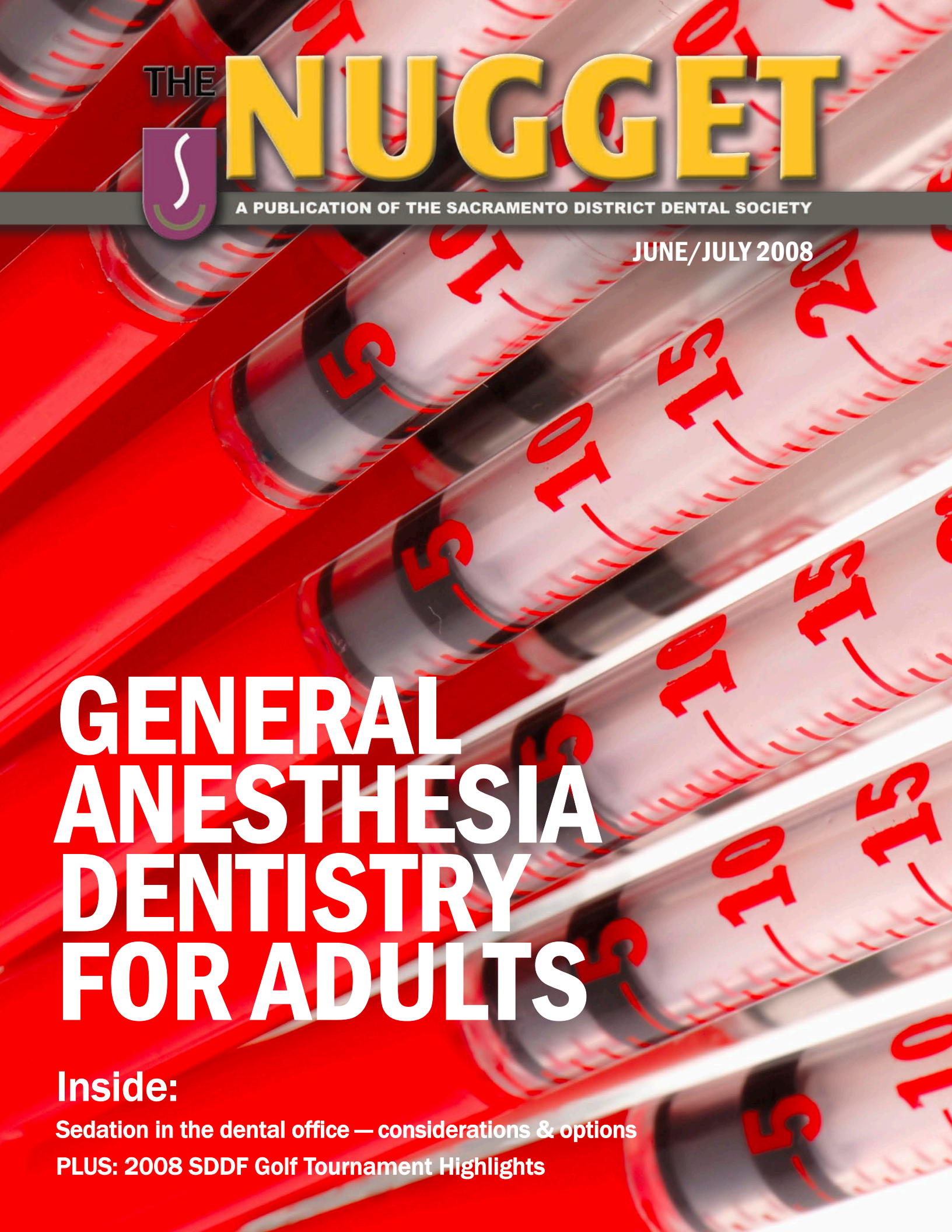
THE NUGGET

A PUBLICATION OF THE SACRAMENTO DISTRICT DENTAL SOCIETY

JUNE/JULY 2008



GENERAL ANESTHESIA DENTISTRY FOR ADULTS

Inside:

Sedation in the dental office — considerations & options

PLUS: 2008 SDDF Golf Tournament Highlights

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THE NUGGET **IS A 2007 INTERNATIONAL COLLEGE OF DENTISTS JOURNALISM AWARD WINNER IN THREE CATEGORIES:**

GOLDEN PEN HONORABLE MENTION AWARD

OUTSTANDING COVER AWARD

OVERALL NEWSLETTER AWARD

PRESIDENT'S MESSAGE

PRIORITIES?

By **Robert D. Shorey, DDS**

When you check into a hotel room to review where you will be living in the coming days, the first matter of business is to scope out the room's window view and then check out the amenities. Shampoo, body wash, Starbuck's coffee pouches, facial lotion, sewing kit and shoe shine kit. Personal care and body hygiene is obviously a recognized priority of the hotel industry for their patrons. But hmm, no toothpaste or tooth brush. Let's go to the conference meeting with great hair, soft skin, bad breath and plaque laden teeth? Priorities?

This year, California has taken in more tax revenue than ever before but our State government's rate of spending has clearly outpaced its revenue increase. Balancing our budget is like a drunk wrestling with alcoholism. The departments within our State are operating with a "protect the Saw Mill" mentality, over-spending to maintain their yearly overstated budgets. Priorities?

Concerning one of our State's priorities, of course educating our children is a logical priority for our communities. We want our children to have the necessary knowledge and skills to be competitive in the emerging world marketplace. What about their future health? Considering we are already spending over half of our State's total budget on education, one might wonder if continually preaching that more money is needed to keep our generations well-educated may simply be a smoke screen to cover an inefficiently administered system – an insatiable appetite to continue spending without objectively reviewing the results of the money spent. Ultimately the aim of our education system has been for our children to attend college. A recent *USA Today* newspaper article (April 30, 2008) questions the value of a college education. Quoting from the newspaper: "The United States spends more per student than any other industrialized nation, yet it ranks at the bottom in degree completion (54%)." The article also sites a report by author Jane Wellman stating "what we see across a broad range of indicators is that States and institutions are spending money in areas that may not be in line with the public priority of preparing more graduates."

Balancing our budget is like a drunk wrestling with alcoholism.

Complaining about the success of the school teacher's union is frankly my way of expressing my frustration and jealousy. Somehow our California school system has consistently convinced our State the answer to better education is to discharge over 50 percent of its money into its system. 55 billion dollars! At the same time only a paltry amount of the budget has been dedicated to dental care for our state's children in need. With the simplest comparison why doesn't our legislature follow the same logic that more money is needed when it comes to dental health? Scientifically we have the proven knowledge, the means and materials to prevent most childhood oral health disease problems. We have the best educated and skilled dentists in the entire world. If our State would focus just one percent of what it has been willing to do for education, dentistry could provide results that would last a lifetime for our newest generation, saving them from future dental procedures, additional costs and yes, needless suffering.

In California, medical and dental have been rewarded for scientifically successful and efficient use of dollars with cutbacks and ignorance. Our State legislature has been ignoring the value of preventive healthcare and most specifically oral healthcare. With a projected 20 billion dollar State budget deficit, Denti-Cal is again on the chopping block and we are on the verge of completely decimating what is left of our Denti-Cal oral healthcare system. Our State has been lacking the intestinal fortitude to invest in the future and get our entire public water systems fluoridated. Our Denti-Cal system has been beleaguered for over a decade and is headed for further cuts. How much more will this cost us in the future as the caries rate of California's children is already one of the highest in the nation? Bad decisions today will lead to more significant problems and greater expenses tomorrow. Bipartisan politics has become code for doing nothing except laying blame to each side of the political isle. Priorities? I'm born and raised in California and, when I look through a window to scope out a future view of California, it leads me to wonder… will we ever get our priorities straight? ■

FROM THE EDITOR'S DESK

GENERAL ANESTHESIA DENTISTRY FOR ADULTS

By **Alexander H. Malick, DMD, FAGD**

Before I became a dentist, I worked as a surgical orderly in a hospital for several years. I was witness to many simple procedures that took less than an hour to do, in which the patients were placed under general anesthesia. When I became a dentist, I wondered why we weren't treating patients the same way, especially when some of the procedures we were doing were a lot more complicated. I took a special interest in this area and discovered many obstacles that needed to be overcome.

In the past, in order to provide anesthesia for dental patients, you basically had a few options. One option was to have a hospital based dental practice. This meant that you had to go through a credentialing process with the hospital administration and join the hospital professional staff. In addition, you had to equip a room full of all needed equipment, materials and supplies and/or bring everything with you. You also needed a dental assistant, not a surgical tech, familiar with hospital procedures. This assistant sometimes needed to be credentialed also. In fact, I knew of many dentists who had a practice limited to hospital dentistry, treating mostly special needs patients and complex medical problem patients. In most cases, the dentistry done was limited to minimally necessary care to prevent or treat pain and infections. Reconstructions and routine restorative dentistry were not usually done. Having worked in a hospital surgery department, I knew that many times the dentist would get bumped for other more serious medical cases, so you had to be ready for that as well.

I knew of many dentists who had a practice limited to hospital dentistry.

Now, most of my knowledge about hospital dentistry was when insurances were generous and considered them special cases. With time, insurance coverage began to be less accommodating and of course, patients could not afford the high cost of going into a hospital on top of the dentist's fees. This phenomenon was also experienced by other sectors of elective medicine.

We soon saw the growth of Surgicenters, and some dentists began to use these centers as a lower cost options. This option is not all that inexpensive either. About ten years ago, I had a knee operation and my four-hour stay at the Surgicenter was around $5000, just for the Surgicenter! I don't know what it is now, but I am sure it is much higher. (A typical Surgicenter facility charge for four hours is about $6000, plus anesthesia, plus the dentist's fees.)

I had heard of a few independent anesthesiologists (MDs) going around offices and providing anesthesia services. I tried to contact a few of them, and they always seemed too busy.

Finally, I started hearing about Dental Anesthesiologists. I decided to look into working with an anesthesiologist to provide basic and complex dental care for adults in my office. I have now been working with a few Dental Anesthesiologists in our area and have been quite happy with our ability to care for these neglected patients.

In this issue, I asked three of our local DAs to write an article. I also did some research to provide our readers with some information regarding this new specialty of dentistry and current programs offering this residency *(see page 23)*.

I also interviewed Dr. Allen Wong, Co-Director of the hospital dentistry education program at UOP School of Dentistry, to get the latest perspective on Hospital based dentistry. For further information, please visit the following web sites:

www.asdahq.org/
www.adba.org/programs.html
www.scdonline.org/index.cfm ■

Although imprecise because patients could be placed in different classes by different anesthesiologists, the American Society of Anesthesiologists' (ASA) physical status classification serves as guide for better communication among anesthesiologists about clinical conditions of patients. It is a way to predict anesthetic/surgical risks — a higher ASA class indicates a higher risk. See below the five classes at last modification in 1961:

ASA CLASSIFICATION

Class 1 Healthy patient, no medical problems

Class 2 Mild systemic disease

Class 3 Severe systemic disease, but not incapacitating

Class 4 Severe systemic disease that is a constant threat to life

Class 5 Moribund, not expected to live 24 hours irrespective of operation

*An **e** is added to the status number to designate an emergency operation.*

*An organ donor is usually designated as **Class 6.***

www.asahq.org/clinical/physicalstatus..htm

CATHY'S CORNER

ARE YOU LEGAL?

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

I've been getting several calls this past month regarding some issues of concern by many of our members. So, in the interest of "education" and practice issues… read on!

Are you showing movies in your office? If so, do you have a license to do so?

A member called a month or so ago, to tell me she received a "cease and desist" letter from none other than the Disney Corporation. Why, you ask? Because the doctor was showing a Disney video in the reception area; and… it was a video that the doctor purchased.

No can do! You need a license from the Motion Picture Licensing Corporation.

In an email to the doctor, it is suggested, "to search for specific titles, you may wish to consult the Internet Movie Database website at www.imdb.com. Simply type in the name of the title you wish to screen. Once you have found the correct selection, click the "Company Credits" button on the left hand side of the screen. On the Company Credits screen, check to see which company distributes the film in the United States (U.S. Distributor). If the U.S. Distributor is listed on the attached producer list, the title is covered by the MPLC Umbrella License."

According to the information provided, the MPLC can provide you with a license for $270 per year for unlimited exhibitions in the waiting area of the dentist. I have contacted the MPLC and hopefully they will be writing an article in next month's *Nugget*. So… be careful what you are showing in your offices! There are spies out there who may report you!

Whitening... at the mall?

Also, as a follow up to MANY phone calls from members, I have asked CDA to write an article (in this issue) about the whitening kiosks in the mall. The national news and the local news have both run numerous stories on this topic. Many doctors are concerned. ADA is looking at it as well. We'll keep you posted and thanks for emailing me with your concerns.

So… keep the questions and the concerns coming; I'll research the info for you. Through the HR Hotline, we hope you are "keeping it legal" with all of your HR issues.

Have a great summer and look forward to the "unveiling" of the **SDDS 2008-2009 Program** of new courses, general meeting topics, and exciting programming in the next issue of the *Nugget* — the August/September issue. Stay cool… and legal! ■

The *Nugget* is published monthly (except bimonthly in June/July and Aug/Sept) by the SDDS, 915 28th Street, Sacramento, CA 95816 (916) 446-1211. Subscriptions are free to SDDS members, $50 per year for CDA/ADA members and $125 per year for non-members for postage and handling. Third class postage paid at Sacramento, CA.

Postmaster: Send address changes to SDDS, 915 28th Street, Sacramento, CA 95816.

Considerations for IN-OFFICE ADULT GENERAL DENTISTRY UNDER DEEP SEDATION/ GENERAL ANESTHESIA

By **Alexander H. Malick, DMD, FAGD**

I have always had a special interest in providing full mouth dental care under general anesthesia (GA) in one or two appointments for adults. However, conditions were never just right for this to be cost effective. Since I relocated from the Bay Area some five years

> *The diagnostic work up & treatment plan must be carefully considered for time efficiency.*

ago, I had the opportunity to change the way I practice dentistry, focusing on more comprehensive restorative cases including implant reconstructions and dentistry under GA. In this article, I will use the term GA interchangeably with IV sedation, but always provided by a certified Dental Anesthesiologist (DA).

Most complex cases require a significant amount of time in diagnosis and treatment planning, especially if they are multi-disciplinary. GA cases are extremely time consuming and can take a month or two to work up before we are ready to go. Scheduling such treatment is also challenging, since the appointments are generally a half day out of the practice and this must be mutually agreeable to the attending dentist, the staff, the DA, any specialists involved, the lab tech and the patient. A few important considerations for in-office Dentistry under GA are as follows:

1. During a GA case, ideally, the patient under treatment should be the only patient in the office. The office doors should be closed so that there are no interruptions (UPS delivery, sales calls, dental supply rep visits, etc).
2. The diagnostic work up and treatment plan must be carefully considered for time efficiency. All necessary x-rays, diagnostic casts, wax-ups, Vacu-form matrix, pre-made provisionals and needed treatment materials must be prepared in advance.
3. All patients must arrange for an escort to and from the office.
4. Instrument set ups must be organized in advance, in good working order, with duplication and contingencies planned.
5. All medical consults, recommendations and clearances must be obtained from the patient's medical providers. Physicians' orders regarding the patient's current medications should be followed and documented.
6. Informed consent and financial agreements must be reviewed and signed by all parties in advance of the day of the appointment. I prefer pre-payment for all services at this time.
7. All equipment must be set up and tested prior to induction. Special instruments such as molt mouth gags and surgical tongue retractors must be on hand.
8. Use of water must be carefully controlled. Throat packs may be necessary.
9. Two high speed evacuations must be available in case one gets clogged.
10. The room must be arranged to allow easy access for the dentist, the assistants and the dental anesthesiologist and monitoring equipment.
11. I prefer all root canal treatments to be performed by an endodontist for time efficiency and minimizing endodontic failures and re-treatments.
12. Extensive oral surgical procedures are best done separately by an oral surgeon. This is much more cost efficient for the patient.
13. It is a good idea to have a recovery room in the office to allow the patient to lie down after the procedure, if needed.
14. Appointments must be confirmed with all parties involved: the patient, the DA, the specialists and lab technicians.
15. For cases involving lab support, a technician's presence in the operatory can provide valuable input and minimize the need for re-preps and re-impressions.
16. The attending dentist must report this kind of clinical activity to his/her liability insurance carrier to make sure all necessary coverages are in place.
17. A copy of the anesthesia log should be kept in the attending dentist's patient chart.
18. Patient should be contacted the night of the procedure and the day following to make sure there are no untoward reactions and to re-assure the patient.

It is important to note that time management is extremely important. The longer the patient is under anesthesia, the more medical risks and complications can develop and the more costly the procedure becomes. With careful planning and organization, treatment can be provided safely, efficiently and cost effectively. ■

SEDATION OPTIONS IN THE DENTAL OFFICE

By **Pankaj Patel, MD**

It's early Monday morning and you arrive at your office, ready to see your first patient. You look at the schedule and see that your first patient is a two-year-old child of one of your other patients. The child has not been eating well and the mother is concerned that his teeth may be causing some pain. Your immediate thoughts are, "How am I going to examine this patient? Will he cooperate with x-rays?" The child is brought back to the operatory by your assistant. As soon as your assistant attempts to take x-rays, the child starts to cry and wants nothing in his mouth. You rush in the operatory to help, but the child is clinging to the mother and will not let go. What are your options in this situation? One option would be to refer this patient to a pediatric specialist - and this may be the best option. However, if you prefer to provide treatment for children and medically compromised patients in your office, there are options and techniques available to enable you treat these patients. In this article, I will provide you with different sedation and anesthetic options that can be utilized.

Your immediate thoughts are, "How am I going to examine this patient? Will he cooperate with x-rays?"

One of the safest methods to treating anxious patients is to incorporate anxiety relief ideas and techniques in your office. This can be accomplished by providing relaxing atmosphere: a clean office with happy staff, relaxing music, nice décor and personal attention. One of your operatories can be children friendly if you want to treat young children. For the elderly, morning appointments may be preferred.

The next method of anxiety relief can be provided by inhalation drugs. Nitrous Oxide inhalation sedation provides most patients with relief of anxiety. It is very easy to administer and no special permit is required. If you have never provided nitrous oxide and feel uncomfortable with this modality, my suggestion is to educate yourself in providing nitrous sedation. There are courses available and equipment costs are minimal. Nitrous oxide sedation is usually for patients with mild anxiety and it can also provide some analgesic effects in higher concentrations.

For some patients, greater anxiety relief is needed than that provided by nitrous sedation. Oral sedation for these patients may be the appropriate technique for anxiety relief. Oral sedation in California requires a permit from the Dental Board. There are courses available that will fulfill the requirements needed to obtain this permit. Oral sedation is a great way to help moderately anxious patients. I believe that all dentists should be familiar and confident with this technique of sedation. Oral sedation, in combination with nitrous oxide inhalation sedation, will allow the dentist to treat most patients with moderate anxiety. It is crucial that the dentist be familiar with patient's medical history and select the appropriate patients for oral sedation. There are some patients who will require more than what nitrous and oral sedation can provide.

For the patient with greater anxiety needs than oral sedation can provide, intravenous sedation may be appropriate. This modality of anxiety relief requires a greater degree of training for the dentist. In California, an IV sedation certificate is required in order to provide this form of sedation. Courses are available and special equipment will be required. If the dentist is not comfortable in providing IV sedation to his or her patients, perhaps another provider can be involved in the care of patients requiring IV sedation. Another dentist with IV sedation certificate, oral surgeon or dentist anesthesiologist can provide this type of service in your office. Most patients with severe anxiety or complex medical problems can be satisfactorily treated with intravenous sedation. For those patients who do not want to feel anything, have multiple medical problems or require complex surgical procedures, general anesthesia may be the appropriate answer.

General anesthesia can be provided in the dental office, licensed surgery center or hospital. A dentist with a general anesthesia permit or a physician anesthesiologist can provide this service in the dental office. Providing general anesthesia in the dental office is the most cost effective method. There are dentist anesthesiologists available as well as some physician anesthesiologists who provide this type of service in the dental office. The physician anesthesiologist must have a certificate from the Dental Board to provide anesthesia services in the dental office. Usually all of the needed equipment and supplies are bought to your office. There are few things that the dental office may be required to have but usually these are already present in a normal dental office. Other options to providing general anesthesia include having the patient treated in a surgery center or a hospital. For some patients with complex medical problems, this may be the only option. In order to provide dental services in a hospital or outpatient surgery center, the dentist must be credentialed and all the necessary equipment and supplies must be taken to the operating room by the dentist.

In summary, there are many modalities available to treat patients with apprehension and anxiety. Some of these require very little training or equipment, and some require services of another provider. Appropriate patient selection and the dentist's comfort with the choice of sedation provided are critical to successful sedation. ■

Dr. Patel is the owner and attending Dental Anesthesiologist in his own Surgicenter in Stockton, CA.

SURGERY CENTER

By **Pankaj Patel, MD**

Most dentists work in their own dental office in which they are very comfortable, with familiar staff, equipment and supplies. These offices allow the dentist to provide proper dental care to most of their patients. However, there may be some patients who need specialty care in a hospital or an outpatient surgery center. Examples of these patients include children, elderly, handicapped or medically compromised patients. There are some dentists who exclusively provide dental services to one of the above population. For these dentists, there has been growth in demand for the use of the facilities of an outpatient surgery center. So, how do you assess the safety of the surgery center for your patients and what are the requirements to build a surgery center?

An outpatient surgery center is a licensed and certified facility that provides an operating room for the use in surgical procedures. Dental surgery is one of the procedures that can be provided in this type of facility. Usually, an outpatient surgery center is certified by an organization such as Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Accreditation Association for Ambulatory Health Care (AAAHC) or Centers for Medicaid & Medicare Services (CMS). A certification is required by CMS if the surgery center provides services to the Medicare and Medicaid population. So, how is this certification obtained?

An outpatient surgery center is a licensed & certified facility that provides an operating room for use in surgical procedures.

A licensed and certified surgery center is a very complex process to complete. A team effort of engineers, architects, consultants and doctors is required for a successful surgery center. It must be OSHPD 3 (Office of Statewide Health Planning and Development) regulation compliant as well as comply with Title XXIV requirements. This means that Occupational Safety and Healthcare Policy Department regulations must be complied with. There are specific requirements with regards to size of the operating rooms, fire and life safety regulations, backup generators and many others that must be adhered to. OSHPD 3 regulations dictate the specific requirements of the building itself.

An outpatient surgery center must also be licensed by the CMS. This accreditation process is usually provided by the California Department of Public Health and dictated by CMS regulations, specifically Title XXIV of the CMS code of regulations. This portion of the licensing is usually the operational mode of the surgery center. It provides for the policies and procedures that the surgery center will follow in its daily operation. The credentialing of the physicians, administrator, nursing and other staff must follow these regulations. A pharmacy clinic permit is also required for the surgery center.

The time that it takes to construct, obtain a license and obtain a certificate can take more than two years. There are many other requirements that are too numerous to list in this article. If the dentist is considering providing dental services in an outpatient surgery center for some of their patients, I would suggest for the dentist to make sure that the surgery center is certified by one of the organization such as JAACHO, AAAHC or CMS. If the dentist has many patients that can benefit from the services provided in a surgery center, it will be very beneficial for the dentist to have privileges at a surgery center. ■

Dr. Patel is the owner and attending dental anesthesiologist in his own Surgicenter in Stockton, CA.

WHEN SOMETIMES YOU NEED A LITTLE MORE...

By **Joel L. Pedersen, DDS**

Dental Anesthesia

Dentists are faced with a wide spectrum of patients, all requiring different approaches to achieve the treatment needed. Although most treatment can be completed with use of good chair side manor and effective local anesthesia, sometimes this is not enough. Oral medications may be the answer for some. However, although often successful, it may fall short of its intended effect. When oral sedation fails, IV sedation and general anesthesia can make otherwise impossible treatment a reality. With this in mind, it is important to recognize what types of patients are most likely to require IV sedation or general anesthesia.

Extreme anxiety

One of the most common patients I come across in my practice is the extremely anxious patient — the patient who is breathing hard and perspiring heavily as he/she sits in the chair. There are several reasons a patient may feel uncomfortable in the dental chair. Many of my patients claim to have had a tough or frightening experience as a child. Often these bad experiences can lead to years of avoiding the dentist and putting off simple treatment until it reaches a point where the work required is quite substantial. Another factor that can play a role is an underlying mental or psychological disorder. These disorders can lead to an unnecessary fear or panic. Abnormal phobias of dental procedures, injections or things associated with the oral cavity are a problem I come across as well. I have dealt with patients who cannot tolerate anything in or around their mouths. This presents a huge problem for a dentist without a deep IV sedation. These along with others, are some of the causes for the anxious patient needing IV sedation.

Patients with chronic pain

This is a problem with longer cases. For example, it is very difficult for a patient with severe back pain to lie in a chair for prolonged periods of time without sedation. I find these patients are cooperative and manageable during the case. Since they are not fighting a fear or phobia to begin with, it is quite effective to give them medications to keep them comfortable and sleepy in the chair while the dentist can finish their lengthy treatment plan.

Patients with a severe gag reflex

This is another common patient that requires IV sedation. This patient does not usually have a fear of the treatment itself. However, he/she is nervous about a gag reflex because it has often been struggled with in previous dental procedures. This patient also does very well with IV sedation. Often these gag reactions are more mental than physical and, with the right amount of medications, they do very well.

I have dealt with patients who cannot tolerate anything in or around their mouths.

Patients who have trouble getting or staying numb

This can be a little bit tricky, depending on the true reason for the patient's resistance to local anesthesia. If the patient truly can't be numbed, they would have to be very deeply sedated or place under general anesthesia in order to perform the work. This is not very common yet within the realm of possibility. A sedated patient will still feel pain and therefore effective local anesthesia is required. However, the deeper the sedation is the less the patient will respond to the stimulus presented. Obviously general anesthesia will not require local anesthesia and if the patient truly can not become numb this would be the route taken.

On the other hand, some patients claim to feel pain even after effective local anesthesia has been administered. This if far more common compared to the previous patient. The mind can confuse and trick a patient into feeling pain when actually the nerve has been profoundly blocked. These patients are one of the easiest to deal with. Sedation can relax the patient and often treatment can be performed without incidence.

Special needs or mentally handicapped patients

The patients I am talking about here are the ones with the severe developmental delay. Often uncooperative and possibly combative, these patients usually don't receive treatment due to the inability to safely attempt work. These patients often require general anesthesia to perform the needed treatment. Sedation is not a viable option in these patients. A big difference between these patients and the ones listed earlier is a willingness to get the work done. Even the severely anxious or phobic patients, although terrified, want to have the work take place. Special needs patients often do not know why they are at the dental office and are unwilling to cooperate, even with sedation, mainly because of their lack of understanding. In office general anesthesia is a great option for most of these patients, assuming proper work ups and qualified people perform the anesthesia.

IV sedation and general anesthesia are not needed for everyone. It should be utilized, when needed, to allow the dentist to provide the best treatment possible for his or her patient. One of the most commonly overlooked parts of IV sedation is the benefit it can give to the dentist as well as the patient. Stress from a difficult procedure can affect the dentist just as much as the patient. Difficult and lengthy work on an extremely fearful or anxious patient can lead to unnecessary pressure and fatigue on the dentist. Many dentists who use IV sedation will comment on how much easier the procedure was with a sleepy, comfortable patient. In all, IV sedation is important for keeping both the dentist and patient comfortable and satisfied with the treatment performed. ■

Dr. Pedersen is an SDDS member practicing mobile dental anesthesiology.

Interview:
ON BEING A DENTAL ANESTHESIOLOGIST

With **Jeffrey P. Fisher, DDS**

Dr. Malick (Dr. M): What kinds of patients do you see mostly?

Dr. Fisher (Dr. F): 99% of the patients I see are children 3–4 years old with rampant caries

Dr. M: Do you ever go into a hospital or surgery center?

Dr. F: No

Dr. M: How many days do you work per week?

Dr. F: Generally, five days per week.

Dr. M: How do you feel your education and training compares with an MD anesthesiologist?

Dr. F: I feel that, for what we do, which is outpatient deep sedation/light general anesthesia (GA), we are as well trained as an MD. However, the MDs do have a lot more training and are involved with more complex medical situations that we normally don't do.

Dr. M: What is the maximum time, you feel, a patient can safely be under GA

Dr. F: I have had cases as long as eight hours,. However, because we are using IV fluids to push the drugs into the patients veins, the longer a case goes, the more problem you will have with fluid control. Basically, the patient will need to get up and go to the bathroom since we do not have the patient catheterized like they are in a hospital or surgicenter. So, this becomes the limiting factor. Also, of course, the rate of complications can go up with time under GA. The typical case that I do is between 2–2 ¼ hours.

Dr. M: What cases will you not take on?

Dr. F: Class III ASA's, cardiac problems, any history of cardiac surgery, and now I do not see Down's Syndrome, since they may have undiagnosed or detected cardiac conditions.

Dr. M: Do you intubate?

Dr. F: I almost always don't. I use a light GA without intubation. That is what I am comfortable with.

Dr. M: What about patient with a history of drug or alcohol abuse?

Dr. F: They are definitely more complicated to handle safely. They tend to use up more medications and compromised liver function changes the metabolism of the drugs we use.

> *99% of the patients I see are children with rampant caries.*

With ex-drug addicts, we have to control the use of narcotics, otherwise they may become addicted again.

Dr. M: Do you handle insurance at all?

Dr. F: We are trying to work with some insurance companies but, in general, we are on a cash basis.

Dr. M: Is dental anesthesiology (DA) a recognized specialty of dentistry?

Dr. F: Surprisingly, no. DA is the only area of practice for which you need special licensing, yet it is not a specialty.

Dr. Fischer, an SDDS member, is a graduate of Loma Linda University Dental Anesthesia Residency in 2001. He also received his DDS from Loma Linda, but does not practice. ■

Interview: CURRENT PRACTICE OF HOSPITAL DENTISTRY

With **Allen Wong, DDS, FACD, FICD**

Since the topic of this issue is in-office dentistry under general anesthesia, there are situations where some patients cannot be treated on an out-patient basis in a private office. These patients need to be taken to a hospital for dental treatment. I interviewed Dr. Wong, co-director of the hospital dentistry education program at UOP School of Dentistry. Here is some information:

Dr. Malick (Dr. M): Considering the medical and dental insurance reimbursement limitations, is hospital / surgicenter dentistry still a viable option for many patients?

Dr. Wong (Dr. W): Yes. If medical necessity can be documented, a patient can be taken to a hospital to have routine dentistry performed, with insurance covering the cost of the hospital and anesthesia services.

Dr. M: What kinds of patients are candidates for hospital dentistry?

Dr. W: Medically compromised patients, such as organ transplant patients, ASA class III or higher (see figure 1), mentally and physically handicapped patients, Alzheimer's, severe dementia and psychiatric patients, etc.

Dr. M: Does one have to be credentialed to practice dentistry in the hospital?

Dr. W: Yes, and the credentialing process is becoming more and more stringent. Many hospitals are now requiring Board Certification. Some require graduation from a formal course in hospital dentistry. Any additional credentials other than a DDS/DMD is helpful.

Dr. M: I assume you take your own dental assistant to the hospital. Does he/she also need to be credentialed?

Dr. W: There is a trend toward that as well.

Dr. M: What special liability insurance do you need for hospital dentistry?

Dr. W: Just the typical Dental Liability Insurance, as long as they are informed that you are doing hospital dentistry. Check with your carrier.

Dr. M: Are most of your patients private pay or Medi-Cal?

Dr. W: Since I have developed a reputation for this kind of dentistry, the majority of patients are Medi-Cal. However, we do have a good number of private insurance patients as well.

At UCSF, depending on when a call is made, there may be several months to a year's waiting list. This is because very few dentists are credentialed and practicing hospital dentistry.

Dr. M: How many hospitals do you work in?

Dr. W: I am credentialed in four hospitals, however, most dentists are credentialed in only one, since the credentialing process is rigorous and some hospitals require attendance in their meetings and various programs. So, belonging to more than one hospital can be challenging. There are also fees involved.

Dr. M: How about scheduling your cases? Do they bump you and give priority to other medical cases, or are you able to schedule within a reasonable amount of time?

Dr. W: Dentistry is generally not profitable for hospitals. However, it can be, depending on the types of cases one does. The more cases you do, the more favorable your ability to schedule. The problem with scheduling is more on the dental side. At UCSF, depending on when a call is made, there may be several months to a year's waiting list. This is because very few dentists are credentialed and practicing hospital dentistry.

Dr. M: How long can you have a patient under anesthesia?

Dr. W: No time limit. However, most cases are between 3–4 hours long.

Dr. M: What about equipment and supplies?

Dr. W: Some hospitals actually will purchase the equipment you need. Others may share in the cost of the purchase. In some hospitals, I have to carry my equipment to and from the hospital. This also depends on how many cases you do per month/year. Each hospital may have a different arrangement. ■

Dr. Allen Wong is a graduate of UOP Dental School, '86. He attended a one year advanced clinical experience residency in Sacramento and a two year AEGD program at UOP. He is a diplomate of the American Board of Special care dentistry and is a currently a candidate in Doctoral Professional Education (Ed. D.) and Leadership Program. Dr Wong is a credentialed Hospital Dentist at Highlands Hospital in Oakland, CA and the co-director of the Continuing Education program for Hospital Dentistry at UOP, San Francisco.

TREATING OSTEOPOROSIS CALLS FOR PHYSICIAN, DENTIST COLLABORATION

ADA JOURNAL

Oral health maintenance important for patients with osteoporosis

CHICAGO, May 15, 2008 — Physicians and dentists should collaborate to improve early detection and treatment of patients who have or may develop osteoporosis, say researchers in the cover story of the May issue of The Journal of the American Dental Association.

The authors of the article, "Osteoporosis and Its Implications for Dental Patients," reviewed the medical and dental literature to examine osteoporosis' effect on public health in the United States. They also assessed the implications of providing dental care to people who have or are at risk of developing osteoporosis.

According to the authors, the literature indicated that osteoporosis and related fractures are more common than coronary disease, stroke and breast cancer. Fractures resulting from osteoporosis can affect a patient's quality of life, as well as result in functional impairment and increased health care cost and mortality.

Their literature search also revealed that medical management of osteoporosis includes diet control, weight-bearing exercise, discontinuation of tobacco and alcohol intake, and use of medications—including selective estrogen receptor modulators, calcitonin, anabolic agents and bisphosphonates—that have been associated with the development of osteonecrosis of the jaw.

The authors determined that oral health maintenance is important in patients with osteoporosis, and that changes to bisphosphonate therapy or other medical treatment should be made only after consultation with the patient's physician. "Dentists need to understand osteoporosis, its treatments and its complications to provide adequate care," write the authors.

All health care professionals involved in the care of all dental patients, particularly patients who are taking oral bisphosphonates, should discuss patient care decisions with the patient's physician, conclude the authors.

The authors were Beatrice J. Edwards, MD, associate professor of medicine, Feinberg School of Medicine, Northwestern University, Chicago, and co-author Dr. Cesar A. Migliorati, professor, Oral Medicine, Nova Southeastern University, College of Dental Medicine, Fort Lauderdale, Fla. ■

SACRAMENTO DISTRICT DENTAL SOCIETY BYLAWS REGARDING ELECTIONS...

CHAPTER VI — ELECTION PROCEDURES

Section 10. NOMINATION BY COMMITTEE: The Board of Directors shall appoint a Leadership Development Committee to nominate qualified candidates for election to all offices including Secretary, Treasurer, President-Elect, Directors, Trustees and Delegates. The Leadership Development Committee shall make its report to the Board of Directors at least 45 days before the date of the election, or at such other time as the Board of Directors may set, and the Secretary shall forward to each Member, with the notice of meeting required by these Bylaws, a list of all candidates nominated by committee.

Section 20. ADDITIONAL NOMINATIONS: Any active or life Member in good standing who meets the qualifications of the office he/she is seeking may be nominated by filing with the Secretary at least 30 days prior to the annual meeting a written nomination signed by at least ten (10) active or life Members in good standing.

Section 30. THE BALLOT: The Board of Directors shall approve the ballot for all offices, including Officers, Directors, Trustees, and Delegates to be voted upon at the annual meeting. All nominees shall be listed in alphabetical order. There shall be no changes to the ballot after approval by the Board of Directors unless a special Board meeting is held to discuss such changes.

Section 40. NOTIFICATION OF MEMBERS: The ballot shall be published to all Members at least ten (10) days prior to the election pursuant to the Notification Requirements of Chapter III, Section 50.

Section 50. THE ELECTION: The ballots shall be secret and shall be cast at the annual meeting of Members. The Secretary shall oversee the casting and counting of ballots. There shall be no campaigning whatsoever for any candidate the evening of the election.

Section 60. COUNTING THE BALLOTS: The Secretary shall select an appropriate number of Members to act as clerks and count all ballots, including mail ballots. The candidate receiving the highest number of votes for any office shall be declared elected.

I. TIES: In case of candidates receiving equal number of votes, a second ballot will be cast. If that ballot results in a tie, the Secretary shall have the candidates draw straws.

II. ANNOUNCING RESULTS: The results of the election will be announced as soon as possible and the list of successful candidates shall be published in the next periodic publication of the Society.

III. DELEGATES AND ALTERNATE DELEGATES: The Secretary shall list the names of the candidates receiving the highest total number of votes to fill the Delegate list. Those candidates receiving the next highest number of votes shall fill the Alternate Delegate list in the order of votes received.

IV. CHAIR OF DELEGATION: The President of the Society shall be Chair of the delegation.

Section 70. ABSENTEE BALLOT: Any Member eligible to vote may request an absentee ballot. The ballot must reach the Society office by 5:00 p.m. of the evening of the election meeting. The Secretary shall make a record of all those requesting absentee ballots and they will not be permitted to vote the night of the general election regardless of whether or not they returned their absentee ballot.

Section 80. INSTALLATION OF OFFICERS: The newly elected officers, Board Members, Trustees and Delegates shall be installed at a date and time designated by the Board of Directors, and shall assume their duties January 1st of the year following their election. ■

NOTICE OF ANNUAL MEETING & ELECTIONS

Elections to be held at General Meeting September 9, 2008

SDDS EXECUTIVE COMMITTEE

President: Adrian Carrington, DDS
President Elect: Terrence Jones, DDS
Treasurer: Wai Chan, DDS
Secretary: Victor Hawkins, DDS
Immediate Past President: Robert Shorey, DDS

BOARD OF DIRECTORS

(to serve a 2 year term, 2009–2010)
P. Kevin Chen, DMD, MS
Matt Comfort, DDS
Dan Haberman, DDS, MS
Viren Patel, DDS
Jeffrey Rosa, DDS

EXISTING BOARD MEMBERS CONTINUING 2009 TERM:
Donna Galante, DMD • Kelly Giannetti, DMD, MS
Craig Johnson, DDS • Kim Wallace, DDS

TRUSTEE

(to serve a 3 year term, 2009–2011)
Donald Rollofson, DMD *(2nd term)*

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

DELEGATES TO THE CDA HOUSE OF DELEGATES

(2 year term, 2008–2009):
(please vote for 4)
___ Matt Comfort, DDS
___ Kelly Giannetti, DDS, MS
___ Ken Moore, DDS
___ Gabrielle Rasi, DDS
___ Kim Wallace, DDS

EXISTING DELEGATES CONTINUING 2008 TERM:
Gary Ackerman, DDS • Donna Galante, DMD

SDDF BOARD OF DIRECTORS:

Matthew Campbell, DDS *(2009–2010: 1st term)*
Kent Daft, DDS *(2009–2010: 3rd term)*
Gordon Harris, DDS *(2009–2010: 1st term)*
Dennis Peterson, DDS *(2009–2010: 2nd term)*
Don Rollofson, DDS *(2009–2010: 3rd term)*

EXISTING BOARD MEMBERS CONTINUING 2009 TERM:
Robert Daby, DDS (Treasurer)
Harry "Skip" Lawrence, DDS • Wesley Yee, DDS

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

In accordance with the bylaws…

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

Deadline: August 9, 2008

SLATE OF NOMINEES • SLATE OF NOMINEES

BABY NUGGET

BROUGHT TO YOU BY YOUR DENTAL HEALTH COMMITTEE

WHEN TO RESIST!

By **Maryam Saleh, DDS**

With the widespread use of antibiotics, many bacteria have become resistant to drugs that once controlled them. The American Academy of Pediatric Dentistry (AAPD) recognizes the need for antibiotic use in children and adolescents and has developed some guidelines to aid the practitioner in proper antibiotic prophylaxis prescriptions and general antibiotic use in the pediatric population.

The AAPD guidelines for antibiotic prophylaxis are derived directly from the American Heart Association (AHA) recommendations on prevention of infective endocarditis. The newly revised 2007 AHA guidelines recommend prophylaxis only for patients with cardiac conditions that will result in the highest risk of adverse effects. A couple of these include patients with an untreated congenital heart defect or a repaired congenital heart defect with prosthetic material during the first six months. Because some parents may not be aware of the exact details of the child's heart conditions, a consultation with the patient's physician may at times be necessary to determine the need for prophylaxis. Once the need for prophylaxis is determined, only dental procedures that involve invasive manipulation of gingival tissue, periapical regions of teeth or perforations of oral mucosa will require pre-medications. In the pediatric population, some of these procedures may include frenulectomies and extractions. Below is a table with suggested prophylaxis regimens.

Many bacteria have become resistant to drugs that once controlled them.

Prophylaxis is not recommended for non invasive treatments such as routine fillings and prophies. For a more complete list of these conditions and recommendations please visit the AHA website under antibiotic prophylaxis.

In addition to antibiotic prophylaxis, AAPD has developed guidelines for proper and judicious use of antibiotics for various oral conditions. Conservative use of antibiotics is suggested to decrease the risk of developing resistance. However, there are instances where antibiotics are needed. Oral wounds (soft tissue lacerations, tooth fracture with pulpal exposure, extensive ulcerations, etc.), especially those due to trauma, occur frequently in children and therefore deserve a close inspection. If it is determined that antibiotics will benefit the wound healing process, a culture test should be done with immediate antibiotic administration IM or IV. In most oral wound cases, the natural host bacteria will be sufficient for healing and no supplemental antibiotics are indicated. In cases of pulpitis, draining fistulas, apical periodontitis and localized intraoral swellings, treatment of the area (pulpotomy, extraction, etc.) and the acute symptoms are necessary. Antibiotics are not recommended for localized infections contained within the pulp and immediate surrounding tissue. When the infection is systemic, such as a facial swelling and fever due to dental infection, immediate treatment is recommended. This may include antibiotic treatment to contain the infection for a few days and allow for adequate anesthesia to be followed by definite treatment or immediate treatment followed by an antibiotic prescription. At times the swelling may be severe enough that an emergency room referral for IV administration of antibiotics is necessary. In cases of pediatric periodontal diseases, it is recommended that the clinician do thorough culture and susceptibility test of the involved tissues before determining the appropriate antibiotic prescription. Chronic periodontal disease may require prolonged antibiotic therapy and further testing for possible underlying immunodeficiency disorders. Diseases such as acute primary herpetic gingivostomatitis should not be treated with antibiotics unless there is strong evidence of underlying bacterial disease. Due to the ever-increasing resistance of bacteria to antibiotics, recommendations call for more conservative and judicious use of antibiotic prescriptions. It is up to the practitioner to stay updated on revised guidelines and to educate patients about the growing problem of antibiotic resistance. ■

Children **not** allergic to penicillin	Amoxicillin 50 mg/kg (maximum 2 grams) orally 1 hour prior to dental procedure
Children **not** allergic to penicillin & unable to take oral medications	Ampicillin 50 mg/kg (maximum 2 grams) intraveneous (IV) or imtramuscular (IM) within 30 minutes before dental procedure
Children allergic to penicillin	Clindamycin 20 mg/kg (maximum 600 mg) orally **or** Azithromycin 15 mg/kg (maximum 500 mg) orally 1 hour prior to procedure
Children allergic to penicillin & unable to take oral medications	Clindamycin 20 mg/kg (maximum 600 mg) IV or IM **or** Cefazolin 25 mg/kg (maximum 1 gram) IV or IM within 30 minutes before dental procedure

2008 SDDF GOLF TOURNAMENT

Friday, May 9, 2008 — Timber Creek Golf Club

HOLE 1
Cornish & Carey Commercial

HOLE 1
Drs. Kent Daft & Charles Stamos

HOLE 2
Blue Northern Builders, Inc.

HOLE 2
Capital Oral Surgery

HOLE 3
Bank of Sacramento

HOLE 4
Kids Care Dental Group

HOLE 4 — HOLE IN ONE
SDDS CE Committee

HOLE 5
Henry Schein Dental

HOLE 6 — CLOSEST TO THE PIN
TDIC Insurance Solutions

HOLE 7 — LONGEST DRIVE
California Dentists Guild

HOLE 8
Prosthodontic Dental Group

HOLE 8
Dr. Don Rollofson (Elk Grove Orthodontics)

HOLE 9
Burkhart Dental Supply

HOLE 10
Olson Construction, Inc.

HOLE 10 — STRAIGHT DRIVE
Drs. Cas, Jonathan & Damon Szymanowski

HOLE 11
Patterson Dental Supply

HOLE 11
MediaMed, Inc.

HOLE 12
Resource Staffing Group

HOLE 12
Endodontic Associates Dental Group

HOLE 13
The Levering Company

HOLE 13
Coca-Cola Company

HOLE 14 — HOLE IN ONE
Dexis

HOLE 15
Capitol Periodontal Group

HOLE 15
Washington Mutual (WaMu)

HOLE 16 — CLOSEST TO THE PIN
First U.S. Community Credit Union

HOLE 17 — LONGEST DRIVE
Ironstone Bank

HOLE 18
Straumann

HOLE 18
Jackson-Heise-Alpha OMFS

PUTTING CONTEST
Citibank

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Northwest Mutual

THANK YOU, SPONSORS!

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Blue Northern Builders, Inc.
CA Dentists Guild
CA Employers Association
Citibank
Coca-Cola (water & soda)
Dexis
Fat's Restaurants
First U.S. Community Credit Union
Heidi Christopher (Temp Hygiene)
Ironstone Bank
Northwestern Mutual
SDDS CE Committee
Sirlin Studios
Dr. Szymanowski (x3!)
TDIC Insurance Solutions
Timilick Golf Course

CONTEST WINNERS:

CLOSEST TO THE PIN (HOLE # 6)
Sponsor: TDIC Insurance Solutions
Winner: **TODD HERB (Sullivan Schein)**

CLOSEST TO THE PIN (HOLE # 16)
Sponsor: First U.S. Community Credit Union
Winner: **JEFF JONES, DDS**

LONGEST DRIVE (HOLE # 7)
Sponsor: CA Dentists Guild
Winner: **MARK VERHAAG**

LONGEST DRIVE (HOLE # 17)
Sponsor: Ironstone Bank
Winner: **ZAQARY WHITNACK**

STRAIGHT DRIVE (HOLE # 10)
Sponsor: Drs. Cas, Jonathan & Damon Szymanowski
Winner: **ANDY MATHEWS (Sullivan Schein)**

PUTTING CONTEST
Sponsor: Citibank
Winner: **BRUCE LEVERING (The Levering Company)**

1ST PLACE FOURSOME
Winners: **BRANDON HARDY (Sullivan Schein)**
JERRY WILSON, DDS (Sullivan Schein)
KELLY WILSON, DDS (Sullivan Schein)
MARK VERHAAG (Sullivan Schein)

2ND PLACE FOURSOME
Winners: Todd Herb (**Sullivan Schein**)
Adam Jones
Andy Mathews
John Micheli

"DFL" AWARD FOURSOME
Winners: **GARY BORGE, DDS**
CARLENE HARDEN, RDA
MARK OLSEN, DDS
FRANK SANCHEZ
(Paramount Dental Lab)

CONGRATULATIONS,
IRONSTONE BANK
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gas-powered blender!

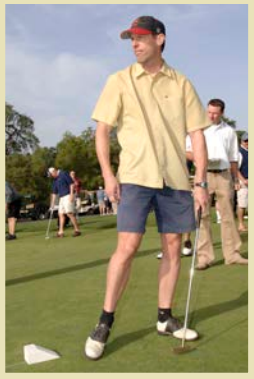
This year's tourney raised **$13,000** for the Foundation!

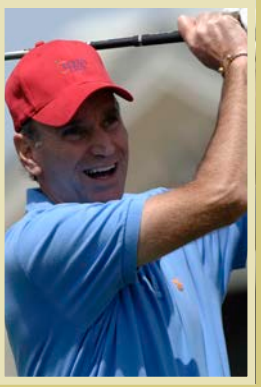
2008 SDDF GOLF TOURNAMENT COMMITTEE

Dr. Jeff Rosa
Chair
Dr. Todd Andrews
Dr. Daisuke Bannai
Dr. Bob Gillis
Sue Nelson
Cornish & Carey
Grant Peterson
Burkhart Dental
Dr. Terrence Robbins
Dr. Marty Rosa
Dr. Maryam Saleh
Dr. Damon Szymanowski
Dr. Jonathan Szymanowski

PHOTOS:
(counter-clockwise from bottom left)

- Dr. Kent Daft lines up for the putting contest, sponsored by Citibank.
- Mike Korn (SDDS DHP member) surveys the green.
- "Fantastic! This was the most well run tournament next to the Olympic Club!" says Dr. David Fein, "spy" from San Francisco Dental Society.
- Dr. Chris Kane, Dr. Don Rollofson, Bruce Levering & Dr. Roger Reich thank Timilick Tahoe for their generous donations.
- The first place winners of the 2008 SDDF Golf Tournament (Dr. Kelly Wilson, Brandon Hardy & Mark Verhaag) collect their prizes to hearty applause.
- The SDDS staff wraps up their favorite event of the year with a raffle and a fabulous lunch.





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BOARD REPORT

MAY 6, 2008

Submitted by **Wai M. Chan, DDS**
Secretary

President's Report

- Dr. Shorey introduced Ms. Suellen Jost, bookkeeper for SDDS and Mr. Keith Rood, CPA for SDDS.
- Dr. Shorey, Dr. Rollofson and leaders of San Joaquin Dental Society attended a meeting with Scott Kamena, OD, an optometrist running for Assembly District 15.
- There are ongoing First Five meetings to explore barriers to Access to Care.

Secretary's Report

In April, 2008, we lost 39 members due to non-payments of dues. We are saddened that Dr. Marty Crane has passed on. Three members had resigned and one had transferred to another component.

Treasurer's Report

- Dr. Terry Jones stated that under the leadership of Executive Director, Ms. Cathy Levering, SDDS is financially in solid ground. We have operating and building reserves that we did not have before. Ms. Levering also makes sure that our reserves are not in risky investments.
- Dr. Jones reported that Dr. Wai Chan, Dr. Kevin Keating and he attended the CDA Leadership Training and shared ideas regarding financial review.

Unfinished Business

Leadership Development

- *It was M/C to accept the Leadership Development Committee nominations*

See page 15 for complete slate of candidates.

Fluoridation committee discussion

- The Board ratified the interim appointment of Fluoridation Task Force by Dr. Shorey.
- Dr. Terry Jones, Fluoridation Task Force Chair gave a brief summary of Task Force goal, historical background, targets, manpower needs, process and timeline. He submitted a report and recommendations. *It was M/C to accept the Fluoridation Task Force Report and recommendations as written.*
- Dr. Dennis Wong reported that Dr. John Orsi has stepped down as Co-Chair of Fluoridation Advisory Committee.
- The Board decided to keep the Fluoridation Committee as an Advisory Committee.
- *It was M/C to appoint Dr. Dennis Wong as Chair of a separate workgroup on fluoridation to implement the Fluoridation Task Force recommendations and to report its progress to the Board at the September Board meeting.*

Cap to Cap

- Dr. Chan and Ms. Levering thanked the Board for sending them on the Metro Chamber of Commerce Cap to Cap trip. They represented SDDS on the Metro Chamber of Commerce Delegation to Washington, DC to lobby on issues important to this region. Dr. Chan was on the Health Care Team and Ms. Levering was on the Small Business Team.

New Business

Access to Care requests

- Dr. Carrington reported on request made to SDDS for members to perform Pro Bono care.
- Dr. Kim Wallace reported that the Dental Health Committee has been doing community screenings and health fairs requested by numerous organizations.
- Ms. Levering reported that SDDS constantly received requests for free dental care.
- Board members shared that SDDS should not take over the county's responsibility to provide care to its indigent population and that Sacramento County should increase its ability to serve its population.

Shriners' Cleft Palate Clinic

- Dr. Rosa reported of Shriners' request for advice on dental clinic/dental service for patients of its cleft palate clinic.
- Ms. Levering will draft letter to the lead person of the cleft palate project to express the support of SDDS.

Alliance Report

Alliance has gifted $5,000 to SDDF. Half goes to the Charitable Fund and the other half is for printing the Smiling Kids brochures.

Next year's Crab Feed is March 27, 2009.

Trustee's Report

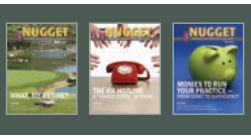
CDA's Leadership Development Committee is accepting applications for leadership positions. Available positions can be viewed at CDA website.

Executive Director's Report

SDDS Executive Director, Ms. Cathy Levering reported:

- **Smoking Cessation Grant application** — SDDF has applied for the Smoking Cessation Grant. If SDDF receives the grant, it will involve SDDS members and low income dental hygiene clinics.
- **House of Delegates** — This November's HOD meeting will be Dr. Matt Campbell's last year on the House.
- **Section 179 deduction —** For 2008, the deduction allowed is $250,000, rather than depreciating over several years.
- **Non-member orthodontist bankruptcy leaving patients without care —** Over 20 member orthodontists have stepped up to provide care for the unfortunate patients affected by this situation. ■

Next Board meeting: **September 2, 2008**



YOU
THE DENTIST, THE EMPLOYER

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

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

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

DISASTER-PROOFING YOUR PRACTICE
preparation is key

By **Peter J. Ackerman, CPA**

Approximately 1,000 dentists retire each year, but more than 1,300 die. Most of them have not adequately prepared their spouses and other heirs to act efficiently and effectively to protect their interests. But with proper planning, you can take steps to avoid disaster for your heirs and leave your practice in sound financial shape.

Know what you have and maximize It

Before you can know what to do to safeguard your family, you must know what you have, including the current value of your dental practice. Shop around and select a professional practice broker that you trust, making sure to include your spouse or another heir in your meetings. In addition to providing essential valuation information in the form of an appraisal, your broker will act as your "quarterback," guiding you and your family through the sometimes daunting process of putting your affairs in order.

The practice appraisal prepares you to assess the factors that drive dental practice values in today's sales environment. This permits you and your practice broker to take the next step of evaluating any areas of concern about your practice that can then be addressed to increase its value and marketability. It is well worth the time and expense to regularly update your appraisal, and subsequently complete any necessary retooling, at least every three to five years.

Prepare an emergency kit

To ensure maximum practice value in the event of your death, make sure your paperwork is in order. Your broker will help you compile the documents detailed below, each of which should be reviewed with your attorney (if you do not have a good estate planning attorney, find one). This emergency kit includes the necessary information your family, attorney and broker will need to wind up your affairs, including valuation of your practice and preparation of a prospectus and financing package for the sale. The following documents must be included:

Letter of direction: Recognizing that most non-dental professionals fail to understand the necessity of immediate action following the death of a doctor due to the exponential decrease in practice value over time, this document directs your heirs, executors and those who have the ability to make decisions on your behalf to take all actions necessary for the immediate sale of the practice assets.

With proper planning, you can take steps to avoid disaster for your heirs.

Current will and durable power of attorney: A durable power of attorney document authorizes an individual to act for another in the event of incapacity without having a court declare incompetence. Without such a document, an incapacitated dentist could lock up the family's ability to either operate or dispose of the practice if the dentist is living but unable to communicate his or her wishes.

For co-owners: If you are in a co-ownership relationship, you must review your buy/sell agreement, which should address if, how and at what value you and your co-owners will be required to purchase your shares (corporation) or membership (limited liability company or "LLC"). Make sure that the remaining entity or owners are required to purchase the deceased or disabled shareholder/member's portion of the practice and all agree as to value and terms.

For solo practitioners: If you are a solo practitioner, you must give the right to either a staff member or a family member to continue the operations of the practice. This means they must have access to the office bank accounts. The practice must be able to continue to pay the bills and accept payments for outstanding balances in the event the dentist is no longer able to do so. In July 2006, the Illinois General Assembly recognized a growing problem and passed a law stating:

> "The executor or administrator of a dentist's estate or legal guardian or authorized representative of a dentist who has become incapacitated may contract with another dentist or dentists to continue the operations of the deceased or incapacitated dentist's practice…"

In order to continue operations under this statute, two conditions must be met prior to the commencement of operations: (i) Proper notice must be given to the Department of Financial and Professional Regulations; and (ii) letters must be sent to all patients of record who had been seen in the previous 12 months, notifying them of the condition of the dentist and how patients may obtain copies of their records. Prior to the passage of this law, the family of a dentist was technically unable to continue the operations of the practice.

continued on page 32

AMERICAN DENTAL BOARD OF ANESTHESIOLOGY
Accredited Programs

University of Pittsburgh
School of Dental Medicine
Department of Dental Anesthesiology
G-89 Salk Hall
Pittsburgh, PA 15261
Michael Cuddy, DMD
Residency Program Director
mc2@dental.pitt.edu
Pitt Dental Anesthesiology Program
36 Month Certificate Program
http://www.dental.pitt.edu/students/residency_program.php

Loma Linda University
School of Dentistry
Department of Dental Anesthesiology
Loma Linda, CA 92350
Larry Trapp, DDS, MS
Residency Program Director
ltrapp@llu.edu
Two Year Certificate Program
http://www.llu.edu/llu/dentistry/anesthesia/graduateprogram.html

Mount Sinai Medical Center
Division of Dental Anesthesiology
One Gustav L. Levy Place
New York, NY 10029
David V. Valauri, DDS
David.Valauri@mssm.edu
Residency Program Director
Two Year Certificate Program
http://www.mssm.edu/gme/program.shtml

Ohio State University
College of Dentistry
Department of Dental Anesthesiology
2131 Postle Hall
305 West 12th Avenue
Columbus, OH 43210
Simon Prior, BDS, PhD, MS
Program Director of Anesthesiology
prior.20.osu.edu
27 Month Master's Degree Program
http://www.dent.ohio-state.edu/anesthesiology/

University of Toronto
Faculty of Dentistry
Department of Anesthesia
124 Edward Street
Toronto, Ontario, Canada M5G 1G6
Daniel A. Haas, DDS, PhD, FRCD(C)
daniel.haas@utoronto.ca
Residency Program Director and
Head of Anaesthesia
Three Year Master's Degree Program
http://www.utoronto.ca/dentistry/academic/graduate/MScDentalSpecialty.html

University of California, Los Angeles
School of Dentistry
Division of Dental Anesthesiology
Center for Health Sciences
Los Angeles, CA 90095
John A. Yagiela, DDS, PhD
jyagiela@dentistry.ucla.edu
Residency Program Director
Two Year Certificate Program
http://uclasod.dent.ucla.edu/divisions/index.asp?id=18

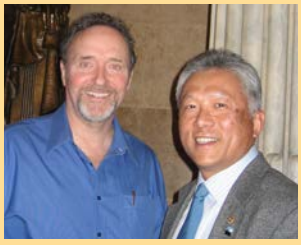
NEW PROGRAM UNDERGOING CODA ACCREDITATION

Stony Brook University Medical Center
Department of Anesthesiology
Stony Brook School of Dental Medicine
1104 Sullivan Hall
Stony Brook, NY 11994-8700
Ralph Epstein, DDS
ralpheddsanes@gmail.com
Residency Program Director
Two Year Certificate Program
http://anes.anesthes.sunysb.edu/
http://anes.anesthes.sunysb.edu/Residency/Residency.htm

This listing provided as supplemental material to this month's Editorial. For complete article, see page 5.

CHAN TO CAP!

Dr. Wai Chan (SDDS Secretary) hobnobs with Congressional representatives, Doris Matsui (left) and Dan Lundgren (right) at Cap to Cap this April.



ABSTRACTS

Ten year follow-up of mandibular advancement devices for the management of snoring and sleep apnea

S. Janhor, et al
J Pros Dent 99:4 2008

Approximately 65% of the respondents were wearing their appliances nearly every night and many reported that they felt more refreshed on waking. The authors concluded that the mandibular advancement device appears to be an effective long-term solution for a significant number of patients with problem snoring and also those with mild to moderate obstructive sleep apnea. Few adverse effects were reported.

Effect of adhesive systems and bevel on enamel margin integrity in primary and permanent teeth

T.K. Swanson, et al
J Pediatr Dent 30:2 2008

Results of the study showed that beveled margins had less microleakage than non-beveled margins for primary and permanent teeth. Total-etch had less microleakage than self-etch on both also, but comparably less microleakage was found for total-etch and self-etch in restorations with beveled margins. Margin beveling has a greater effect in minimizing microleakage than the type of adhesive used.

Effect of periodontal therapy on pregnancy outcome in women affected by periodontitis

F. Taraniem, et al
J Perio 78:11 2007

There is evidence to suggest that infections affecting the mother during pregnancy may produce alterations in the normal cytokine and hormone regulated gestation which can result in preterm labor, premature rupture of membranes, and preterm birth. The study compared women with periodontitis that received non-surgical periodontal therapy during pregnancy to those that received treatment after the delivery. Results showed the former group had approximately 25% less pre-term births and nearly 45% more infants were recorded with lower birth weight in the latter group.

RTB

Dentistry Gets a Makeover: USING TAX DEDUCTIONS TO SAVE MONEY ON EQUIPMENT PURCHASES

By **Joseph Mitchell**
GE Healthcare Financial Services
SDDS Vendor Member

Dentistry is in the midst of its biggest evolution. While there's still plenty of business to be found in routine cleanings and maintenance work, growing consumer demand for extreme makeover smiles is driving the market for dental technology that seemed futuristic and out of reach as little as five years ago. According to a survey of nearly 9,000 dental offices by the American Academy of Cosmetic Dentistry, aesthetic/cosmetic services grew an average of 12.5 percent from 2000-2005. Furthermore, some dentists reported an almost 40 percent increase in those services.

More might be willing to take the high-tech plunge if they realize the pay-off for their investments can happen sooner than they thought.

With this shift, laser systems, digital radiography equipment and CAD/CAM equipment are replacing drills as the "must have" tools of the trade. As the demand for cosmetic dentistry procedures increases and state-of-the-art offices become mainstream, a growing number of dentists are seeing the pay-off potential for the large investments needed to transform their drill-and-fill practices into high-tech, cosmetic dentistry centers. More might be willing to take the high-tech plunge if they realize the pay-off for their investments can happen sooner than they thought.

By spreading out payments and maximizing tax deductions, dentists can boost their cash flow while their new equipment generates more income and/or greater efficiencies for the practice. That incentive, coupled with a bill President Bush recently enacted to enhance certain tax breaks, can help offset the cost of equipment acquisition.

Understanding the New and Improved Section 179 and Bonus Depreciation

In recent years, Section 179 of the tax code has given dentists some significant financial incentives to upgrade their practice equipment. The *Economic Stimulus Act of 2008* enhances this popular provision of the tax code and provides for Bonus depreciation in 2008.

Beginning this year, the maximum Section 179 deduction has increased to $250,000 (up from the $125,000 figure that applied in 2007 before the new law). Taxpayers can elect to expense the cost of qualifying equipment up to $250,000, rather than depreciating this amount over several years. Note, however, that the maximum Section 179 deduction is reduced, dollar for dollar, by the amount of qualifying equipment purchased by the taxpayer in excess of $800,000.

Under the *Economic Stimulus Act of 2008*, Bonus depreciation is generally applicable to new equipment purchased during 2008. Under Bonus depreciation, 50% of any amount remaining after the Section 179 deduction can be depreciated during 2008. Any amount remaining after the Section 179 deduction and Bonus depreciation can be depreciated under the regular rules for equipment depreciation.

For example, a dentist who purchases $300,000 in equipment can deduct $250,000 of the cost based on Section 179. Half of the remaining $50,000 can be depreciated during 2008 under Bonus depreciation, and the remaining $25,000 can then be depreciated over the remaining useful life, depending on the equipment type.

These benefits only apply to purchases and financed purchases of equipment. Lease agreements are not eligible.

For any dentist considering a major capital investment, the tax benefits provided by Section 179 and Bonus depreciation may be too good to pass up. Couple this with the increasing demand for cosmetic procedures and expectations among patients to see the latest technology in their dentist's office, taking advantage of these generous tax benefits to create a state-of-the-art office could be a smart move.

However, there are specific eligibility requirements for Section 179 and Bonus depreciation. Therefore, you should consult your tax advisor for advice that is based on your particular circumstances. Once you've confirmed your eligibility to take advantage of these tax benefits, be sure to arrange to receive the equipment before the end of the year. If the equipment is not placed in service before Dec. 31, 2008, you will not be able to claim these benefits on your 2008 tax return.

How to Take Advantage of the Benefits

Most dental offices operate as a small business and rarely have spare cash lying around to make the investments required to obtain state-of-the-art equipment. Fortunately, there are more and more options available to help you to remain competitive and grow your business.

For example if you want to finance equipment, start with the dealer or manufacturer, who often has special plans in place to alleviate the up-front burden. You can also tap into your dental CPA or dental attorney, who usually has a good understanding of the dental lenders. Independent lenders — who may specialize in a specific industry or a geographic region — are another option. And unlike traditional banks, these organizations don't report activity to credit agencies. Finally, some new small business credit cards on the market include an equipment financing line of credit for upgrading or expanding the practice with new equipment or technology.

Whatever you decide, beware of mixing business and personal finance. While it might be tempting to tap into something

like a home equity line of credit for your practice's needs, entrepreneurs can risk potential bankruptcy if they don't draw a clear line between their business and personal funds.

Conclusion

If a high-tech upgrade is part of your practice's growth strategy, there's never been a better time to move forward. The new and improved Section 179 and bonus depreciation gives you an incentive to think seriously about acquiring technology that you might normally put off until next year. ■

Joseph Mitchell is a senior vice president and the dental and eye care segment leader for GE Healthcare Financial Services' vendor & practice solutions team. In this role, he oversees a team of healthcare financing experts committed to delivering specialized financing products to dental and eye care professionals throughout every stage of their career — from starting or purchasing a practice to expanding or upgrading their equipment and business offices. For more information on GE Healthcare Financial Services and its comprehensive business and financial solutions, please visit www.gehealthcarefinance.com.

MEMBER ALERT: WHITENING... AT THE MALL?

By **Teresa Pichay**, CDA Practice Analyst

Over the past few months, the SDDS office and CDA have received numerous calls regarding the "legality" of the whitening kiosks at various malls and shopping centers. Below is some information that may (or may not!) answer some of your questions. Thanks to Teresa Pichay, CDA Practice Analyst, for doing the investigative research! Teresa can be reached at 554-5990.

A 16% peroxide solution is used. The lamp is an LED light, according to the staff person. I observed customers placing and removing trays from their own mouths. At no time did a staff person place their hands inside a customer's mouth. After a customer removed the tray, the staff person handed her a cup of water to rinse and another cup to spit into.

We understand the idea of shopping mall teeth whitening booths raises concerns among our members. We have received many, many phone calls about them. We understand the Dental Board also has received numerous phone calls, and may have sent an observer to the mall. I have researched information and shared it with those who have contacted CDA. Please feel free to share this information with your members who call you with concerns.

1. Teeth whitening products with peroxide are not regulated by the FDA. The FDA attempted to regulate the products in the early 1990s but a manufacturer successfully sued to stop the action. The manufacturer argued teeth whitening products are cosmetic products. As such, manufacturers determine how they want to distribute their products — through dental offices, over-the-counter, or direct to consumers. I am not aware of any regulation that limits the percentage of peroxide contained in OTC whitening products.
2. The FDA does regulate heat sources for teeth whitening. I looked at the FDA database for these products. Forty-one products are FDA-registered. Some heat sources require a prescription for use and others do not require a prescription. Observers have claimed the light used in the mall kiosk is a Zoom light, but no one knows for certain.
3. There is no federal or state law prohibiting consumers from whitening their own teeth. There is no federal or state law prohibiting consumers from fabricating their own impressions or trays (think boil-and-bite mouthguards).

The state Dental Practice Act defines the dental scope of practice (see Business & Professions Code 1625, http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=01001-02000&file=1625-1636.6). The DPA does limit who may take an oral impression and render dental treatment. The DPA authorizes licensed dental personnel to work within respective scope of practice in defined settings. If an unlicensed person is observed taking an impression of someone else's teeth for the purpose of making a bleaching tray, that person and/or company should be reported to the Dental Board. If licensed allied dental personnel are known to be offering whitening services outside of a dental practice, those individuals should be reported to the Dental Board.

Regulation of this issue may differ in other states due to their respective dental practice acts. Regulatory agencies are more likely to act if there are reports of adverse impacts to consumers.

The iSmile company has a web site, http://www.mysmileexpress.com/. The company appears to be in the midst of changing its name to MySmileExpress. ■

VENDOR MEMBER SPOTLIGHTS

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Bank of Sacramento opened the doors on July 13, 1998 at 1750 Howe Avenue in the Point West area of Sacramento.

The genesis of the Bank actually occurred almost a year earlier. A group of local business people concluded that the financial needs of local businesses and the people who own and run them were not being adequately met by existing institutions.

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SDDS VENDOR MEMBERS

Vendor Members are vendors who support Sacramento District Dental Society through advertising, special discounts to members, table clinics and exhibitor space at General Meetings, CE courses, Member Forums and the MidWinter Convention. **SDDS members are encouraged to support our Vendor Members as OFTEN AS POSSIBLE when looking for products and services.**

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2008 SDDS COMMITTEE MEETINGS:

Auxiliary Advisory • SDDS • 6:30pm
Future meetings TBA

Board of Directors • SDDS • 6:00pm
Sept 2 • Nov 4

CE Committee • SDDS • 6:30pm
Oct 6 • Dec 1

CPR Committee • SDDS • 6:30pm
Future meetings TBA

Dental Health Committee • SDDS • 6:30pm
Sept 30 • Dec 9

Ethics Committee • SDDS • 6:00pm
Oct 6

Foundation (SDDF) • SDDS • 6:30pm
Sept 30 • Nov 19

Golf Committee • SDDS • 6:30pm
Completed for 2008

Leadership Dev. Committee • SDDS • 6:00pm
Completed for 2008

Legislative Committee • SDDS • 7:00pm
Sept 15

Mass Disaster / Forensics Committee • 6:30pm
Sept 17 (yearly calibration)

Membership Committee • SDDS • 6:30pm
Sept 22 • Dec 1

***Nugget* Editorial Committee • SDDS • 6:15pm**
Oct 28

Peer Review Committee • 6:30pm
July 10 • Aug 14 • Sept 11 • Oct 9 • Nov 13 • Dec 11

SacPAC Committee • SDDS • 6:00pm
Sept 15

For dates & times not listed above, visit the SDDS calendar at www.sdds.org/calendar.htm

LINK OF THE MONTH

Need more info on AB 895?

Read up on the responsibility of insurance companies as secondary payers at:

www.cda.org

Click on the link on the right that says, "CDA Sponsored Legislation to Clarify the Payment Responsibility of Secondary Payers"

Stumbled upon a great link?
Email it to melissa@sdds.org, to submit it as a possible link of the month!

ADVERTISER INDEX

COMMITTEE CORNER

Submitted by **California Employers Association**

Gabrielle D. Rasi, DDS
Legislative Committee Chair
(pictured)

Legislative Committee:
AB 2716: PAID SICK LEAVE

A bill requiring paid sick leave for California workers has been approved by a state Assembly committee. The measure by Assemblywoman Fiona Ma cleared the Labor and Employment Committee on Wednesday, April 9, 2008, with a 6-2 vote. AB 2716 would enable workers to qualify for up to nine days of paid sick leave a year. Employers with fewer than ten employees would have to provide up to five days annually.

AB 2716 would enable workers to qualify for up to nine days of paid sick leave per year.

Ma, a San Francisco Democrat, says nearly six million California workers do not have paid sick leave now, forcing them to choose between going to work ill or losing pay. She predicts the bill will save businesses money by reducing turnover, preventing co-workers from becoming ill and increasing productivity.

The National Federation of Independent Businesses, CEA and many other employer associations oppose the bill, predicting it would cost jobs. The measure now moves to the Assembly Judiciary Committee. We will keep you abreast of future progress on this bill.

More specifics of this bill:

1. Provides that an employee who works in California for seven or more days in a calendar year is entitled to paid sick days, compensated at the same wage the employee normally earns during regular work hours.
2. Specifies that paid sick days accrue at the rate of no less than one hour for every 30 hours worked.
3. Provides that paid sick days shall be carried over to the following calendar year, but an employer can limit their use as follows:
   - A small business employer (defined as having ten or fewer employees) may limit an employee's use to 40 hours or five days in each calendar year.
   - All other employers may limit an employee's use to 72 hours or nine days per calendar yr.
4. Specifies that an employee shall be entitled to use paid sick days beginning on the 90th calendar day of employment.
5. Requires an employer, upon oral or written request of an employee, to provide paid sick days for the following purposes:
   - Diagnosis, care or treatment of an existing health condition of, or preventative care for, an employee or the employee's family member.
   - For an employee who is a victim of domestic violence or sexual assault, as specified.
6. Defines "family member" to include a child (as specified), a parent (as specified), a spouse, a registered domestic partner, a grandparent, a grandchild, a sibling, or another "designated person" for whom the employee may use paid sick days, as specified. ■

SACPAC COMMITTEE

The SDDS SacPAC currently supports the following candidates through contributions to their campaigns:

Kevin Johnson
Candidate for Mayor
Sacramento

Dave Jones
Candidate for State Assembly
9th District: Sacramento

Scott Kamena
Candidate for State Assembly
15th District: Elk Grove, Galt, Stockton, Lodi, Oakley, Brentwood, Walnut Creek, Danville, San Ramon, Livermore, Wilton

For more info on SacPAC, visit:
www.sdds.org/SacPAC_comm.htm

WE'RE BLOWING YOUR HORN!

CONGRATULATIONS TO...

Dr. Vickie Sullivan, for passing the Board for American Academy of Pediatric Dentistry (AAPD). Dr. Sullivan is now a Diplomate of AAPD.

Dr. Herbert Hooper, on the celebration of his 80th birthday on April 19, 2008.

Dr. David Knepshield, on being named an Associate Clinical Professor at UCSF School of Dentistry. Dr. Knepshield lectures and holds labs three times per week.

Dr. Brock Hinton, on his original wood carving, which won First Place at the 2008 Ward World Championships in the "Advanced Life-sized Decorative Waterfowl" category. *(photo at right)* ■

Dr. Brock Hinton's original wood carvings won First Place!

Have some news you'd like to share with the Society? New babies, achievements, retirements, new offices — we'll report them all! Please send your information to SDDS via email (melissa@sdds.org), mail (915 28th St, Sacramento, CA 95816) or fax (916-447-3818). Call SDDS at (916) 446-1227 for more information.

WELCOME

to SDDS's new members, transfers and applicants.

IMPORTANT **NUMBERS:**

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CDA . . . . . (800) 736-8702
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We can only refer you if we know where you are; and we rely on having your current information on file to keep you informed of valuable member events! Give us a call at (916) 446-1227.

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

NEW MEMBERS

JUNE/JULY **2008**

Alexander Antipov, DDS
Oral Pathologist
6600 Madison Ave, Ste 10
Carmichael, CA 95608
(916) 961-1902
Dr. Alexander Antipov graduated from Loma Linda University in 2003 with his DDS and just recently completed his specialty in oral pathology at A. Einstein Montefiore Medical Center in NYC. He is currently practicing in Carmichael.

Daniel Harvey Lee, DDS
Pediatric Dentist
Pending Office Address
Dr. David Lee graduated from Loma Linda University in 2003 with his DDS and later completed his specialty in pediatric dentistry from St. Barnabus Hospital in 2006. He is currently living in Roseville with his wife, Michelle Lee, DDS.

Mark Macaoay, DDS
General Practitioner
Pending Office Address
Dr. Mark Macaoay graduated from an UOP Arthur A. Dugoni School of Dentistry in 2004 with his DDS. He is currently living in Sacramento.

NEW TRANSFER MEMBERS:

David Amid, DDS
Transferred from Western Los Angeles Dental Society
Periodontist
2428 Professional Dr, Ste 100
Roseville, CA 95661
(916) 786-6585
Dr. David Amid graduated from UCLA School of Dentistry in 2002 with his DDS and later completed his specialty in periodontics at USC School of Dentistry in 2005. He is currently practicing in Roseville.

Adrian Clinciu, DDS
Transferred from Tri-County Dental Society
General Practitioner
8908 Madison Ave
Fair Oaks, CA 95628
(916) 536-5151
Dr. Adrian Clinciu graduated from Loma Linda University in 2006 with his DDS. He is currently practicing in Fair Oaks and living in Orangevale with his wife, new SDDS member, Diana Clinciu, DDS.

Diana Clinciu, DDS
Transferred from Tri-County Dental Society
General Practitioner
3428 Watt Ave
Sacramento, CA 95821
(916) 485-1555
Dr. Diana Clinciu graduated from Loma Linda University in 2007 with her DDS. She is currently practicing in Sacramento and living in Orangevale with her husband, new SDDS member, Adrian Clinciu, DDS.

Preddis Sullivan, DDS
Transferred from Tri-County Dental Society
General Practitioner
Pending Office Address
Dr. Preddis Sullivan graduated from University of Illinois in 1985 with his DDS. He is currently living in Roseville.

NEW APPLICANTS:

Raymond Beitez, DDS
Angel Soto, DDS
Grace Min, DDS
Marjorie Lara, DMD

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

TOTAL MEMBERSHIP (AS OF 5/22/08): 1,491
TOTAL ACTIVE MEMBERS: 1,259
TOTAL RETIRED MEMBERS: 184
TOTAL DUAL MEMBERS: 2
TOTAL AFFILIATE MEMBERS: 8
TOTAL STUDENT MEMBERS: 3
TOTAL CURRENT APPLICANTS: 4
TOTAL DHP MEMBERS: 31
TOTAL NEW MEMBERS FOR 2008: 29
DROPPED FOR NON-PAYMENT OF DUES: 47

CONTINUED FROM PAGE 24

Tax returns: Make complete copies of your federal tax returns for the past three years available.

Patient information: Document the number of active patient charts, the number of patients treated in the past two years, the average number of patients treated daily and the number of recall notices sent each month.

Production Information: Maintain a computerized printout of all production of the most recent year broken down by procedure or code. It should include the quantity of each procedure produced and the total dollar amount for all production for the year for each procedure. If you are not computerized, an estimated percentage breakdown of production by category (such as the percentages of restorative treatments, endodontic treatments, oral surgery, etc.) will suffice.

Fee schedules: Document your current fee schedule and fee schedules for any plans.

Contracts: Include a copy of all contracts with any associates, partners or employees. If you have an associate in your office without a well-drafted "non-compete and non-solicitation" contract, please understand that your heirs will be giving—not selling—the practice to your associate. Review these documents annually and make any changes or additions promptly.

Office lease: If you lease, include a copy of your current lease and all renewal options.

Keys: Attach your office keys to written instructions for security systems.

Telephone numbers: Do not forget to include the important telephone numbers for your broker, accountant, attorney, banker and a colleague who will provide treatment until the practice is sold.

Miscellaneous: Make sure to include your personal information, such as the names of the institutions from which you graduated (undergraduate as well as graduate and dental school), as well as the degrees earned and the years of graduation. If your spouse is employed by the practice, include his or her job title, position description and salary. As the practice owner, include how much time you work at the practice on a daily, weekly and monthly basis, as well as your salary and the practice's hours of operation. Also include any information about any litigation in which you have been involved including malpractice litigation, civil or criminal litigation, bankruptcy, tax issues and whether you have been disciplined by the State dental board.

Help your practice survive until it is sold

Dental practice death and disability support groups can be extraordinary resources for the support of both the family and the practice in such a situation. One inherent issue that arises with temporary coverage from such a group, however, is the perceived and real concern of prospective purchasers with the patient base being treated by local competitors. With the help of a practice broker, you should be able to arrange a cross-cover with a "sister" death and disability group from a separate but commutable community. This arrangement eliminates the concern of prospects that your patient base will leave the practice for a competitor while at the same time maintaining coverage by quality professional temporary dentists.

Time is of the essence

It is essential to appreciate and be equipped for what happens in this situation in order to protect your family from destruction in value of your practice. Following is the typical chain of events:

Week One: Within a week of the practice owner's demise or incapacity, the broker should have established a team that includes an accountant, attorney, lender, landlord and staff (patients may also be helpful). The broker will create a comprehensive marketing plan and will already have begun to seek prospects by identifying and contacting dentists currently looking to purchase a practice. The practice and/or real estate should be appraised within the first week. Patients will begin receiving letters announcing the dentist's death and informing them who will be treating them until the practice is sold. If a temporary dentist has not already been retained to treat patients, the broker will arrange coverage.

Month One: Within a month of the doctor's demise, the broker should be showing the practice and fielding offers. As a side note, a good broker will never stop showing the practice until the sale is closed. Perfect prospects have been known to suffer cold feet, and time is not a friend. Regardless of how carefully a temporary replacement has been chosen, and regardless of how well that dentist treats the patients, some patients will leave a practice that is in transition—and the practice value decreases with every lost patient.

Month Two: In my experience, practices not sold within eight weeks of the dentist's death are very difficult to sell.

In summary

As you know from your daily work, a dental practice requires constant attention to survive. Without proper recognition of this fact, the value of one of your most valuable assets will unnecessarily dissipate. Instead, I urge you to spend a few moments and follow the steps outlined above. Not only will you maximize the value of your estate for your loved ones, but you will give them the gift of removing the burdens and stresses that unprepared families must handle.

Mr. Ackerman is president of The Dental Marketplace Inc., and past president of ADS Transitions. Contact him at (312)240-9595 or pjackerman@aol.com.

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IN MEMORIAM

MARTIN A. CRANE, DDS

Dr. Martin Crane lost his fight with Leukemia on April 29, 2008. Dr. Crane practiced in Carmichael for 32 years, after receiving his degree in dentistry from UCSF. Dr. Crane had been a member of SDDS for 36 years.

EVENT HIGHLIGHTS

MAY GENERAL MEMBERSHIP MEETING

May 13, 2008 — Foundation Night

Dr. Gary Benson, Lori Daby & Dr. Svetlana Lisetski take our temporary location change in stride.

*Dr. Dorothy Rowe, along with Dr. Robert Shorey (right), presents the **Western Career College Hygiene Award** to Diana Neff, for her exceptional skills and overall contribution to the dental industry.*

*Dr. Cindy Weideman receives the **Harry Wong Community Service Award,** presented by Dr. Shorey, in honor of her generosity in the form of community outreach.*

*Dr. Skip Lawrence accepts the **Helen Hamilton Award** from Dr. Bob Gillis, in recognition of his outstanding contribution to the Foundation.*

*Attending **Smiles for Kids site hosts** are thanked for their contributions: Drs. Don Rollofson, Adrian Carrington, Bob Daby, Paul Denzler, Vic Hawkins, Dennis Peterson, Janice Work and Cindy Weideman.*

*The Foundation (represented by President, Dr. Bob Gillis) receives a **$5,000 donation** from the Alliance (presented by Alliance President, Gayle Peterson).*

*The Foundation (represented by Dr. Bob Gillis) receives a **$10,000 donation** from SDDS (presented by Dr. Terry Jones).*

PHOTOS (left to right): Attendees take in careful instruction, and they're off! • Drs. Rosemary Wu, Steve Koire and Jim Everhart proudly display their trophies.

TIME FLIES WHEN YOU'RE HAVING FUN • SUPER FUN • EXTRA FUN • EVEN MORE FUN THAN THE LAST ONE, IF YOU CAN BELIEVE IT • LET THE GOOD TIMES ROLL •

PRESENTED BY

FUN TIMES!

SDDS MEMBERSHIP COMMITTEE

Thanks to Dr. Jim Everhart for providing photos from this event!

DENTAL-ANAPOLIS 500 • APRIL 28, 2008

PART OF THE SDDS MEMBERSHIP COMMITTEE "FUN TIMES" PROGRAM • THANKS TO DR. KEVIN CHEN FOR ORGANIZING THIS FUN EVENT!

RACE PLACE MOTORSPORTS (SACRAMENTO, CA) VISIT WWW.SDDS.ORG FOR FUTURE EVENTS!

Nugget Classifieds

Positions Wanted

ENDODONTICS: In your office 2–3 days/month or ? 30+ yrs experience. References upon request. Contact Dr. Koett, Sr. (916) 337-6202. *02-07*

I AM RETIRED AND ABLE TO SUPERVISE YOUR OFFICE, do exams and treat emergencies, while you vacation or take leave. Dr. Leif C. Overby, FAGD, MAGD. Ph (916) 434-7033. *05-08*

GP LOOKING TO RENT A CHAIR in Sacramento area 2–3 times/month. Please contact @ (917) 749-3410 or vadim_s@comcast.net. *06/07-08*

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

SEEKING SAT EMPLOYMENT: I am an RDA looking for RDA or DA work on Saturdays. I am dependable, professional, motivated and friendly. Interested? Please contact Anita (916) 217-3091. *06/07-C1*

Practices For Sale

EAST CONTRA COSTA COUNTY, CA — Beautiful, four op (3 equipped) GP located in professional building. Collections in 2007 exceeded $340,000 on a part-time schedule. Practice Transition Partners, (888) 789-1085, www.practicetransitions.com. 06/07-08

ROSEVILLE FAMILY PRACTICE. High visability location, 6 ops with 4 equipped. Great opportunity for growth. Yours for only $235,000 Call Todd Gooding, Diamond Dental Practice Sales for details 916-797-6240 06/07-08

STOCKTON GENERAL PRACTICE. High volume 7 Op Practice collecting 1.3 million with great profitability. Call Todd Gooding, Diamond Dental Practice Sales for details and a private showing 916-797-6240 06/07-08

For Lease

EL DORADO HILLS! 1490 SqFt. for lease, Build to Suit. Perfect for Specialist! Adjacent to Endodontist/ Owner. Close to new Town Center. Professional buildings have beautifully landscaped courtyard (waterfall, putting green, creek). Rent will be reasonable, with modest TI allowance to help build to suit. eldoradoendo@yahoo.com (916) 205-8825. *05-05*

SUITE FOR LEASE — 2 OPERATORY: Sacramento Dental Complex — Midtown. Possible to purchase existing equipment. Great for new practice. Please call (916) 448-5702. *03-07*

HIGHLY VISIBLE LINCOLN OFFICE SPACE — Divisable up to 8,000 sq ft for lease or purchase. Ground up built by a dental contractor specialist. Call (916) 772-4192 for details. *01-08*

DENTAL OFFICE SPACE AVAILABLE FOR LEASE in professional building. Located in Elk Grove. 1800 sq feet, 5 operatory spaces, large reception room, business office, laboratory and private office. Ph Mel Bell (916) 479-1827. *03-08*

DENTAL SPACE FOR LEASE — 2 nicely appointed spaces in established Carmichael Dental Building. 820 sf and 955 sf with 3 patient areas and private office in each. $1.35 psf plus utilities. Agent (916) 443-1500. *04-08*

FOLSOM DENTAL OFFICE FOR LEASE: Creekside Drive, five operatories, TI complete, excellent location. Won't last long. Dr. Rufo (916) 521-7730. *06/07-08*

SOUTH SACRAMENTO. 1,395 sf Dental suite available in the Pocket area. Excellent location. Competitive rents. Immediate availability. (916) 563-3086 or deron.morillas@colliers.com *06/07-08*

HIGH VISIBILITY TURNKEY OPPORTUNITY — Office located in North Natomas in Natomas Marketplace Shopping Center with 4 operatories fully equipped with ADEC Cascade Planmeca xrays, Miele Dental Disinfector and other top of the line equipment. 1600 sq.ft. (916) 928-9212. *06/07-C1*

SCRIPPS DR OFFICE — Modern 5 operatory dental suite available for rent. Ideal for satellite office or upgrade from present facility. For info on turnkey suite, please call Michael (707) 246-1141. *06/07-C1*

Employment Opportunities

A GREAT OPPORTUNITY! If you are planning or considering opening a practice in El Dorado Hills, give me a call!!! Dr. Linssen (916) 952-1459. *02-07*

DENTIST — RURAL HEALTH CLINIC — in Corning, twenty minutes north of Chico. Good salary percentage. Part/Full time. Serving mostly Medi-Cal patients. Opportunity for partnership. Call James at (530) 321-2927. *06/07-07*

CALIFORNIA DENTAL ASSOCIATE — MALE/FEMALE. Placerville, CA — Fee for service, long established practice. Great, professional, sophisticated, expanded function staff. 12 day hygiene week. Family oriented, great schools, friendly community, in gold country. $600/day + production, PT start / FT future. Experience requested. Resume to: drsands@jps.net or Dr. Sands, DMD; 2900 Cold Springs Rd; Placerville, CA 95667. *10-07*

ORTHODONTIST — Help!!! Too many patients!!! Kids Care Dental Group is looking for an orthodontist to help with our huge patient base. More consults than you could ever imagine. Seeking a long-term commitment and a dedicated individual. Great private practice with unlimited potential. Call Derek at (530) 263-2454 or fax your resume to (916) 290-0752. 06/07-08

PEDIATRIC DENTAL PRACTICE located in Folsom seeks dentist. Excellent opportunity for skilled dentist to join our practice. Please fax resume to (916) 983-9012. *08/09-06*

STATE OF THE ART DENTAL PRACTICE in Roseville, California. Excellent compensation. One to two days a month. Email CV to rockyridgedental@surewest.net or call Art at (951) 217-6749. *05-08*

FLYING SAMARITANS, MOTHER LODE CHAPTER, a non-profit volunteer group is in need of IFR pilots and dentists for its monthly healthcare missions (second Saturday of each month, weather permitting) in San Quintin, Baja Mexico. For details, call Alan Rabe @ (916) 488-8251. 06/07-08

Equipment For Sale

MERGING PRACTICES — Too much stuff! Dental equipment, instruments, office furniture. What do you need? Chairs, vac former, file cabinet, cure lite, surveyors, forceps and more — Just ask, I may have it! kguyellis@aol.com. *06/07-08*

SDDS Members Can Place Classified Ads For FREE!

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

SDDS CALENDAR OF EVENTS

JUNE

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

6–7 CDA Board of Trustees
Sacramento, CA

11 Alliance Board Meeting
Noon / SDDS Office

12 Peer Review Committee
6:30pm

13 Peer Review Committee
11:30am / SDDS Office

19 RiverCats Game
7:05pm / Raley Field

For more calendar info, visit
www.sdds.org

JULY

4 *Independence Day*
SDDS Office Closed

9 Alliance Board Meeting
Noon / SDDS Office

10 Peer Review Committee
6:30pm

AUGUST

13 Alliance Board Meeting
Noon / SDDS Office

14 Peer Review Committee
6:30pm

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

23–24 CDA Board of Trustees
Sacramento, CA

SEPTEMBER

1 *Labor Day*
SDDS Office Closed

2 Board of Directors Meeting
6:00pm / SDDS Office

9 General Membership Meeting
Using Sports Dentistry & Cosmetics to Create a Winning Practice
Derric Desmarteau, DDS
New Member Night
Sacramento Hilton — Arden West
2200 Harvard Street, Sacramento
6:00pm Social
7:00pm Dinner & Program

10 Alliance Board Meeting
Noon / SDDS Office

11 Peer Review Committee
6:30pm

13–14 CDA Scientific Sessions
San Francisco, CA

MARK YOUR CALENDAR FOR THE **29TH ANNUAL MIDWINTER CONVENTION**
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