a practitioner’s office. The problem I have is that it is one of the largest expenses of any individual’s office, and currently there are few if any insurance companies that are compensating for Cone Beam CT. But this is now being promoted as somehow a cost saving measure. It is also promoted as a liability relieving measure in the case of placement of dental implants and removal of wisdom teeth. Panoramic X-ray machines cost one-tenth of what a CBCT cost and the average fees for panoramic X-rays in Pennsylvania run anywhere from $70-$100. It would seem that the CBCT scans should be approximately $700-$1,000. In my evaluation of this area, it is obviously difficult to find fees, but by a verbal sampling, most dentists are charging between $350 and $600 for a CBCT, yet no insurance companies are paying for it. I am therefore somewhat skeptical as far as the ability of an individual to purchase one of these units and make it financially viable without appropriate reimbursement for these scans.

I do not want to seem to skeptical about CBCT technology and it clearly provides superior imaging, as the units are specific to this area of the body. In addition, I feel that there are clearly indications to use these devices in many cases:

1. Certainly in the removal of major tumors, they provide very accurate imaging as to dimensions and volume of a tumor.

2. In the placement of certain implants where after 2-D imaging there are concerns about possible sinus lift and vertical height, in concern for the neuro-vascular bundle or width of the jaw.

3. In orthodontic care, rule out impacted teeth, which are interfering with orthodontic management, whether it is mesiodens, other supernumery teeth or other impacted teeth, more commonly being cuspids than pre-molars and molars.

CBCT is even being promoted to endodontists without clear guidelines. The onus therefore is on our parent organization to obtain or provide funding for independent assessment of this new technology. If that occurs, it may provide avenues to obtain third-party reimbursement for these procedures, so that we can move forward in an orderly fashion for the benefit of our patients, who we would be exposing to the minimum radiation dosage necessary, and to provide good care without the current “willy nilly” approach to the new technology; this most certainly, will change as new information comes to light as this technology advances. The suggested studies could compel insurance companies to provide reimbursement for these procedures making the availability of these scans, when appropriate, more available to our patients.

In conclusion, there are a number of items to be sorted out with CBCT:

1. Scientifically, indications and radiation dosage.
2. Financially, real cost of the units and scans.
3. Third party reimbursements.

We all need to evaluate the resources of information we get, to assess if we are wearing clothes or not, or if we should have no concern about a new high dose radiation source.
Sometimes I worry about things I don’t need to worry about. Not too often, but sometimes. And one of those things is getting a second opinion.

A doctor friend said it can be a bigger deal for the patient than it is for the doctor. Maybe so. But still…

What’s the big deal? Well, for me it depends on several factors. How long have you had a relationship with your current doctor? How good has it been over the years? I don’t have an issue if it concerns a doctor I’ve seen only once or twice. But the longer — and better — the relationship, the more difficult it is, for me anyway, to ask for a second opinion. I feel like I’m being unfaithful.

And, gulp, do you have to ask for records and film so the doctor from whom you’re getting a second opinion can review them? Then, if the second opinion confirms the first opinion and you go back to your “regular” doctor, has the relationship changed, however slightly? Does he or she feel the bond of trust has been weakened?

(And before I move on, I must say that this has never been an issue with any of my present doctors. In fact, I am fortunate to have the relationship I have with my dentist. His care, concern and professionalism have been extraordinary. I am blessed to call him my dentist and my friend.)

Now, moving from the hypothetical to wrenching reality about a second opinion. Several years ago my wife experienced back pain. She made an appointment with a specialist — and before she went to see him, she started getting pain in her hip as well.

She assumed, as did I, that both pains resulted from new and strenuous exercises she was doing at the gym.

I went to the doctor with her. After examining her, he ordered some tests, told us to come back in a week. When we returned, he said that she had some arthritis in her back, no discernible problem with her hip. He prescribed a shot for her back, and then, for both her back and hip, a regimen of physical therapy.

Things were moving quickly and my wife was relieved that we had a plan; she was eager to eliminate the pain. Before we left we were introduced to the doctor who would administer the injection. We made an appointment for a few days later.

But when we left the office, I felt uneasy about something. Maybe it felt like a rush to judgment. Maybe it was how “no-doubt-about-it sure” the doctor seemed. I can’t tell you just what it was, but I will forever be grateful that a caution flag went up and prompted me to get a second opinion. Truth be told, I was hoping it would confirm what the first doctor had told us, so my wife could get the shot, start the physical therapy, and soon be out of pain.

But the second opinion was far different from the first. After examining my wife, the new doctor said he didn’t know what the problem was, but he was sure it was not in her back — it was in her hip. He ordered some tests.

The tests showed that she had a very large, inoperable tumor in her hip. Had we followed the first doctor’s directions, and my wife had the physical therapy, a terrible situation could have been made disastrously worse.

Now, more about second opinions. We were devastated, stunned, lost in a foreign country without a map. When we went to the oncologist, he outlined the situation as best he could then determine it, and he laid out a treatment program. And when we were about to leave his office, he said: “I encourage you to get a second opinion. Not only for your peace of mind, but for mine as well.”

We did. It confirmed what he said. He took the “second opinion” issue off the table.

Though I was advised not to, though people told me to “just move on,” I felt that I had to go back to the first doctor who was so far off base, whose diagnosis and recommendations could have caused my wife incalculable grief and pain.

I am not by nature a confrontational person. But I needed to look directly at him and tell him how things turned out and let him know how I felt. I just plain had to.

So, for sure, all second opinions are not created equal.

About The Author
Howard Rice is a professor at Temple University’s School of Communications, a teacher at Main Line Night School, and conducts various types of writing workshops, including two for women who have survived cancer. Howard was a partner and creative director of Kalish & Rice Advertising from 1970-1984. He has had 30 plays produced in theaters around the country.
Just Imagine...

By Joseph R. Greenberg, DMD, FAGD, FCPP
I gratefully applaud the $16 million initiative that the W.K. Kellogg Foundation has taken to address increasing oral health needs in the United States. Yes, oral health is essential to overall health, and, yes, good, regular oral health care seems out of reach for far too many people in this country. We’ve known about this for more than 10 years now, and many have offered solutions. To this point, it may appear that nothing has worked; however, we don’t know for sure, due to inconsistent or absent measurements. Official sources do say that the incidence of oral disease is still rising for the youngest age group (0 to 4 years) and mostly in our minority populations.

The experts in oral health are we dentists. The most effective dentists I know start with thorough data collection and then formulate a solid treatment plan. This plan needs to first address all the disease priorities for the patient and then establish a sequence of evidence-based therapy to attain a state of maintainable physiologic health.

The Dental Therapist Project sounds like a great way to help those citizens located in remote areas of our country, like Alaska, where ground transportation is limited (if not totally absent) from one community to another. But the greater number of people in need of oral health care live in inner city, “at risk” communities, like Detroit, Philadelphia and Washington, D.C. where access to care is not the issue—barriers to care are the issue. While the Dental Therapist Project might appear in our “treatment plan” to address the needs of the underserved community, it should be very low on the priority list. Consider how many years it will take to create the new programs, get them licensed/approved and train even a relatively few providers. We need to stop the rising rate of disease now. So, we need to look at other solutions first.

A. The Data Collection

How do we measure the level of need? Currently, there is no one, universally accepted Oral Health Detection System. There is a unified effort right now to finalize an electronic screening device using accepted methodology (ICDAS) that would allow a dentist or dental auxiliary to evaluate large populations of citizens (especially young children) and store that data in a central location. The Pennsylvania Dental Association (with national collaborators) will have such a program within a few months and begin testing it. Without measurement tools we cannot assess progress or lack thereof. Without baseline data we can’t really be sure where our efforts should focus. A very small portion of the resources you have committed to oral health would get this project completed more quickly. Even though we are working on this important tool, we can still address high priority emergency care solutions that impact large numbers of patients.

B. The Treatment Plan

Until we have measured data, we must use available best practice evidence. The most important single determinant in a person’s health is genetics. Second is health literacy (“Low Oral Health Literacy: An Elusive Dream of Dentistry’s Target for Advocacy?” Reardon, G.T. Compendium 2010; 31(3):184-189). Therefore, the most effective, immediate solution to the oral health cares crisis starts with education and information transfer. Here are some examples of actions that impact the most people, in the shortest time, and at low cost:

1. The American Dental Association’s (ADA) “Team up with Rite Aid for National Oral Health Campaign.” This is a public health initiative to promote the link between good oral health and overall health. We need more such programs and partnerships.

2. The Detroit Dental Health Project, Detroit Center for Research on Oral Health Disparities, Dr. Amid I. Ismail, Director. National Institutes of Health grant #U54DE 14261-01. This was a community wide campaign to raise Oral Health Literacy and promote use of available treatment facilities.

3. The Fit For Schools Program (FFSP) in the Philippines recently won awards from the World Bank, the United Nations Development Program and the World Health Organization for it’s use of existing school structures for implementing a package of preventive strategies called the Essential Health Care Program. The program reaches more than 1 million children at a cost of 50 cents per child per year (“Revitalizing School Health Programs Worldwide” Benzian, H.B. Compendium 2010; 31(8): 580-582). Supervised daily brushing with fluoride toothpaste is part of the program. Oral health programming and preventive interventions in elementary
schools could be a very powerful and pervasive tool for change. A program such as this one could a model that is used globally.

4. The National Children's Oral Health Foundation (www.ncohf.org) is the only foundation solely dedicated to conquering childhood oral disease. This organization is only four years old and has established a myriad of programs based on best evidence to address the needs of this “at risk” population. Their Scientific Advisory Board is preeminent, including four dental school deans. They have state of the art educational programming and a growing network of affiliate treatment centers all across the USA, which have now touched more than 1 million children. These programs are in place and working. NCOHF has more grant requests from energetic, responsible non-profit dental health projects all across the country than we can possibly fill at this time—as a volunteer grant reviewer for NCOHF, I know this firsthand.

C. The Treatment.

The vast majority of people stricken with oral disease have access to treatment facilities, but need help—“patient navigators” to guide them through paperwork and benefit selections.

As an example, the ADA has undertaken a pilot project to develop a new, expanded community health worker, the Community Dental Health Coordinator (CDHC) whose responsibilities include community education and outreach, system navigation for the patient, as well as the ability to perform simple cleanings, assessments and palliative treatments. Such workers are recruited from the communities they serve.

Second, the number and distribution of dental schools in the United States is growing. Many are forming Oral Health Zones around them and encouraging student outreach to serve the surrounding communities.

Third, the number and distribution of non-profit dental treatment centers is growing. I founded the non-profit Kids Smiles Children’s Dental Health Centers (www.kidssmiles.org) about 10 years ago. We now serve more than 50,000 “at risk” children in the Philadelphia area and opened our newest center in Washington, D.C. this past month. The children in our nation’s capital suffer from some of the highest rates of dental disease in the entire USA. All of the children seen at Kids Smiles get positive choice/preventive health education (the “Dental Detectives Program”) delivered by dedicated team members on site and by outreach teams in surrounding communities (at daycare centers, Head Start programs, and now, in the Philadelphia Public Schools). In addition, they receive first-rate treatment by experienced dentists, dental specialists and dental team members. We know how to treat “at risk” children with dignity and challenge them and, their caregivers, to achieve higher oral health literacy. Kids Smiles and other such successful programs have already invented the “wheel.”

With the magnitude of funding that W.K. Kellogg could provide, we could roll it all over the USA in less time than it would take to train 10 dental therapists. Finally, let us not forget the fact that there are many, many people in this country who simply won’t go for care even when finances are not the issue. There are many other barriers for these folks. Moreover, it is important to recognize that we will never be able to “treat” our way out of oral disease. The best possible course of action is to raise the oral health literacy of more people so they can employ simple, preventive health strategies on their own every day, e.g. xylitol, fluorides and dietary changes. Those who benefit most from the improved health of a population (hospitals, health care insurers, employers, schools, and governments) could incent people to learn about oral health. This takes creativity more than dollars. The return on investment is high.

After 80 years of research and experience with dental therapists in “many countries...dental caries remains the most common chronic disease of childhood in the world” (source: World Atlas of Oral Health). The dental therapist is not the answer. While new training programs are being developed and new therapists are being trained, children will continue to suffer. We need new thinking now and to promote new programs that are already working. Just imagine how financial support for the NCOHF, as an example, would quickly magnify and leverage W.K. Kellogg’s dollars to help eradicate childhood oral disease in this country. Imagine how financial support from W.K. Kellogg could help dental schools expand their outreach programs to the surrounding communities. Imagine how many children could be reached if W.K. Kellogg funded the development of a Fit For Schools Program in a major U.S. city. Imagine the response if W.K. Kellogg promoted an Innovation Prize and challenged the international community to come up with the most innovative ways to promote oral health literacy.

JUST IMAGINE!

Dr. Greenberg is chairman of PDA’s Access to Care Committee. He also is the Founder and first President of Kids Smiles as well as the founding Vice President of the National Children’s Oral Health Foundation.
S O C I A L N E T W O R K I N G
WHEN IS BEING SOCIAL POTENTIALLY DANGEROUS?

By Thomas J. Weber, Esq

Fifteen years ago, the term “social networking” meant attending a local Kiwanis or rotary club meeting for purposes of developing potential business contacts in the community while pursuing a charitable goal. With the introduction of computer social networks, such as Facebook and Twitter, the term has developed an entirely different meaning.

Evidence as to the popularity of these social network programs is readily available. If all members of Facebook constituted a country, it would be the fourth largest country in the world. It is believed that there are more than 300 million bloggers routinely entering information on the Internet. Utilization of Twitter is so prolific that professional sports leagues have had to pass rules prohibiting their participants from engaging in the practice during games.

The existence of these outlets provides an enormous opportunity to you as individuals, employers and members of the Pennsylvania Dental Association. Currently, the PDA subscribes to the following social networking outlets: Facebook, Twitter and LinkedIn, in addition to having its own Social Network right on the PDA website. However, in addition to these enormous opportunities, there is also potential risk presented by participation in social networks. This article is intended to identify some areas of concern and potential best practices to enable you to maximize your social networking while minimizing the associated risk.

**Individuals/Employees**

If you are maintaining a site on a social network, you should follow the philosophy that you should not post anything that you do not want to become public. Although sites may allow you to limit access to your information to “friends,” this does not prevent the disclosure and/or discovery of your information. In addition, recently, a Pennsylvania Court of Common Pleas determined that participants in such sites do not have a reasonable expectation as to privacy and, therefore, cannot prevent discovery of the information on such sites.

Furthermore, you should be cognizant of the growing trend of consumers to Google professionals prior to seeking their service. Therefore, you should be careful not to undermine the potential expense of an advertising program you have launched by some careless posting to your social page regarding your 20th high school reunion. Also, recognize the impact your posts could have on your employer.

Also recognize that even if you do not maintain a Facebook, but instead, post comments on blogs and other Internet sites, there are mechanisms to trace the same back to you, even if done anonymously.

**As an employer**

There is a growing trend of employers to utilize social networking sites in the hiring process and to monitor employees’ conduct. Recently a Pennsylvania hospital terminated a significant number of employees as a result of activity conducted on social networks. The activity ranged from potential HIPAA
violations to disparaging comments about the employer to reporting conduct that the hospital believed placed it in an improper light.

If you are reviewing social network sites in the interviewing and hiring phase, you should be careful that you not base your hiring decision on improper grounds. By way of example, most employers recognize the prohibition to asking a female applicant her intentions regarding starting a family or asking any applicant their religious or political views. However, access to the social network page may reveal a proud expectant mother’s announcement of her recent pregnancy or an individual’s religious denomination. Although you may not have obtained the information in an improper way, use of it in a hiring decision could still be deemed improper. Some employers are utilizing an intermediary, their attorney or accountant, to do the Internet search and then filter out the potentially improper information.

In the event you utilize social network sites to monitor employee conduct, it is advisable to alert employees of this activity and provide them with clear direction as to what type of posting would be deemed inappropriate and the potential basis for a disciplinary action. As mentioned above, employers have begun using social site posts as ground for termination. As with most employment matters, there is starting to be some employee focused push back. Therefore, if you want to maintain the ability to use such information in the employment setting you will be better protected if you have developed and broadcast a clear policy on the issue.

In connection with your district and local organizations
Similar to PDA, your district, local, study club or other organization may have recognized the ease with disseminating information through social network sites. Again, these vehicles provide an efficient mechanism to link individuals with similar interests. However, the use does not come without risk. What follows will identify some of the more important risks or mechanisms to avoid them.

- You need to be extremely careful posting any information obtained without permission. Anything obtained pursuant to a license must only be used in strictest conformance with the licensing agreement. In addition, make sure you provide proper attribution to the source and creator of any information posted.
- Rules should be established governing the posting of materials by members and third parties. Recognize that one could argue the host of the site is responsible for all content. In addition to a disclaimer to such responsibility, the rules and procedures for posting need to be communicated and need to provide an opportunity to remove posts from the site and ban repeat offenders.
- Caution should be used when sending unsolicited emails, particularly if they carry commercial content. It is safest if there is a mechanism by which participants in the social networking site have given their consent to receipt of information generated by the host.
- Caution should also be used in respecting the rights of privacy of all individuals. Prior to publishing any notice that may not be public knowledge regarding any individual, permission from that individual should be sought. Even if the content is perceived to be complimentary of the individual, the individual still may not want it disseminated throughout the Internet.
- When posting materials from others, attempt to limit your editorial control or input. By merely acting as a conduit to the information, you can increase your chances of enjoying some of the limited immunity available under the Digital Millennium Copyright Act of 1996 and the Communications Decency Act of 1996. Associated with this policy is utilizing hyperlinks. When utilizing links, you should avoid actively directing other users to exploit or use content or materials available on the third-party link. Your use of a hyperlink should not constitute an endorsement of the other site.
- As in the situation of employer, your local or district should develop policies and procedures to govern the maintenance and use of any social networking sites that it hosts.

This article is intended to provide a summary overview of the issues associated with social networks. It is not intended, nor should it be relied upon, as an exhaustive examination of all legal issues. For specific guidance you should consult with an attorney.

Thomas J. Weber, Esq. serves as general counsel to PDA and PDAIS. He devotes a substantial portion of his practice to dental-related matters and frequently writes and lectures on legal issues pertinent to dentists. Tom is a shareholder in the Harrisburg law firm Goldberg Katzman, P.C. where he serves on the executive committee and is chair of the civil litigation department. He can be reached at TJW@goldbergkatzman.com.
Here’s a list of trends to look out for in 2011 that will help you achieve your IT goals, according to Forrester Research.

1. Business and Personal Communications Come Together in the Workplace
While more effective mobile technology creates efficiency for employees, it also creates security and management challenges for small businesses and their customers. Researchers estimate that one billion workers will be mobile at least part of the time or remote from their business’s main location by the end of 2011. As this happens, you will need to address the associated challenges by adopting new models for security and implement more web security policies for your employees.

2. Prepare for Significant Cyber Attack and Data Loss
With cyber attacks becoming more significant, small and medium-sized businesses (SMBs) should be turning their attention toward prevention as they are learning just one attack, or one lost device that compromises critical information can impact profitability and place their business quickly in the red. You need to prepare for such cyber attacks by implementing complete protection on your devices and educate your employees on best practices to prevent these attacks.

3. Managed Services Will Continue to Thrive
While software continues to drive innovation, 2011 will bring new delivery models in response to the need for small businesses to ease IT operations, especially in the areas of security and storage. Cloud computing, hosted services and appliances are examples of increasingly attractive delivery models that provide small businesses with flexibility and ease of deployment for your security, backup, and storage needs. ebLogix can help by guiding you through the decision-making process by assessing what your storage needs are, and which delivery model will be best to address your business needs.

4. Time to Make Disaster Preparedness a Priority
SMBs are responsible for large amounts of private customer information and financial data and are just as accountable as any large enterprise for ensuring it is completely protected. Critical information must be recoverable in the event of a disaster or outage. When the unexpected strikes, you need to know your critical information is recoverable. Your business could depend on it.

5. Social Media
The way we communicate will continue to change in 2011 as small businesses increasingly leverage social media to improve customer communication and employee productivity. However, you will also need to understand how to protect and manage these nonstandard applications, since business information that is communicated in these outlets will still need to be secure.
Norton’s Top Five Cyberthreats Facing Consumers

Social Media Identity Theft — The tremendous popularity of social media sites can come with a dark side as well. Virus writers and other cybercriminals go where the numbers are and that includes these popular sites. Beware of any unusual messages or requests from your friends online, and never give out your password to anyone.

Smartphone/Tablet Hacking — Although cyber criminals have shown little interest in mobile devices in the past, as devices grow more sophisticated and as a handful of tablets corner the market, it is inevitable that attackers will hone in on mobile devices in 2011 and confidential data loss will become increasingly problematic.

Beware of Trending Topics — Cyber criminals are savvy when it comes to the latest social trends. Whether it’s X Factor or Strictly Come Dancing gossip, cyber criminals catch on to these trends and poison search engine results, which can leave users at risk of clicking on an infected link.

Shortened Web Addresses — Internet users should be careful about clicking on shortened URLs. They can be found everywhere on social media sites, but the URL hides the full location. Clicking on unknown links can direct users to their intended site, or one that installs malware on an Internet connected device.

Pharming — Another form of online fraud very similar to its cousin, phishing. Pharmers are more difficult to detect because they are not reliant upon the victim accepting a “bait” message, but instead redirect victims to a bogus Web site even if they type the right Web address of their bank or other online service into their Web browser.

eb logix is a complete IT service company in Exton. For more information, contact Beth Suero at beth@eblogix.com or call (610) 458-1919.
Characteristics of Bonds
By Mark J. Funt DMD, MBA

So far I have discussed the economy, interest rates, the yield curve and their relationships to bonds and bond yields. Today, I will discuss the specifics of bonds and bond terminology.

A bond is nothing more than a loan. Unlike stocks, you have no ownership or voting rights in the company; you do not benefit if the stock goes up or lose if the stock goes down. Your biggest risk is if the company goes bankrupt.

Let’s look at an example of a bond purchase. You buy a $10,000, 5 percent General Electric bond maturing in 2025. You are essentially lending GE $10,000. In return, GE will pay you $500 per year (usually $250 every 6 months) until 2025, at which time GE will return your $10,000. During those 15 years the value of your bond will fluctuate in price both over and under $10,000, but as long as you hold your bond to maturity (2025), you will get your initial investment back providing GE doesn’t go bankrupt. By the way, if a company does go under, bondholders are the first to get their money back if there is any kind of financial settlement.

TYPES OF BONDS

There are many different types of bonds, which range from very safe to very risky. The safest of these bonds are those issued by the federal government. As with most assets, the lower the risk, the lower the yield. The most common bonds issued by the government include Treasury bills, which have a maturity of anywhere from a few days to 52 weeks. These bills are typically sold at a discount to its par value. For example, a $1,000 bond will be sold for $900 and the interest rate will be the difference between the purchase price and the face value. There is no coupon with a Treasury bill. Treasury notes are issued with maturities of 2, 3, 5, 7 and 10 years. Treasury bonds are issued with a term of 30 years and pay interest every 6 months.

I bonds are purchased at face value and their return is based on a fixed rate of interest plus an inflation factor which is adjusted every 6 months. The inflation rate is based on the CPI-U, which represents the Consumer Price Index for all Urban Consumers or city dwellers if you will. Presently the fixed rate of 0.20 percent is added to the semi-annual inflation rate of 0.77 percent, which gives you a yield of 1.76 percent from May 1 to October 31. A new yield will begin on November 1. This is actually a very good yield for six months at this point in time. You cannot purchase more than $5,000 worth of I bonds per year and the yield can never be less than zero. If you redeem these bonds in less than five years you will lose your last three months interest.

Treasury Inflation Protected Securities (TIPS) — increase or decrease their principal according to the Consumer Price Index (CPI). If the CPI increases, the principal of the bond will increase and if the CPI decreases the principle will decrease. TIPS are issued with terms of 5, 10 and 30 years. As with most bonds, the principal and interest rate are determined at time of auction. Interest is paid every six months but these rates will vary because they are applied to the adjusted principal.

Zero coupon bonds are bonds sold at a discount to their par value at maturity. These bonds do not have a coupon but are redeemed at par value when they mature. For example, you may buy a $10,000 bond for $9,250 for a specific number of years and when the bond matures you will receive the $10,000 in lieu of an annual payment. The number of years to maturity will determine the actual interest rate you will earn. These are similar to Treasury bills.

Municipal bonds pay interest that is tax free and in some cases, triple tax free where you pay no federal, state or local taxes. These bonds are generally issued by municipalities to fund roads, bridges, utilities, airports and hospitals. There are two kinds of municipal bonds — revenue and general obligation (GO) bonds. Revenue bonds are backed by the revenue generated by the bond you are buying. The payout on a turnpike or bridge bond will depend on the revenue generated by that particular entity.

The GO bonds are backed by the taxing power of the municipality. In most cases, GO bonds are considered safer than revenue bonds. Many municipal bonds are insured meaning if the municipality decides to default on their bonds, the insurer will step in and give you your principal back. Of course, a lot depends on the financial strength of the insurer. Municipal bonds have a very low rate of default, less than 1 percent, but there is concern that the current financial crises facing states may cause an increase in defaults. There was a recent article in the Wall Street Journal stating that...
Harrisburg was thinking of defaulting on some bond payments but that did not come to pass. Some municipal bonds have what is called ATM (alternative minimal tax), which would decrease your tax-free earnings. Municipal bonds can be sold as zero coupon bonds. I recently purchased a bond that is a zero coupon bond for the first five years and when it reaches par, it converts into regular coupon bond.

Mortgage Backed Securities (MBS) — are batches of residential mortgages that are pooled together and issued as a single security. The Government National Mortgage Association known as Ginnie Mae is such an example. These securities are backed by the full faith and credit of the United States. MBS issued by Fannie Mae and Freddie Mac have no government guarantee. There are other types of MBS as well. As with any bond, as interest rates increase, the value of your bond will decrease and visa versa. Most people purchase Ginnie Mae's via mutual funds. As people pay their mortgages, you will get a return of both interest and principal. As interest rates decrease and people refinance their mortgages at lower rates, your principal could be returned much sooner than expected essentially decreasing your return.

As part of the American Recovery and Reinvestment Act, the government has issued a new class of bonds called Build America Bonds. These are issued by state and counties to finance expenditures similar to municipal bonds. These are essentially taxable municipal bonds. States love these bonds because the government pays 35 percent of the interest. These bonds have some very nice yields relatively speaking and are perfect for tax-deferred plans. I recently bought several bond in the 6-7.5 percent range.

Finally, there is the world of corporate debt or corporate bonds. Corporations usually issue debt to finance the expansion of their business. These bonds run the gamut from relatively safe to very risky bonds. The good news is that there are agencies that exist that will rate the relative safety of the bond, but more about that later. Of course, any rating the bond may be given at the time of issue could be very different years later. Generally, there is more risk
in a corporate debt than most other types of bonds because you never know whether or not the company will go out of business before the bond’s maturity date. Secondly, because they are taxable, they generally will yield more than municipal bonds in order to make them more attractive.

**HYBRID BONDS**

Convertible bonds are corporate bonds that can be converted into the company’s common stock at a predetermined number of shares. Because of this feature, these bonds are often issued at a slightly lower coupon (interest) rate than their other bonds. The conversion ratio or conversion premium determines how many shares can be converted from each bond. For example, if the bond had a conversion premium of 20 percent and the stock was at $40 at the time the bond was issued, it would cost $40 x 1.25 percent = $50 per share. Therefore you could convert your $1,000 bond into 20 shares of stock. If the stock zooms to $60 per share you would make $10 per share. This gives you the advantage of participating in any appreciation in the stock price while continuing to collect the coupon. On the other hand, if the stock price falls, you have nothing to lose, because at maturity you will still get back the par value of the bond.

Preferred stocks are actually stocks that act more like bonds. They are usually offered at $25 or $50 with a fixed rate of interest and in many cases they also have a maturity date. Their prices tend to fluctuate with interest rates but can also move with the stock price. If a company goes bankrupt and there is a settlement, bondholders are paid first, then preferred stockholders and finally stockholders. Many companies that issue common stock also issue preferred stocks. Financial companies, real estate investment trusts and utilities offer preferreds. The advantage is that the yield on preferreds are often much higher than that of the common stock.

**BOND RISKS**

**Maturity**

Every bond comes with a maturity date, the date at which your bond will come due and your loan will be repaid. As we saw, with the yield curve, the longer you go out in maturity, the higher the interest rate. As I previously mentioned, who would have thought General Motors would be close to declaring bankruptcy when people bought those bonds only 5 or 10 years ago. You want to get paid for the risk you take on as you go further out in time. Besides the business risk of longer-term bonds, there is also interest rate risk. The longer the maturity, the greater the chance of interest rate changes, which will affect the price of your bond. If interest rates are high and you believe they can only go lower, what a perfect time to lock in those interest rates for an extended period of time. In addition to receiving a high interest rate payment, your bond will appreciate in value as interest rates decline. The opposite is true for low interest rates as we have now. Of course, it is all relative.

**Quality (Safety)**

Most of your risk with bonds lies with corporate bonds. The biggest risk is default. This is where the corporation declares bankruptcy and you lose your entire investment. There are several rating agencies that rate bonds regarding their “safety.” Standard and Poor’s, Moody’s and Fitch are the three main rating companies. Moody’s and S&P rate according to investment grade and below investment grade. Moody’s rating system starts with their highest rated bonds as Aaa, Aa, A and Aa while S&P rate their bonds AAA, AA A BBB. Anything lower then Baa by Moody’s or BBB by Standard and Poor’s is considered below investment grade and are referred to as junk bonds.

Although junk bonds carry the highest interest rates because they are considered the riskiest bonds, they are probably the least sensitive to interest rates but the most sensitive to economic changes. This is because as the economy improves there is the feeling or hope that the economic condition of the company issuing the bond will improve making it less a candidate for default. When a company or municipality is going to issue a bond, they will hire one of the rating agencies to rate their bond. It is to the issuer’s advantage to rate the bond as safe as possible because the issuer can issue them at a lower coupon or interest rate.

The rating quality of each bond is related to the credibility of the rating agency and there has been some speculation recently that perhaps some of these agencies haven’t been as honest as they could have been.

Dr. Mark Funt is a Board Certified Oral and Maxillofacial Oral Surgeon who maintains a full-time practice in Elkins Park. He received his MBA from Temple University in 1994. Since that time, he has lectured and written articles on practice management and investing topics.
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In Memoriam

Dr. Philip C. Thomas Jr.
Stoneboro
University of Pittsburgh (1970)
Born: 4/23/43
Died: 11/1/10

Dr. Jack J. Pontoriero
Erie
University of Pittsburgh (1965)
Born: 6/10/35
Died: 11/11/10

Dr. George Paustenbach II
New Kensington
University of Pittsburgh (1975)
Born: 7/29/49
Died: 1/20/11

Dr. Anthony R. Krizner
Uniontown
University of Pittsburgh (1955)
Born: 1/1/26
Died: 1/20/11

Dr. John R. Thompson
Harrisburg
University of Pennsylvania (1937)
Born: 11/22/13
Died: 1/20/11

Dr. Cletus M. Bonds III
Lionville
University of Louisville (1975)
Born: 3/2/49
Died: 1/31/11
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Upcoming Events

Spring All Day Program: Friday, March 18th, 2011
The Buck Hotel, Feasterville, PA
"Top 50 Most Prescribed Drugs" & "Review of Antibiotics and Analgesics"
Presented by Dr. Harold Crossley

Spring Dine Around: Wednesday, May 4th, 2011
Positano Coast Restaurant, 212 Walnut Street, Philadelphia, PA
"The Future of Lasers in Periodontal Therapy: Science, Hype, or Snake Oil?"
Presented by Dr. I. Stephen Brown

Annual Golf Outing: June, 2011
Tentative: Meadowlands Country Club, Blue Bell, PA

For more information on Eastern Dental Society, please contact Dr. Michael Salin at Info@Eastern-Dental.org or (215) 322-7810, or visit us online at www.Eastern-Dental.org
University of Pittsburgh
Contact: Lori Burkette
Administrative Secretary
(412) 648-8370

Off-Campus Programs

Altoona
April 21
Medical Emergencies in the Dental Office
Dr. Michael Cuddy

Bradford
April 28
Biofunctional Esthetic Dentistry and More: Take Your Practice to the Next Level in Esthetic Dentistry
Dr. Marshall Fagin

Butler
April 21
Periodontics 2011: Pearls for the General Practice
Dr. Francis Serio

Erie
April 13
Options for the Restoration of the Dental Implant
Dr. Steven Kukunas

Greensburg
April 15
Current Issues In Health and Disease
Dr. Kenneth Etzel

Johnstown
April 17
Achieving Excellence in Treating and Counseling the Oncology Patient
Sandra Boody

Pittsburgh (VAMC)

April 13
Restoration of the Complex Denture, Fixed and Implant Patient; And Pitfalls to Avoid
Dr. Carl E Driscoll

May 11
Current Concepts In Bone Biology, Bone Harvesting and Bone Grafting for Dental Implants
Dr. Arun Garg

Pottsville
April 14
Smart Bonding: Extraordinary Solutions For Ordinary Problems
Dr. Howard Strassler

Reading
April 8
An Overview of Oral Pathology
Dr. Bobby Collins

May 20
Achieving Excellence in Treating and Counseling the Oncology Patient
Sandra Boody

Scranton
April 6
Current Issues In Health & Disease: The Whole Story!
Dr. Kenneth Etzel

Steubenville, OH
April 28
Smart Bonding: Extraordinary Solutions For Ordinary Problems
Dr. Howard Strassler

Titusville
April 27
New Developments in Endodontic Therapy
Dr. George Just

Williamsport
April 20
Periodontics 2011: Pearls For The General Practice
Dr. Francis Serio

17th Annual Bowser Memorial Lecture
March 26
Dr. Paul L. Childs, Jr

May 28-June 5
Under the Tuscan Sun Italy and Land Tour of Tuscany
Topics: Bone Regenerative Procedures
Periodontics
Restorative Dentistry and Endodontics
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Temple University
Contact: Dr. Ronald D. Bushick or Nicole Carreno
(215) 707-7541/7006
(215) 707-7107 (Fax)
Register at www.temple.edu/dentistry

April 1
Predictable Extraction Socket Therapy — Techniques and Materials to Form Vital Bone (Hands-On)
Robert A. Horowitz, DDS

April 8
A Complete Guide to Predictable and Profitable Anterior and Posterior Esthetic Restorations (Hands-On)
Marvin A. Fier, DDS, FASDA, ABAD

September 10
Advanced Lawsuit Protection and Tax Reduction Strategies
Larry Oxenham, Author, Senior Advisor
September 16
Implementing Evidence-Based Dentistry in Practice (Hands-On)
Richard Neiderman, DMD

September 23
Occlusion Based Restorative Dentistry
Jack Shirley, DDS

October 14
Lasers in Dentistry: The Journey to MID
Howard Golan, DDS, JD

October 21
Turning Assessments into Action
Brian B. Nový, DDS

November 4
A Partial Course on Partial Dentures with Hands On RPD Framework
Design Principles Workshop (Hands On)
M. Nader Sharifi, DDS, MS

November 9
Impression Techniques, Concepts and Technology (Hands On)
Marc Gottlieb, DDS

November 18
Drugs and Dentistry Including Herbs and Nutraceuticals
Richard L. Wynn, PhD

Brookville
Educational Conference Center,
Brookville Hospital Annex
Contact: Rebecca Von Nieda, PDA
(800) 223-0016, ext. 117

April 15
The Link between Oral and Systemic Disease
Scott S. De Rossi, DMD

St. Marys
Gunnery Inn and Restaurant
Contact: Rebecca Von Nieda, PDA
(800) 223-0016, ext. 117

May 6
Practical, Predictable Prosthodontics
Nels Ewoldsen DDS, MSD

Wellsboro
Pennsylvania College of Technology,
North Campus
Contact: Rebecca Von Nieda, PDA
(800) 223-0016, ext. 117

May 6
A Simple Path to Excellent Endodontics
Michael J. Ribera, DMD, MS

September 16
Updates in Pediatric Dentistry: Treating Tiny Tots to Teens
Lance E. Kishy, DMD

October 21
Ethics in Dentistry—Ethical Principles and Code of Professional Conduct
Lillian Obucina, DDS, JD

Greensburg
Gianelli’s II Restaurant & Banquet Facility, Greensburg
Contact : Rebecca Von Nieda, PDA
(800) 223-0016, ext. 117

April 29
A Comprehensive Review of Pediatric Dentistry for the General Practitioner and Staff—2011
Lance E. Kishy, DMD
May 20
New Perspectives in Esthetic Restorative Dentistry
Steven P. Weinberg, DMD

PDA and PDAIS
Pittsburgh
Crowne Plaza Pittsburgh South
Contact: Rebecca Von Nieda, PDA (800) 223-0016, ext. 117

June 3
Oral Pathology for the Joy of It — You Are the Object of My Infection
John A. Svirsky, DDS, Med

PDA Forensic Odontology Committee
Contact: Rebecca Von Nieda, PDA (800) 223-0016, ext. 117

April 16
Detecting Abuse in Vulnerable Populations — Psychological Warning Signals for Dentists and Their Staff
Daniel A. Martell, PhD
Thomas J. Weber, Esq.

Dental Society of Chester County and Delaware County
DKU Continuing Dental Education
Springfield Country Club
Delaware County
Contact: Dr. Barry Cohen
(610) 449-7002
DKUdental@aol.com

April 15
Innovations in Implant Dentistry
Dennis Tarnow, DDS

May 12
Growth and Planning Strategies to Improve Your Practice
Mark Murphy, DDS

Beaver Valley Dental Society
Contact: Dr. David Spokane
(724) 846-9666

April 14
Site Preparation for Dental Implants
Dr. Mark Silberg

May 12
Updates in Third World Dental Care
Dr. William Manteris

Seventh and Eighth District
The Penn Stater Hotel and Conference Center, State College
Contact: David Schimmel, DMD (814) 234-8527
drschimmel@verizon.net

April 1
Restoration of the Worn Dentition
Terry Donovan, DDS

May 13
Introducing Sleep Medicine into your Dental Practice
W. Keith Thornton

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DOCSeducation.org
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May 20-21
N20 and the Single-dose Sedative: An Effective Partnership
Anthony S. Feck, DMD, DOCS
Dean of Faculty, DOCS Education

The Institute For Facial Esthetics
Contact: Linda Maroney, CE Coordinator
(215) 643-5881
On-Line Registration:
www.iffe.net/registration

April 16
Advanced Scanning Procedures for Procera Implant Bridges
Robert Winkelman, CDT, MDT
Anna Marie Saccomandi

April 25
Severely Atrophic Maxilla
Thomas J. Balshi, DDS, PhD, FACP
Glenn J. Wolfinger, DMD, FACP
Stephen F. Balshi, MBE

May 7
Dental Assisting in the Implant Practice
James R. Bowers, DDS
Hillerie Swinehart, EFDA

May 13 and 14
NobelClinician™ 3D Computerized Planning
Thomas J. Balshi, DDS, PhD, FACP
Glenn J. Wolfinger, DMD, FACP
Stephen F. Balshi, MBE
Robert Winkelman, CDT, MDT

June 17
NobelClinician™ Software Update
Stephen F. Balshi, MBE

June 20
All-On-4 and More
Thomas J. Balshi, DDS, PhD, FACP
Glenn J. Wolfinger, DMD, FACP
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PRACTICE FOR SALE

PRACTICE FOR SALE

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Hudson County, NJ - Beautiful office in busy area close to NYC. General family practice w/ 4 ops. Digital freestanding bldg. (for sale), doctor retiring. Rev $340K. Call Donna at (800) 988-5674.
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Please call Nancy Schoyer at (888) 237-4237 or e-mail nschoyer@comcast.net and ask about our 19 listings in PA. We have practices for sale near Harrisburg, four in York County, the Pittsburgh and Philadelphia areas, Linesville, Williamsport, Berks County and Hanover. Call THE McNOR GROUP AT (888) 273-1014, ext. 103 or e-mail johnf@adstransitions.com.

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Near Chambersburg and Bedford — Practice and building for sale. Great practice.
Near Philly — Seeking an associate to buy-in and buy-out. $1.4 million in revenue in this modern highly profitable practice just 30 minutes from Philadelphia.

Please see John McDonnell’s article in the November issue of the Dental Economics magazine, page 94 titled “Why Not Sell Now?” Contact THE MCNOR GROUP AT (888) 273-1014, ext. 103 or johnf@adstransitions.com for more information on these and other opportunities in the area. www.mcnorgroup.com.

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- Soft tissue model with analog
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* Noble or High Noble alloy is additional

For more information, please call our Implant Coordinator, Mark Cherewka, DMD, FICOI at: 800.382.1240

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