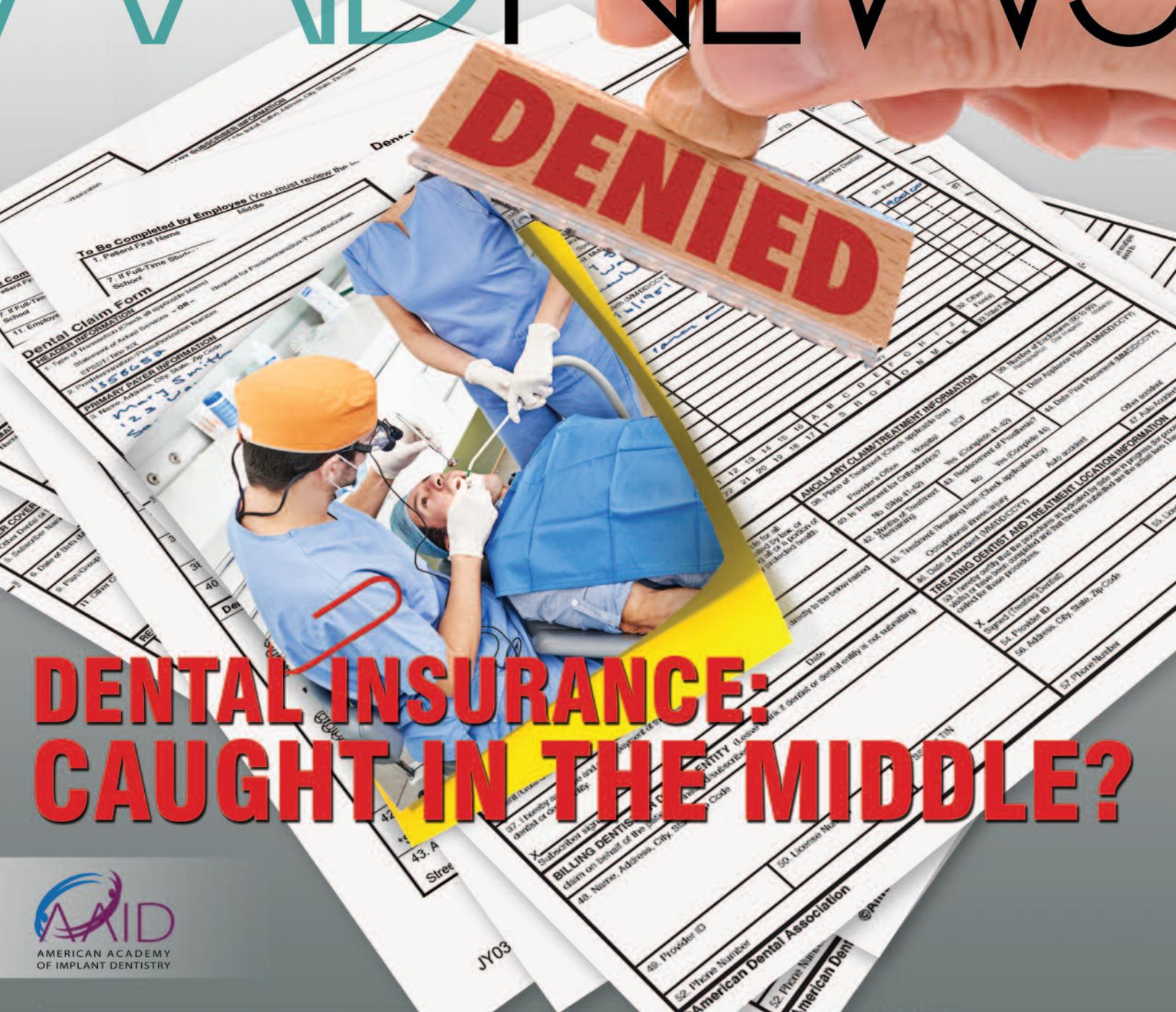


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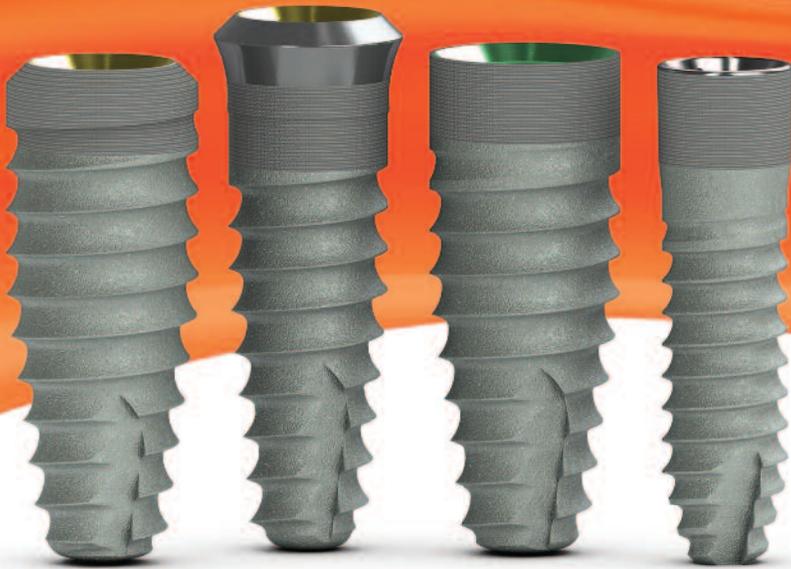


DENTAL INSURANCE: CAUGHT IN THE MIDDLE?



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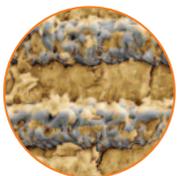
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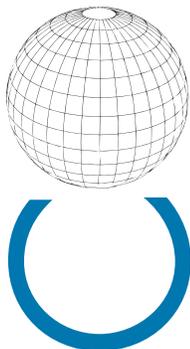


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By James E. Ference,
DMD, MBA, AFAAID, DABOI/ID
Editor, AAID News

The New Kid on the Block

As the new editor of *AAID News*, the first order of business is to acknowledge the significant achievements of the previous editor, **Dr. David Hochberg** and AAID staffer, Max Moses. These fellows have developed the newsletter into its latest impressive formulation.

As noted by Dr. Hochberg in his Editor's Notebook in the last issue of *AAID News*, the newsletter has evolved from an association newsletter to one that reports on important issues facing the entire profession of implant dentistry. I call your attention to the cover feature for this issue beginning on page 8. We are covering a topic that is of interest to our patients and each of the Academy's members...the sometimes

rancorous battle between dentists and the third-party payers—the insurance industry.

This has been a subject of great interest to me as I witness the evolution in dentistry related to “insurance.” While the technological changes in

Decisions can be unknowingly influenced towards inferior outcomes by the design of insurance policies.

dentistry generally move us forward, there are ways in which insurance can become a negative force relating to patient care. Decisions can be unknowingly influenced towards inferior outcomes by the design of insurance policies. And worse, the patient can remain unaware of the downward pressure on the quality of care he likely prefers. As we all know, the patient's health and welfare can be adversely impacted. Notwithstanding the bias we bring to the table, dentists are the “experts” and can better see all the moving parts of what affects patient care. They should play a bigger role in the design of policies. What can we do as individual implant dentists or as the Academy, the leading organization in the practice of implant dentistry? One step may be to pursue the addition of a formal representative on the ADA's Code Maintenance Committee to represent the interests of implant dentistry. See the sidebar on page 12 for more information about that group.

It's very satisfying to work with the AAID and its magazine. I long ago recognized this organization as a source of professional growth and invigoration. Attending my first national meeting many years ago, I realized that colleagues in this complex and

see [Editor's Notebook p. 50](#)

Do YOU have ideas, strategies, comments, or observations about insurance that you want to share with your colleagues? Send them to me at editor@aaid.com.



Ti-max Education presents their 2nd Annual “Under The Mediterranean Sun” Program July 25-28, 2016

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Dr. George Arvanitis BSc, DDS

**Co-Director: Ti-Max Education & AAID
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Diplomate: American Board of Oral Implantology
Fellow: American Academy of Implant Dentistry
Fellow: Academy of General Dentistry
Fellow: International Congress of Oral Implantologists

A 1990 graduate from the University of Western Ontario he maintains a full time general dental practice in Waterloo, Ontario focused on implant and advanced restorative dentistry.



Dr. Rod Stewart DDS

**Co-Director: Ti-Max Education & AAID
Maxicourse Ontario Canada**

Diplomate: American Board of Oral Implantology
Fellow: American Academy of Implant Dentistry

A 1983 graduate of the University of Toronto, he maintains a general dental practice in Hamilton, Ontario with a focus on advanced dental reconstructive treatment and he is a part time clinical instructor at the University of Buffalo, School of Dental Medicine, AEGD Program. He is chair of the AAID Maxicourse committee and a member of the AAID Admissions & Credentialing Board.

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ASI has released a line of assistant's systems to complement its doctor/dental delivery systems and eliminate the need for a cabinet. The system can be configured for ambidextrous use for both right- and left-handed operators. The system has numerous configurable options including small storage bins, sharps containers, file caddies, apex locator brackets and arm-mounted trays that can be bracketed onto the rail system and custom-configured for the operator or for the specialty.

The system allows IT management with monitors and CPUs to be mounted onto the system, with cabling concealed.

The cart system comes standard with a large work surface, a self-contained water supply with waterline disinfection, and includes the assistant's instruments: a titanium straight high volume evacuator, saliva ejector, and air/water syringe on a swivel mount. A nitrous-ready option is available. ●

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Glidewell Laboratories Releases BruxZir NOW Chairside Milling Blocks Prep, Mill and Cement BruxZir Crowns in Just One Appointment

Glidewell Laboratories announces the release of BruxZir NOW milling blocks. For the first time ever, clinicians are able to mill and deliver high-strength, authentic BruxZir Solid Zirconia restorations in a single appointment.

BruxZir[®] NOW

BruxZir NOW milling blocks produce restorations that can be designed and fabricated in-office and are available in 14 shades that correspond to the VITA Classical shade system. Finished crowns exhibit flexural strengths of greater than 1,100 megapascals (MPa), without the need for sintering, staining or glazing.

At launch, BruxZir NOW is compatible with the TS150 Chairside Milling Solution from IOS Technologies, Inc. The TS150 along with FastDesign software from Glidewell Laboratories seamlessly connects with the Align Technology iTero, 3Shape TRIOS and the 3M True Definition Scanner to facilitate an end-to-end digital workflow.

BruxZir NOW milling blocks are indicated for single-unit crowns anywhere in the mouth, though they are ideal for molar and premolar preparations.

[BruxZir NOW milling blocks or BruxZir Solid Zirconia](#)

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www.bruxzir.com

ContactEZ Releases the Gold Narrow Strip, Sub-Gingival Trimmer

ContactEZ announces its newest dental product: The Gold Narrow Strip, the Sub-Gingival Trimmer, which allows clinicians to easily access and trim away small, hard-to-reach overhangs after dental restorations. In addition, this unique strip is perfect for cleaning out otherwise unreachable cement debris from the interproximal space after definitive crown cementation.

The Gold Narrow Strip's versatility and effectiveness come from its three key design features. First, the narrow, stainless steel strip allows dentists to access the subgingival area at the



proper angle easily and without damaging the patients' soft tissues. Second, the blank central gateway makes entering the interproximal space easy, and it ensures the abrasive surfaces are only used where necessary. Lastly, the Gold Narrow Strip is built with the patented ContactEZ auto-

clavable strip handle, consistently praised for giving clinicians both optimal control and comfort.

Combined with the other Sub-Gingival Strips—the Blue Narrow Strip for cutting away more prominent overhangs and the Copper Narrow Strip for final polishing to restore a natural surface—the new Gold Narrow Strip represents the ultimate solution to what were once nearly inaccessible overhangs and composite and cement remnants.

Request a sample
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www.ContactEZ.com/Gold

Restful Jaw Company Introduces New Medical Device Designed to Curb Malpractice Claims



What's the leading cause of dental post-treatment jaw pain? Lack of jaw support during treatment, according to Karen Kloser, CEO of the Restful Jaw Company (RJC). The result, Kloser says, can lead to a malpractice suit against the dental professional.

The Restful Jaw Company is the manufacturer and distributor of the Restful Jaw[®], an easy-to-use, clinically-proven device that supports the jaw during treatment. Designed by dental researcher and educator, Eric L. Schiffman, DDS, the device has been tested in

clinical trials for over a decade.

According to a recent TMD study, more than 30% of all cases are attributed to opening the jaw too wide, too long, or having too much force on their jaw. The study found prolonged mouth opening is associated with a 400% increase in TMD issues. The Restful Jaw[®] device supports your jaw when downward force is placed on it. Patients do not have to tense their jaw muscles to resist the force of their doctor's or hygienist's hand on their jaw.

But it's the increase in dental malpractice suits that has focused renewed attention on the Restful Jaw as a way to substantially mitigate post-treatment complications. According to the U.S. Bureau of Justice Statistics, the median price tag for a dental malpractice judgment in 2014 is \$53,000—which doesn't include the cost of legal defense. Dropped and dismissed cases can still cost dentists between \$2,000 and \$5,000 (or more).

651-231-1838
www.restfuljaw.com

The Aurum Group Announces Draw Winner at 2015 CDA National Conference

Aurum Group congratulates Cheryl Beaton of Victoria Road Periodontics in Dartmouth, Nova Scotia, on winning the "Economy Airfare for Two Anywhere Westjet Flies!" drawn at the recent Canadian Dental Association National Conference held in St. John's, Newfoundland. The Grand Prize trip was supplied courtesy of The Aurum Group and Custom Travel – Calgary.

www.aurumgroup.com



DENTAL INSURANCE: CAUGHT IN THE MIDDLE?

BY CHRIS MARTIN

According to the National Association of Dental Plans, 65% of the US population is covered by some form of dental insurance. Of those, 70% obtain their dental insurance through their employer or a group. And therein lays the rub.

Economists have a term for it: “the agency-principal” problem.

In short, employers—i.e., the agents—are making the decision on the insurance to be made available for a third party—i.e., their employees. The interests of the employers and employees are not necessarily aligned. Although both consider cost, the quality of care is of more importance to the employee.

This “agency-principal” problem is further exacerbated by the relationship between the insurance carrier and the dentist. In a nutshell, the carrier wants to pay the lowest cost, while the dentist must provide a high standard of care, often regardless of the reimbursement from the carrier.

Implant dentists in particular, along with their patients, are caught in the middle. And neither has much influence on the real drivers of the dental insurance system—employers and insurers.

This article provides guidance to implant dentists, beginning with the question of whether to even accept insurance. We explore key items to consider in a contract with the insurance carrier and tips to make certain that claims are paid by the insurer. The unique challenges when providing implant services are addressed. Immediately following this feature article, is an article from AAID’s attorney, Dr. Frank Recker on how to survive an audit by an insurance carrier.



Understand your market

The Internet is awash with comments from dentists expressing dismay and frustration with dental insurers, ascribing the most cold-hearted business practice characteristics to these plans and the companies that write them.

A quick review of online chat boards such as *Dental Town* shows that most dentists believe insurance is a necessary evil. There is empirical evidence of the breadth of acceptance of dental insurance by implant dentists. AAID's 2015 Implant Practice Benchmarking Survey found that 81% of implant dentists have signed contracts to provide dental care to patients. However, that same survey showed that only 13% of implant dentists reported that insurance directories were a common way new patients learned about their implant practice.

One approach is to change to a complete "fee for services" (FFS) model. Most who did so quickly found that the number of patients seeking their services declined significantly. The handful who stuck to their FFS model reported that over time, patients received better quality care while the practice's net collections increased substantially.

One piece of advice that carried throughout the thread was the need to know and understand your specific market. For example, if your practice is in a major metropolitan area with a large number of employers, refusing to take dental insurance will likely reduce the number of patients willing to pay full price for your services. However, if you are located in a more rural area where large employers are few, the FFS model is probably more workable.

Ultimately, you have to make your own decision. A doctor practicing in Columbus, Ohio, summed it up rather well: "Sad to say, now I take a bunch of 'plans.' 20% off is better than spending the day playing computer solitaire. I have gone from denial to acceptance."

Why won't insurers listen to dentists when they provide feedback about fee schedules and claims? Why can't dentists and insurers just get along? Or better yet, how can they get along better?

If you turn to the Internet, there is no shortage of advice. A quick search on the *DentalTown Forum* turns up a dozen

What types of dental plans are there?

While there are some similarities to the medical healthcare insurance programs that exist today under the Affordable Care Act, there are many more permutations of dental insurance and benefit plans offered. Following is a brief summary of those as found on the American Dental Association website.

Fee-for-Service Plans

Direct Reimbursement

Benefits in this type of plan are based on dollars spent, rather than on the type of treatment. Direct Reimbursement is a self-funded plan that allows patients to go to the dentist of their choice. Depending on the plan, the patient pays the dentist directly (or the benefit can be directly assigned to the dental office) and then submits a paid receipt or proof of treatment. The administrator then reimburses the employee a percentage of the dental care costs. With some plans there are no insurance claim forms to complete and no administrative processing to be done by the dental office or an insurance company. Direct Reimbursement is the ADA's preferred method of financing dental treatment.

Indemnity Plans

An indemnity dental plan is sometimes called "traditional" insurance. In this type of plan an insurance company pays claims based on the procedures performed, usually as a percentage of the charges. Generally, an indemnity plan allows patients to choose their own dentists, but it may

also be paired with a PPO. Most plans have a maximum allowance for each procedure they refer to as "UCR" or "Usual, Customary or Reasonable" fees. A common misperception is that the terms "Usual, Customary and Reasonable" are interchangeable; they are not. Dentists determine their own "Usual" fees. The insurance company's fee schedule is called "Customary," but it may or may not reflect the fees that area dentists charge. Insurance companies usually do not disclose how their fee schedules are determined. Reimbursement is made according to the patient's plan of benefits, usually a percentage of the insurance company's fee schedule.

Managed Care Dental Plans

Preferred Provider Organization (PPO)

A PPO plan is regular indemnity insurance combined with a network of dentists under contract to the insurance company to deliver specified services for set fees and according to the provisions of the contract. Contracted dentists must accept the fee schedule as dictated by the plan. Patients who see a non-contracted dentist may incur a greater out-of-pocket expense.

Dental Health Maintenance Organization/Capitation Plan/Pre-paid Plans

A dental health maintenance organization (DHMO) is a common example of a capitation plan. Under a capitation plan, contracted dentists are "pre-paid" a certain amount

categories of posts associated with dental insurance, with some very good advice from a range of dental industry consultants.

Dennis DeLoach, DDS, for instance, promises “legal and ethical ways to negotiate with your insurer.” Sandy Pardue advises dentists to avoid mentioning insurance to patients who are uninsured, and Gary Moore offers 12 things to look for when discussing dental insurance.

All well and good. But here at AAID, we sought out dental consultant and frequent contributor to *AAID News*, Dr. Roger Levin, to get some practical, positive advice for dentists who have signed contracts with insurers and are seeking ways to reduce claims denials and foster a positive working relationship with insurers.

To get the other side of the story, we talked to Dr. James Bramson, chief dental officer at United Concordia. Many of you may remember Dr. Bramson from his two decades of work with the American Dental Association, most recently as executive director. He recently transitioned to his position at United Concordia.

each month for each patient that has designated or been assigned to that dentist. Dentists must then provide certain contracted services at no cost or reduced cost to those patients. The plan usually does not reimburse the dentist or patient for individual services, and therefore, patients must generally receive treatment at a contracted office in order to receive a benefit.

Other Types of Dental Plans

Discount or Referral Dental Plans

Discount/referral plans are technically not insurance plans. The company selling the plan contracts with a network of dentists. Contracted dentists agree to discount their dental fees. Patients pay all the costs of treatment at the contracted rate determined by the plan.

Point of Service Options

Point of service options are arrangements in which patients with a managed care dental plan have the option of seeking treatment from an “out-of-network” provider. The reimbursement to the patient is usually based on a low table of allowances; with significantly reduced benefits than if the patient had selected an “in-network” provider.

Table or Schedule of Allowances Plans

These types of plans are indemnity plans that pay a set dollar amount for each procedure, irrespective of the actual charges. The patient is responsible for the difference between the carrier’s payment and the charged fee. The plan may also be paired with a PPO that limits contracted dentists to a maximum allowable charge.

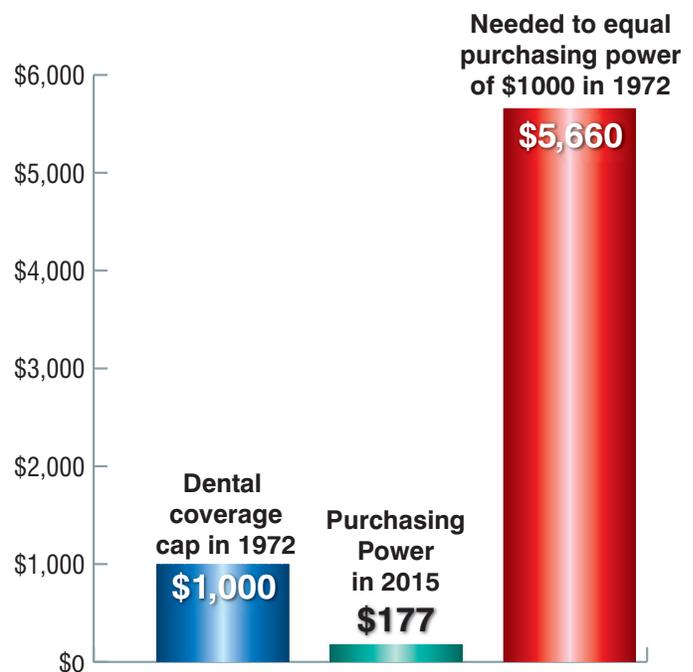
Sign the contract?

To begin, let’s start at the beginning. You have received a contract from an insurer. Do you sign?

“Remember that you will not be getting 100 percent of your usual, customary or reasonable fees (UCR) for the patients who are in network for the plan you are going to sign,” Dr. Levin said. He encourages his clients to think about the following factors before making a decision:

1. How is your practice is doing? Dental insurance plans can deliver patients, but are they the right patients for your practice?
2. What are the reimbursements? Are they initially lowering your UCR by 10 percent? 20 percent? But if in

Why won’t insurers listen to dentists when they provide feedback about fee schedules and claims?



In 1972, the cap on dental service reimbursement was \$1000. For many carriers, it hasn’t increased since then. \$1,000 would only purchase \$177 in 2015. Conversely, it would require \$5,660 in 2015 to cover the purchasing power of \$1,000 in 1972.

Sources: Article by Thomas P. Connelly, DDS entitled “The Trouble with Dental Insurance” originally posted in the Huffington Post on 3/31/2011 and updated on 5/31/2011: www.huffingtonpost.com/thomas-p-connelly-dds/why-is-dental-insurance-s_b_842186.html

subsequent contracts they lower the fee schedule even more, how will that affect your practice?

3. How many additional patients will you get by accepting that particular plan? Most dentists sign with insurers to have access to new patients.
4. Evaluate return on investment over time.
5. What is the termination notice plan?

The MBAs and accountants out there tend to summarize the decision-making with numbers and percentages. For example, assuming that everything else remains the same, with your overhead accounting for 60% of your revenue, and your carrier requires a 30% reduction in your UCR fees, your profit goes down a whopping 75%.

According to information emailed to us from the American Dental Association for this article, there are a number of things to look for in a contract. Because the contract you sign has specific language that ultimately defines your relationship, responsibilities, and rights with the provider, don't just refer to documents on websites. Your specific contract will outline the explicit terms on what will be covered and how payment will be made. Don't gloss over the audit clauses and dispute resolution mechanisms. "Most Favored Nation" or the "Hold Harmless" clauses are often elements to closely look for in a contract. The ADA has some resources on its Center for Professional Success site at ADA.org/success to help dentists understand contracts.

Still unsure? The ADA offers a contract analysis service in response to member requests for guidance on third-party payer contracts. The service provides a plain language explanation of the terms of a provider contract. This is a service free to ADA members when requested through the state dental society. The service is intended as a tool to aid members in understanding and analyzing a proposed contract, and is not intended to constitute legal advice. More information at www.ada.org/en/member-center/member-benefits/legal-resources/contract-analysis-service.

The ADA stressed that contracts are a two-way street. Looking for both responsibilities and rights is important to ensure a balanced contract. Dentists should re-evaluate their contracts from time to time. Building a positive relationship with the provider representatives can also prove helpful.

Whom do you really work for?

If you decide to sign, it pays to figure out a way to make your contract work for you and your patients to reduce claim rejections. Understanding how the carrier views the system, plan, and players provides a helpful perspective as well as some possible reasons that are at the root of the tension between insurers and dentists.

First, it pays to remember that dentists are not the insurers' customers—employers are. This fact creates one of the first potential conflicts. Typically, the ultimate recip-

A different approach to fees

Dentists in Canada operate under a very different fee system than their colleagues in the U.S.

In fact, what is done in Canada hasn't been allowed in the United States for over four decades.

In Canada, the dental association of each province (other than Alberta) sets a suggested fee guideline. Dentists are not required to charge according to the guidelines, and many treatment options may not be covered.

For example, **Dr. William Liang**, who practices in British Columbia, Canada, reports that "insurance companies do not pay anything on dental implants and bone grafting services. But we like it that way. It is not in the best interest of our patients for insurance companies to dictate to dentists what treatment they can and cannot provide and at what fees."

In the United States, fee schedules adopted by organizations representing various professions have been accepted as being anti-competitive and thus not allowed by both court decisions and the Federal Trade Commission for decades.

While establishing fee guidelines is not allowed, the American Dental Association has created a Code Maintenance Committee (CMC) that has as its goal "to

allow the CDT Code to be more responsive to the needs of the profession and the public," according to the January 18, 2012, announcement of the formation of the Committee. The Committee was created as a successor to the former Code Revision Committee, which was created under a legal settlement agreement between the ADA and the corporate members of the Delta Dental Insurance Company.

The new CMC membership consists of representatives from the ADA at large, each of the nine ADA-recognized specialties, the Academy of General Dentistry, and the American Dental Education Association. The insurance industry is represented by one participant from each of the following industry organizations:

- America's Health Insurance Plans
- Blue Cross and Blue Shield Association
- Centers for Medicare and Medicaid Services
- Delta Dental Plans Association
- National Association of Dental Plans

The CMC meets annually, usually in March, to consider requests from dentists and others in the dental community for new codes, deletions of existing code and significant revisions to existing codes. ●

ient of the dental services to be rendered under the plan have little or no say in the plan or carrier they use. Most of the time, they don't know whether the coverage is good, bad, or indifferent. They didn't choose and have little choice about the plan other than to take it or leave it.

Second, the provider of the service—the dentist—frequently has little or no significant opportunity to negotiate fees or services to be covered with the insurance carrier. Again, it is a take-it-or-leave-it situation, so the two parties most impacted by the plan and the treatment to be provided have little or no choice.

As Dr. Levin pointed out, dentists often act as a defacto agent of the insurer because the patient may not know or understand what dental benefits they are entitled to. That is unfortunately left to the dentist and is frequently communicated on the day of treatment.

Dr. Bramson pointed out that since the 2008 financial meltdown that sparked a recession, the economy has slowly made a comeback, but employers are still being frugal with wage and benefit increases.

"If an employer will support a dental plan that covers 100 percent of all dental coverage, I will write a policy for that," Dr. Bramson said. Unfortunately, employers are simply not that generous, and no employer will say they are going to want to pay more. "We are stewards of our clients' resources and must manage them carefully," he said. There is, however, good news.

Implant coverage

"More and more employers want plans that cover dental implants and employers are recognizing that implants are a very good option for their employees," Dr. Bramson said.

Evelyn Ireland of the National Association of Dental Plans said national trends support Bramson's claim.

"Implant coverage is more common now and most commonly assigned to major coverage which is paid at 50% of the discounted fee when dentists are in network and 50% of usual fees when not," Ireland wrote in an email to AAID. Also, coverage of implants is most often limited by both a "dentally necessary standard" as well as frequency limitations per tooth. Annual maximums in the range of \$1000-\$1500 are a further limit on multiple implants in a single year, she stated in an email to AAID.

Dr. Levin said that it's critical for dentists to educate their patients about whether implants are covered.

"I tell my dentists to find out in advance if implants are covered by their insurance. As soon as you know the patient is a candidate for an implant, you should review their insurance with the patient and advise them accordingly," Dr. Levin said. "Every patient who is missing teeth and has coverage should be told they have coverage," he said. "Dentists need to be proactive and even look at the patients covered under their plans and reach out to them via email or direct mail to let them know they have coverage."

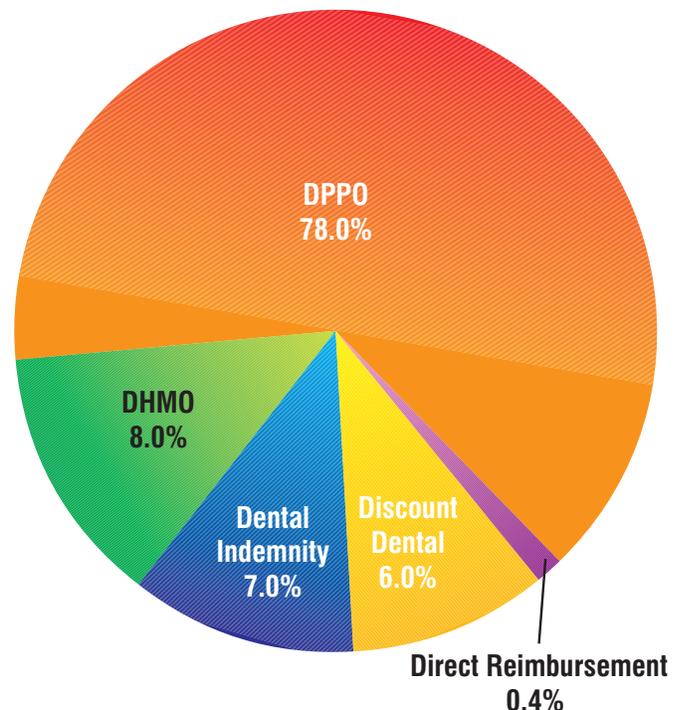
Dr. Levin stressed that the conversation about dental insurance coverage for implants must occur before treatment begins.

Some dentists may be tempted to talk to a patient after treatment has begun and blame the insurance company when the patient discovers they are on the hook for full payment, he said. But, this is not usually an effective strategy for establishing good rapport with the patient.

To many, this is a double-edged sword. If the insurance carrier deems that a treatment option is not "dentally necessary" or will only cover a portion of the cost, many patients simply opt to not have the treatment performed. Often this seemingly benign intervention by the insurance carrier drives a wedge further between the dentist and the

...the conversation about dental insurance coverage for implants must occur before treatment begins.

Commercial Dental Benefits by Plan Type 2012



Source: 2013 NADP/DDPA Joint Dental Benefits Report: Enrollment

patient. Not only does the patient often seek a cheaper treatment option or elect to have one that is covered even though neither is the best approach. Many simply decide not to have treatment at all.

Which is cheaper for the patient? As Dr. Elston Wong, who practices in Barrie, Ontario, Canada, pointed out, the cost of a simple 1-surface white filling on a molar might cost less than \$200. However, the cost of a four-canal root canal, core, and crown on the same molar because the cavity was allowed to get too deep can be ten times that amount or more.

Reduce rejected claims

Assuming your patient follows your professional advice on treatment, how do you help ensure your claims sail through

approval? As a chief dental officer for a large insurer, Dr. Bramson, with his team review numerous claims and have developed guidelines for dentists who want to avoid implant claims denials:

1. Submit an image and a narrative
2. Send a complete claim with an original image, not a paper copy

Dr. Bramson said sometimes a dentist will submit a claim, hear nothing in response, and submit the claim again as a second claim for the same procedure.

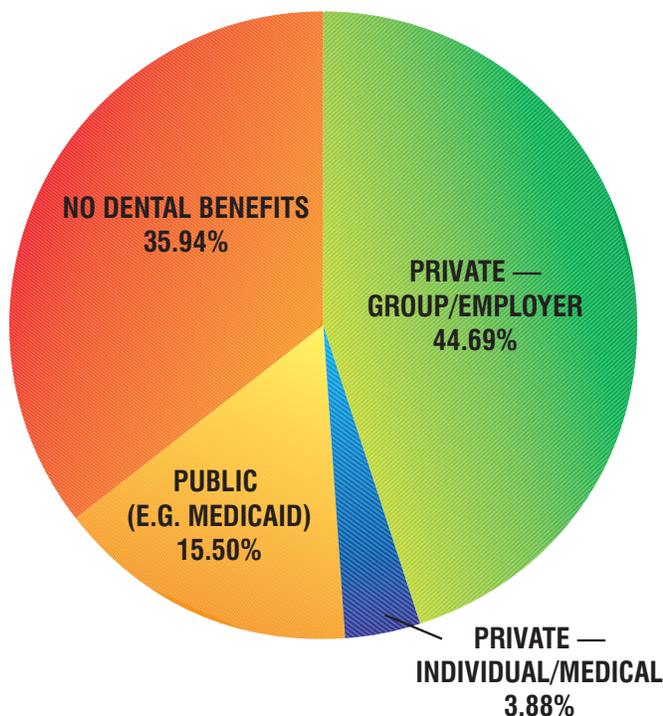
“Frequently, an office sends in a claim without a film so we call them to send in the film. But instead of sending in the film, they file a new claim so the first one becomes suspended pending review, and the second one is denied,” he explained.

All insurance plans have an appeal process, and any dentist can appeal a claim, Dr. Bramson said. He typically assigns a different dentist to handle the appeal.

“If there is new information in the appeal that wasn’t in the claim, there is a good chance the claim will get approved,” he said.

According to the National Association of Dental Plans, only 30% of seniors have dental insurance coverage.

Who has dental benefits?



Source: “Who has dental benefits?” National Association of Dental Plans; www.nadp.org

Tired of Rejection?

By James V. Anderson, DMD, CEO, eAssist Dental Solutions

May 14, 2002 was an exciting date for endosseous dental implants and abutments because they were approved by the FDA. For decades dental implants have been safely placed and rigorously tested for longevity of treatment and resulting long term health benefits.

That being said, where is dental insurance on this issue? According to the people in the trenches filing claims daily, this issue is complicated. Payment for implants has improved in the last five years as insurance companies have slowly added coverage based on the clinical success demonstrated. For the most part, dental implants still fall into a “cosmetic” category. As a result, they are usually reviewed by a dental consultant, who is a licensed dentist whose job is to verify whether the procedure or service provided is covered by the dental plan.

Before a dental office sends the claim, whether for pre-estimate or for payment, a detailed process must be exactly followed or the claim will be denied. The result will be a lengthy and complicated appeal. This process normally includes:

- Filing claims according to the insurance company’s guidelines, including:
 - Correct payer ID
 - NPI number of the care provider
 - Proper codes (be aware of coding additions, deletions and revisions)

Dr. Levin recommended that a dentist seeking an appeal call the dental director and make an appointment to discuss the appeal.

“Make sure the director has all the information on the claim, including images, a narrative, proper codes and a phone number to reach you,” he advised.

When asked about the qualifications of his dentists, Bramson pointed out that each dentist on staff who reviews claims is licensed and follows the same continuing education requirements private practice dentists follow. Some of his reviewers are specialists or boarded, and typically are used for those unique cases.

“We read the same journals and go to the same meetings most dentists go to,” he said.

Dr. Levin echoes much of what Bramson advises, but because he consults directly with dentists, has some pointed advice for dentists.

“First, read the contract!” Levin said that 97% of dentists don’t read the entire contract and often focus only on the fee schedule and ignore other important terms, including how to appeal.

Will it work?

The nature of the business relationship between insurers and dentists ensures that peace will not prevail on a widespread basis. But both Drs. Levin and Bramson believe that, like any relationship, both sides can take meaningful, positive steps to make it work. And remember that the dentist and patient—sometimes the least influential parties of the insurer/employer relationship—may be the ones who must make the system work to achieve optimal oral health for the patient while compensating the trained, educated, and experienced dentist appropriately for his or her skills.

Chris Martin, MPH, has more than 20 years’ experience in communications and public relations, including more than 15 in various health care positions. He worked for the American Osteopathic Association, American Dental Association, the Blue Cross and Blue Shield Association, and Rush University Medical Center. More information about Chris and contact information can be found on www.addcmpr.com.

- 10% to 30% of claims filed for implants are not coded correctly according to our claims processors
- Note: Most dental software automatically updates code additions but not deletions or revisions. That usually falls to administrative staff to do manually.
- Having access to clinically excellent supportive material such as:
 - Clinical notes in the form of SOAP (Subjective, Objective, Assessment and Plan)
 - Diagnostic quality radiographs
 - Supportive oral photo images
 - periodontal charting
 - Precise narrative containing the information that the insurance companies deem necessary to support the policy provisions not the necessity of the service.

Insurance companies say that the pre-estimate is “not a guarantee of payment” even though, according to the contract with the insured, it is a covered benefit. That is because the claim will not be adjudicated through the payment process unless it matches the Processing Policy Manual provisions. For example, a dental implant was a covered benefit, but the claim was denied because there was a missing tooth clause, and the tooth being replaced had been extracted prior to the date of coverage.

Beware of medical policies, particularly those issued in the last two years under the Affordable Care Act, that have an embedded dental policy. The medical is billed first, a denial Explanation of Benefits (EOB) is sent to the dental

policy. The catch here is the deductible. If you get benefits under the medical policy, it may be subject to a much higher deductible than traditional dental plans.

We expect that future dental insurance policies will cover some costs for surgical insertion of the dental implant. However, it is crucial to check the policy’s coverage, benefits, limitations, and exclusions. For example, Delta Dental has more policies that allow some implant coverage, but that will change from policy to policy under the same insurance company. Some policies will cover the implant placement but not the bone graft. Some policies will not reimburse for the implant but rather for an alternate treatment, such as a removable partial or fixed partial. Other policies will cover the restorative placed on the implant. The single unit abutment-supported or implant-supported crown is the most commonly paid treatment.

Mini Implants don’t have the track record of placement success as the endosteal implant. When placing the mini implant, use the mini implant code not the full size code. A healing cap is not an interim abutment and cannot be billed as such. D2799 can be reported as an interim provisional according to the ADA.

Dr. James Anderson is a member of the WhiteCap Institute of Dental Implantology and currently lectures at the WhiteCap Institute. He founded eAssist Dental Billing in January 2008 when he identified a need for professional claims processors in the ever complicated arena of dental claims filing. More information can be found online at dentalbilling.com.



By Frank Recker, DDS, JD

Survive a Dental Insurance Audit

Requests from dental insurance carriers to provide them with a specific list of patient records for “audit” purposes is not uncommon.

Dentists often express concern and frustration over such “audits” by various dental carriers or plans. Most policies give the insurer the right to access the dental records of insured participants for such purposes.

But the dentist is often concerned about issues relating to forgiving copays, deductibles, charging other companies or plans different fees for the same services, or perhaps charging out procedures that are not documented in the patient records. Such audits underscore the importance of maintaining accurate treatment and billing records.

Unfortunately, we may not be as good at documenting our contemporaneous thinking about a case, including specific radiographic findings, clinical findings (i.e., fractured tooth surfaces, broken down margins, translucencies, facets, discolorations, occlusal anomalies, etc.), and patient wishes.

So, independent of any audit request, I recommend using a clinical master sheet/chart by which we can check, for each tooth, such things as broken down margins, undermined enamel, recurrent decay, traumatic occlusion, open margin (on existing restoration), radiographic radiolucency or radiopacity, angulation or rotation of

tooth, etc. A pre-treatment, high-resolution, pre-op, intra-oral photograph will assist, but does not alone replace the “written record.”

When the audit request comes, I recommend cooperation, without panic, as the best way to deal with such inquiries.

Depending on how the “audit” proceeds and the outcome, here are some concerns, questions, and issues that should be considered about how the “audit” was performed:

- Who reviewed the material submitted? Was it a dentist as opposed to a non-professional, administrative staff person?
- Did the insurance company use an extrapolation methodology that is appropriate for the procedures at issue?
- Will an extrapolation-based determination meet accepted standards or judicial review?
- What is the policy language relating to the CDT or CPT codes utilized?
- Is the company “bundling” or “down coding?”
- Is the dentist consultant used by the insurance provider properly licensed in the state in which the dental office is located?

Such audits are important to ensure plan integrity and prevent abuse, but the audit process itself needs to be scrutinized if the results appear unfair or unjustified. ●



Dr. Rod Stewart (from left), **Jay Elliott**, and **Jason Kim**, judges for the Table Clinic competition, view the presentation by Dr. Gabriela Fernandes. Not pictured are judges of the Poster competition, **Dr. Larry Nalitt**, **Matt Young**, and **Doug Clepper**.

2015 Poster Display and Table Clinic Award Winners

Research support is one of the cornerstones of how the American Academy of Implant Dentistry (AAID) advances the science and practice of implant dentistry. At the Academy's 64th Annual Implant Dentistry Educational Conference recently held in Las Vegas, Nevada, 27 poster displays and 12 table clinics were available for attendees to view. These also were judged by a panel of experienced implant dentists and researchers. The poster displays and table clinics were evaluated based on the following six criteria:

- Extent to which the subject is important, timely and/or pertinent

- Level of innovation represented, e.g., creative idea or new technique
- Subject has practical application to clinical practice or patient care
- Presentation is scientifically sound and supported with documentation
- Organization and flow of presentation
- Visual appearance (e.g., effective graphic representation, effective use of space)

Following is a list of winners in each category. Complete details about each award winning poster or table clinic is available online on AAID's website at www.aaid.com.

POSTERS

1st Place:

"Incidence of Maxillary Sinus Membrane Perforation During Lateral Window Approach by Lateral Bone Planing Antrostomy Technique"
Mina Nishimoto, DDS, et al
Loma Linda University

2nd Place:

"Full Mouth Rehabilitation of a Patient with Excessive Maxillary Bone Loss Using Implant Supported Removable Partial Denture (ISRPD): A Case Report"
Jae-Woong Yeon, DDS, MS, et al
South National University

3rd Place:

"Radiological Evaluation of Influence of Die Spacer Application on Opposing Cast Synergised with Occlusal Equilibration Using Tekscan® III and Occlusal Equilibration Using Articulating Paper on Crestal Bone Level after Delayed Implant Loading in Single Crown Implant Restoration"
Suresh Sajjan M C, MDS, MBA, et al
Vishnu Dental College

TABLE CLINICS

1st Place

"A Novel Technique for Immediate-Loading Single Root Form Implants with an Interim CAD/CAM Milled

Screw-Retained Crown"

Bader AlBader, DDS, and Periklis Proussaefs, DDS, MS
Loma Linda University

2nd Place:

"Osseodensification as a Novel Crestal Sinus Augmentation Technique"
David Lipton, DDS
University of Florida

3rd Place

"Non-Passively Fitting Implant Superstructures Induce Bone Adaptation"
Matthias Karl and Thomas Taylor
University of Connecticut



By Roger P. Levin, DDS

Three Systems that Fuel Implant Growth

Introduction

The potential for overall growth of the implant market—and for any practice that pursues it wisely—is tremendous. To capitalize on this potential, doctors must examine three key business systems, each of which, in its own way, has a profound effect on how many patients receive implants at their practices.

1. Make a Strong Case for Implants

How do the doctor and treatment coordinator (TC) present the recommendation for implants? Of the many possible answers, some work much more effectively than others. Understanding why requires thinking like a patient.

Except in rare cases, patients lack the scientific or dental training to understand implants technically. Patients must say “Yes” if treatment is to proceed, so the practice needs to put the case to them in terms they will understand. The presentation should focus not on technical features but on patient benefits: a beautiful smile, permanent solution, closest thing to a natural tooth, easy care, etc.

The best way to ensure that the language and content of presentations will be persuasive is with scripting. By carefully crafting scripts — not only for the TC, who’ll handle 90% of the presentation, but also for the doctor — the practice can shape and control the process in a way that will achieve positive results, time after time.

Another important part of the practice’s case presentation system is visual aids. Using them will help patients better understand implants and their benefits while adding excitement to the presentation.

One other component of a well-conceived case presentation system is follow-up. Unless there’s a definite “No,” practices should follow-up with patients after the first presentation. This often results in case acceptance.

2. Address the Cost Issue

Cost makes implants seem out of reach for many people. A practice’s financing system can transform wishful thinkers into actual implant patients if it offers a range of payment options that includes something for everyone. Typically, choices would include:

- 5–10% discount for payment in full up front
- Acceptance of major credit cards
- Half payment up front, half before completion
- Outside patient financing

The last option can be especially effective at breaking down the payment barrier for patients.

3. Keep Patients on Track through Treatment

Even after patients accept treatment, the doctor and staff need to keep giving them evidence that they made the right decision. This is accomplished by providing excellent customer service. The

specifics of a customer service system will be unique, based on the nature of the practice, but all practices will want to pay special attention to these areas:

- **Building Trust**—In all their communications with implant patients, team members should continue reinforcing confidence in the doctor and practice.
- **Keeping Patients Informed**—What’s obvious to a doctor or staff member may not be obvious to patients. The team should take the time to explain what’s happening...or about to happen.
- **Responding to Their Needs and Questions**—Treating patients like VIPs is a fundamental aspect of excellent customer service, and it’s especially important with implant patients.
- **Maintaining Interdisciplinary Continuity**—If more than one office is involved in a case, each practice should strive to ensure that:
 - (a) both surgical and restorative practices are well-coordinated and communicating effectively, and

(b) that patients are kept “in the loop.”

By approaching customer service systematically rather than haphazardly, a practice will be able to achieve high levels of patient satisfaction with greater effectiveness and consistency—and lay the groundwork for more patient and doctor referrals.

Conclusion

For practice owners interested in increasing their share of the large and growing dental implant market, the first step is to upgrade their practice’s case presentation, financing and customer service systems. Once this has been accomplished, more implant candidates will be comfortable and confident as they move from interest to acceptance.

To learn more about growing your practice, attend one of Dr. Roger P. Levin’s up-to-the-minute, results-oriented seminars. Go to www.levingroup.com, click on the link for your specialty in the “Seminars” box, and choose a date and location that’s convenient for you.

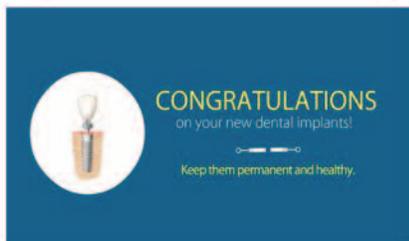


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AAID members have exclusive access to the Academy’s patient education vinemations. Vinemations are short, animated, and informative videos. AAID provides current members with the URL and embed code for each video for use in the member’s practice.

Visit AAID.com > “For Members” for URLs and embed code for each video.

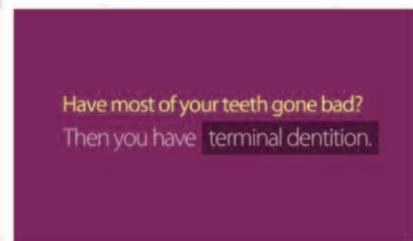
Dental Implants Post-Op Care



Dental Implants for Missing Teeth



Terminal Dentition





\$80,000 in research grants awarded by AAID Foundation

The AAID Foundation awarded \$80,000 to four researchers to help them continue their work in dental implant-specific research. This brings the amount given in 2015 to \$100,000 and over \$800,000 since the inception of the Foundation's Endowment Fund.

TITLE: Microbial Analysis of the Dental Implant Abutment Interface

PRINCIPAL INVESTIGATOR: James A. Katancik, DDS, PhD; Professor and Chair, Department of Periodontology; Oregon Health & Science University School of Dentistry

ABSTRACT: The long term goal of our work is to understand how the configuration of the dental implant-abutment junction optimizes the health and stability of the peri-implant tissues. The objective of this exploratory study is to characterize the microbial colonizers of the implant platform and abutment. The rationale for the proposed project is that, once the colonizing microbial species are known, we will be well positioned to obtain funding and launch a study of the bacterial biofilm composition, map the biofilm on the implant and restorative components, and study the microbial maturation and resultant tissue health long-term.

We plan to accomplish the objective of this application by pursuing

the following two specific aims:

1. Identify the microbial species composing the bacterial biofilm of the implant platform and healing abutment.
2. Compare the microbial populations of switched and non-switched implant platforms.

Experimental Design and Methodology

In this exploratory study, 30 healing abutments randomly and equally distributed between platform-switched and non-platform-switched will be collected at the time of implant temporization — typically 6 months following single-stage (healing abutment placed) surgical implant placement. At the same time-point a clinical assessment of soft tissue healing will be made. Microbial analysis will be accomplished by DNA extraction, PCR amplification of 16S rRNA genes, Illumina library preparation/sequencing, and bioinformatics analysis. A percent comparison of common species will be made between the switched and non-switched systems.

The proposed research is significant because it is expected to provide the groundwork knowledge of microbial colonization needed to develop optimal implant-abutment designs that result in long-term tissue health. With knowledge of why platform switching improves outcomes, there is promise that future

implant component designs will be based on a sound scientific basis. Furthermore, better fundamental understanding of how the soft tissues and bone react to implant components can be anticipated.

TITLE: Enhancement of Bone Augmentation and Prevention of Infection for Dental Implant

PRINCIPAL INVESTIGATOR: Daniel S. Oh; Assistant Professor; Oral & Maxillofacial Surgery, College of Dental Medicine, Columbia University

ABSTRACT: Reconstruction of three-dimensional alveolar bone to support dentition remains a challenging procedure. Bone regeneration requires a spatiotemporal coordination of multiple processes involving resident cells, marrow stromal elements, and vasculature. Autogenous onlay bone grafts have been considered the “gold standard;” however, harvesting of autogenous bone is invasive, technically demanding, and often requires extraoral donor sites, which all increase the morbidity of the procedure. Moreover, resorption of autogenous bone grafts by up to 50% has been demonstrated in cases of vertical ridge augmentation.

To overcome low efficacy and limited success associated with autogenous grafting, many of the advances have been made in bioengineering with supplements of cells, required growth factors, and/or a choice of scaffolds. However, the technical challenge of achieving vertical alveolar ridge augmentation remains unsuccessful. Thus, we made extensive efforts to develop less invasive surgical modalities in vertical alveolar ridge augmentation, which is also able to prevent infection.

Our proposal focuses on the translational feasibility of repairing vertical alveolar bone defects and prevention of infection utilizing a novel hydroxyapatite-based biogenic microenvironment scaffold (BMS) armed with drug delivery system (DDS). The BMS consists of multiple components: inter-connected primary-pores (300-400) that mimic the trabecular bone, micro-channels (25-70) within each trabecular, and nano-pores (100-400 nm) on its surface. The DDS was composed of poly(lactic-co-glycolic acid) (PLGA) microspheres and antibiotics. This technique that would eliminate the need for donor site preparation and/or implantation of xenografts/allografts would be beneficial in reducing the incidence of complications and increasing success in reconstruction of vertical alveolar bone.

Three key processes of bone regeneration in the bioengineering construct, including active endogenous cell recruitment into scaffold, homogenous distribution, and

inhabitation are required for the use of a large synthetic three-dimensional architecture bone grafts. To date, stem cell-scaffold constructs have been actively developed as a cutting-edge technology for bone regeneration. While many different types of synthetic scaffolds have been proposed to replace bone grafts, the current scaffold organizations—absence of internal micro-channel and nano-pores—do not implicate cell infiltration, distribution, and inhabitation deep into scaffolds. They could not provide a microenvironment for pioneering cells to efficiently, rapidly, and uniformly migrate deep into the scaffold (inactive migration). The cells at the scaffold periphery consume most of the oxygen and nutrients, which hinders flow of oxygen and nutrients to access into the interior part of the scaffold. Thus, we introduced capillary action via engineered micro-channels in the trabecular bone-like scaffold. The capillary action accounts for the primary dragging force of cells infiltration and distribution (active migration) deep into the BMS system. The goal of this project is to simplify the current paradigm of bioengineering for bone reconstruction and regeneration i) by adopting anatomically conforming 3D-constructs with micro-channels and nano-pores which induce rapid cell absorption, homogenous distribution and inhabitation and ii) by delivering antibiotics to prevent infection. Our overarching hypothesis is that an anatomically conforming BMS can reconstruct and regenerate bone in critical size bone defects without loading of exogenous stem cells and/or growth factors followed by functional rehabilitation.

To test this hypothesis, the following aims are proposed:

- Aim 1-1 (aseptic model): Evaluate the in vivo capability of bone regeneration of the anatomically conforming BMS in aseptic critical size defects.
- Aim 1-2: Examine the in vivo mechanism of action by means of intramembranous ossification in the BMS.
- Aim 2-1 (septic model): Evaluate the in vivo capability of the prevention of infection and bone regeneration of the BMS in infected (septic) critical size defects.
- Aim 2-2: Define an antibiotic treatment under infected condition can alter the intramembranous ossification into the BMS while repairing bone defects.

The reconstruction competency of the BMS will be assessed and compared with that of a structural allograft.

TITLE: Blood Perfusion and Gene Expression Dynamics During Wound Healing of Bone Grafted Ridge

PRINCIPAL INVESTIGATOR: Binnaz Leblebicioglu; [see Clinical Bite p. 22](#)

Clinical Bite

continued from page 21

Professor; Division of Periodontology, College of Dentistry, Ohio State University

ABSTRACT: *Objective:* Despite the significant progress in regenerative procedures, the fate of buccal plate is not predictable especially in maxillary anterior sextant. Recent studies report continuous remodeling and bone resorption even following immediate implant and/or graft placement. This, in turn, creates peri-implant hard and/or soft tissue defects challenging to treat and causing major physical, economical and emotional discomfort to patient. This study aims to determine the rate of recovery from surgical trauma through blood perfusion following bone regeneration surgery. The working hypothesis is that the rate of recovery is different between a wound in which repositioned flap is used and a wound in which biomaterials are introduced between flap and host bone depending on soft tissue biotype.

Methods: Patients who are scheduled to receive bone placement surgeries in maxillary anterior sextant for single tooth site will be recruited. Laser Doppler will be used to determine tissue blood perfusion level prior to, immediately after surgery, and, at 3, 7, 14 days, 1 and 4 months, Wound closure will be determined through clinical parameters. In addition, a soft tissue biopsy will be obtained during surgery, at 7 days and at 4 months. This tissue sample will be histologically studied, and different tissue and cell types will be differentiated by using laser capture microdissection technology. This, in turn, will allow determining the gene expression dynamics at various tissue levels depending on soft tissue biotype.

Significance of the Findings: The findings of this study may help better understand the role of soft tissue biotype on hard tissue regeneration and develop treatment modalities to have a more predictable outcome following regenerative procedures.

TITLE: Extended Release Efficiency of Dental Nanotubes Loaded with Antibiotics

CO-PRINCIPAL INVESTIGATORS: Cimara Fortes Ferreira, DDS, MSc, PhD, MDS; Assistant Professor, Director of Implant Dentistry; Department of Periodontology, College of Dentistry, University of Tennessee Health Sciences
Tolou Shokufer, PhD; Associate Professor, Director, In-situ Nano Medicine Laboratory, Department of Bioengineering; University of Illinois at Chicago

ABSTRACT: The overall objective of this project is to improve oral, dental and craniofacial health related to implants. This aim will be achieved through introducing a novel surface alteration coupled with loaded antibiotics that can improve the state of currently well-established titanium dental implants without the need for modifying the surgical technique or changing the implant design. The ultimate goal is to improve the oral health of implant-receiving patients toward reducing the healing time, improving the healing process, and preventing, controlling, or eliminating infection after implant placement.

In order to shorten the healing time and increase the success rate, one effective strategy is to alter the surface of the implant to select the type of cell that interact with it. Our approach is to modify titanium implant surfaces by forming TiO₂-nanotubes (TiNT) using a patent-pending method and to employ the nanotubes as drug reservoirs for drug-eluting dental implants treated with TiNT surface (DINS). We propose to verify antibiotic releasing efficiency of DINS evaluated and loaded with amoxicillin, amoxicillin + metronidazole, and doxycyclines, which are the most, indicated antibiotics and antibiotic combinations to treat periodontal diseases. Loaded DINS will be incubated in media containing *Escherichia coli* (*E. coli*) and *Porphyromonas gingivalis* (*P. gingivalis*) to evaluate antibiotic activity by measuring the turbidity of the suspension using a spectrophotometer, at 2-day intervals for 30 days. The control groups will be the unloaded dental implants submitted to the same experiments as indicated above. DINS loaded with antibiotics will be incubated with monocytes in order to determine cytokine expression by means of ELISA. Kruskal Wallis statistical study will allow verification of statistical significance amongst the groups. Student-t test statistical study will allow verification of statistical significance between the groups. This technology is amenable to delivery of antimicrobial agents directly on other hardware such as plates and screws that are commonly used in orthopedic and dental procedures.

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All refunds are subject to a \$50 administrative fee regardless of when requested or the reason. Requests for refunds must be made in writing and received by September 26, 2016 for a full refund (less the \$50 administrative fee). Between September 26, 2016 and October 3, 2016, a 50% refund (less the \$50 administrative fee) will be given. **Due to advance commitments to the hotel, no refunds will be made after October 3, 2016.**



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PRESIDENT'S MESSAGE



Richard Mercurio,
DDS, FAAID, DABOI/ID

Inaugural Address presented at 64th Annual Business Meeting

Several months ago I decided to research the history of the Academy. I found that I am assuming the 63rd presidency of the American Academy of Implant Dentistry. In its 65th year the list of men who have sat in that chair before me reads like a “who’s who” in the history of implant dentistry. I am honored and humbled to have my name included on that list.

I believe it is time for the Academy to assume the task of achieving the position as the leader in unbiased, dental implant education.

On January 11, 2014, **Drs. John Minichetti, John Da Silva, Shankar Iyer, David Hochberg, Nick Caplanis, Fran Ducoin, Bernee Dunson, Natalie Wong** and I met in Chicago to discuss a strategic plan for the Academy. As you’ve heard here today much has been accomplished and much still remains. It’s impressive to see how much has been already accomplished. In response to those accomplishments, I would like to recognize the leadership ability of our

past several presidents: Drs. Minichetti, Caplanis and Da Silva. At our Board of Trustees meeting on Tuesday, our executive director, in her Director’s Report listed 97 actions that have taken place this year by our central office to further the progress of our plan. Congratulations to the central office and our executive director, Sharon Bennett.

The remaining directives from the strategic plan are to:

1. Enhance/increase the quality of education
2. Increase membership/grow credentialed membership
3. Raise professional and patient awareness of the Academy
4. Achieve specialty status

It is my vision as president to continue the accomplishment of these goals. The education offerings at our Annual Conference are outstanding. Our Districts present excellent programming. AAID MaxiCourses® provide the foundation for a doctor’s implant career. I believe it is time for the Academy to assume the task of achieving the position as the leader in unbiased, dental implant education. We should set the standard for the world. Twenty years ago we were ahead of the curve with our bone grafting courses. We need to identify the next great trend in implant dentistry and set the curve once again.

Earlier you heard from **Dr. Jaime Lozada** about the “Wish a Smile” program that the AAID Foundation has cre-

ated. I ask all credentialed members, including the new members here today, to volunteer by offering to provide your implant dentistry expertise to those in need.

We are at a unique position in the history of implant dentistry...a time when several other recognized specialties are trying to attach the practice of implant dentistry to their specific specialties. In the past several months three separate specialties have taken measures to imply to the public and profession that their members are the "real providers" of implant dentistry. I challenge the Academy to address this incursion head on by investing in a campaign to raise professional and patient awareness of who we are. Our message should be clear: the American Board of Oral Implantology/ Implant Dentistry is a credentialing board that has been in place since 1969. The examination process has been deemed "bonafide" by state and federal courts. I believe implant dentistry should be a specialty in its own right, and its certifying board should be the American Board of Oral Implantology/Implant Dentistry. Successfully challenging the Board of the ABOI/ID should be the deciding factor of who is an implant specialist. Implant dentistry needs to be a specialty because it's what's right and is best for our patients.

Last year Dr. Da Silva used this time to humanize himself to the Academy. He talked a little bit about his family and heritage. I thought it was a great form of introduction, and I'm going to do something similar:

I'm the first person in my family to graduate dental school. I'm the first person in my family to graduate college. And I'm the first person in my family to graduate high school. My maternal grandfather was from Portugal (the only grandparent I ever knew). He stowed away on a ship coming to America when he was 15 years old and never saw his family again. My maternal grandmother, an immigrant from Spain passed away in my mother's sophomore year in high school. My mother was told she had to quit

school to take care of her brother, her father, and the house.

My father is my hero. He was the youngest of six children. He was orphaned by the time he was eight years old. He never graduated high school. He never went to high school. He was drafted and fought in WWII as a paratrooper in the 101st Airborne Division. He jumped onto Normandy when the Allies invaded the beach and was in Bastogne in the Battle of the Bulge. When he came home, the government gave him an opportunity to go to trade school under the GI bill. He became a jewelry polisher. They gave him an opportunity to work. He started his own business. He sent three sons to college, and when he retired he had a company that employed 12 people.

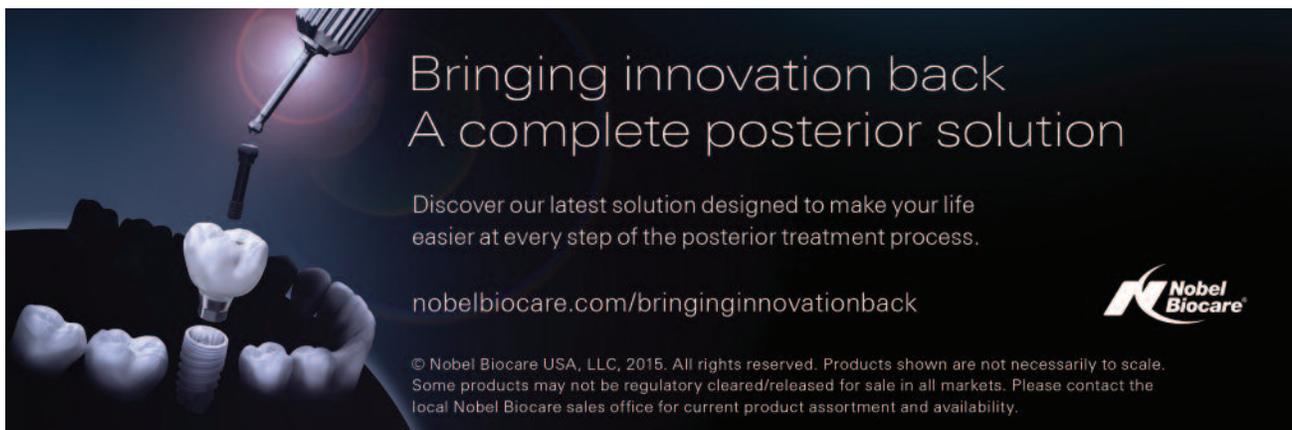
He always told me, "This is America. The harder you work the better you do." He was the epitome of the American dream. I never heard him use a racial slur. He taught me that we are all equal, and we are all entitled to our opinion, without criticism. He was tough, and he was the kindest man I ever knew. He was and continues to be my inspiration.

Finally, I'd like to address our newly credentialed members. When I first became active in the Academy, I was impressed by the friendly, selfless demeanor of its credentialed members. These members made me feel they were approachable and had a willingness to help. My advice to you is to become involved. Feel free to approach the leaders or members of the Academy and ask advice. All of us here have stood where you stand now. Become involved.

Three years ago I stood before you as Treasurer and told you that the financial future of the Academy was bright. Today, I stand before you as your President to tell you the future of the Academy itself is bright. And it is bright because of the credentialed members who stand before me.

Be proud!! Be proud because today you have become credentialed members of the oldest and greatest implant organization in the world.

Thank you. ●



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Oregon AAID MaxiCourse[®]



Hands-on clinical experience is a hallmark of the Oregon AAID MaxiCourse[®].

The Oregon AAID MaxiCourse[®] started during the 2007-2008 academic year. It meets three days per month beginning each Thursday from September to June.

Director of the MaxiCourse[®], **Shane Samy, DMD, FAAID, DABOI/ID**, takes a multiple philosophical approach to cover all aspects of implant dentistry. "This has helped the Oregon MaxiCourse[®] achieve a 100% pass rate for participants taking the written portion of the AAID Associate Fellow exam," said Dr. Samy.

The first three-day session every September is held at Western Oregon Health Sciences University Medical School in Lebanon, Oregon. Students receive an in-depth head and neck anatomy update using fresh-frozen whole cadaver heads. They perform hands-on surgical clinical procedures including incisions, soft tissue manipu-

lation, hard tissue grafting, implant placement, tissue release and suturing.

This three-day anatomical session is open to all Oregon AAID MaxiCourse[®] first-year participants as well as advanced and past participants.

Each Friday during the course, participants engage in individual hands-on clinical training performing different procedures, including soft and hard tissue grafting and implant placement on live patients. A teaching-assistant doctor, skilled in the procedure, scrubs in with the participant to provide needed help. Intravenous sedation is available on an as-needed basis for patients.

The Oregon AAID MaxiCourse[®] also offers an advanced second-year clinical participation training program for participants who have completed the first year Oregon AAID MaxiCourse[®] program. The second year program

consists of an additional eight Fridays of clinical participation throughout the calendar year. Doctors have the opportunity for hands-on individual clinical participation with their patients and are assigned skilled teaching assistant doctor who will scrub in with them on their procedure.

This is an opportunity for participants to gain knowledge and experience in more advanced clinical procedures and techniques. Participants learn the latest in literature, techniques, pharmacology, and materials. They also work with their own patients—under supervision—doing more advanced techniques.

Participants at the Oregon AAID MaxiCourse® may now elect to attend only the lecture portion of the first year course at reduced cost. This allows doctors who wish to obtain the 300 hours of didactic instruction required for the AAID Associate Fellow written exam to do so at reduced

cost. In addition, the Oregon AAID MaxiCourse® offers reduced rates for recent dental school graduates. The Oregon AAID MaxiCourse® is able to obtain temporary Oregon dental licenses for our out-of-state participants from to treat their patients in our program.

For more information:

Oregon AAID Implant MaxiCourse®

c/o Medonline, Inc.

P. O. Box 51419

Eugene, OR 97405

Director: S. Shane Samy, DMD

Telephone: 800-603-7617

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2015 Associate Fellows



Alfadhli Abu, DDS, Bellevue, WA, is a 2011 graduate from the University of Washington, School of Dentistry.



Mohammed Jasim Mohammed Al-Guboori, BDS, MSC, Kuala Lumpur, Malaysia, received his dental degree from Baghdad University in 1998 and master's degree at Universiti Sains Malaysia in 2010.



Mohamed Attia, DDS, Alexandria, VA, received his dental degree in 2002 from Alexandria University, Egypt, and is a graduate of the 2011 AAID/Rutgers University MaxiCourse®.



James E. Clayton, Jr., DMD, Northampton, MA, is a 1982 graduate from the University of Pennsylvania, School of Dental Medicine.



Mahmoud Ahmad, DDS, Temecula, CA, received his dental degree from the Jordan University of Science and Technology in 1997 and is a 2011 graduate of the AAID/Las Vegas MaxiCourse®.



Venkateswara Allu Reddy, BDS, MDS, Bangalore, India, received both his dental degree (1997) and masters degree (2000) from the A.B. Shetty Memorial Institute of Dental Sciences, India. He also completed the AAID/Asia MaxiCourse® in 2010.



Ruben Begino, DDS, Santa Ana, CA, earned his dental degree at the University of California, San Francisco in 2001.



Pasquale A. D'Orlando, DDS, Massapequa Park, NY, received his dental degree in 2001 from SUNY Stony Brook, School of Dental Medicine.



Mohamad Taisir Albik, DDS, Elk Grove, CA, received his dental degree from the Aleppo School of Dentistry in 1998 and completed AAID Loma Linda MaxiCourse® in 2012.



Dr. Mosa Mohammed Altassan, Loma Linda, CA, received his dental degree from the Kind Abdulaziz University, School of Dental Medicine, Jeddah, Saudi Arabia in 2006. He is also a 2014 graduate of the Implant Fellowship program at Loma Linda School of Dentistry.



Jonathan Bullard, DMD, Martinez, GA, is received his dental degree from Georgia Regents University in 2010. He was a 2010 AAID Dental Student Award Recipient.



Ahmed Eltanty, BDS, DDS, Sarnia, ON, Canada, received his dental degree from the University of Toronto in 2008. In 2011, Dr. Eltanty completed the AAID/Georgia Regents MaxiCourse®.



Joseph Field, DDS, Los Altos, CA, received his dental degree in 2008 from the University of Southern California.



N. Cory Glenn, DDS, Winchester, TN, is a 2008 graduate of the University of Tennessee, College of Dentistry and completed the AAID/Georgia Regents MaxiCourse® in 2012.



Helios Houenou, DDS, Lawrenceville, GA, received his dental degree from the University of Detroit in 1998 and completed the 2007 AAID/Georgia Regents MaxiCourse®.



Paul Kwon, DDS, Quincy, WA, graduated from Loma Linda University, School of Dentistry in 2008 and completed 2013 AAID/Loma Linda MaxiCourse®.



Russell Fitton, IV, DDS, Barrington, IL, earned his dental degree from the University of Illinois at Chicago, College of Dentistry and completed the AAID/Georgia Regents MaxiCourse® in 2012.



Juhyo Ha, DDS, Yongin, South Korea, received her dental degree from Chonnam National University College of Dentistry in 1998 and completed the AAID/Korea MaxiCourse® in 2013.



Jerry Chi Hu, DDS, Soldotna, AK, earned his dental degree in 1998 at the University of Michigan School of Dentistry.



Kyu Sung Lee, DDS, Daegu, South Korea, graduated from the Kyungbink University Dental College, Korea, in 2007 and is a 2014 AAID/Korea MaxiCourse® graduate.



Wael Ahmed Ghabban, BDS, Dammam, Saudi Arabia, received his dental degree from King Saud University, Dental College, Riyadh, Saudi Arabia, in 2004. Dr. Ghabban completed the 2013 AAID/Asia MaxiCourse®.



Hisashi Hayashi, DDS, PhD, Matsusaka-shi, Japan, earned his dental degree at the Kyushu Dental College in 1998 and completed the AAID/Korea MaxiCourse® in 2014.



Hiroshi Kato, DDS, Aichi, Japan, received his dental degree from Tokyo Dental College in 2000. He completed the AAID/Korea MaxiCourse® in 2013.



Su-In Lee, DMD, Seoul, South Korea, received his dental degree from Kyung Hee University and completed the AAID/Korea MaxiCourse® in 2011.



Peter Glavas, DDS, Great Neck, NY, graduated from New York University School of Dentistry in 1997 and earned a certificate in prosthodontics in 2002.



Jennifer Lynn Holtzman, DDS, Sterling Heights, MI, is a 2005 graduate from the University of Michigan, School of Dentistry and completed the 2012 AAID/Ti-MAX Implant MaxiCourse®.



Fred J. Kim, DDS, Redondo Beach, CA, is a 2003 graduate of Loma Linda University, School of Dentistry.



Edward Tsz Hin Liu, DDS, Markham, ON, Canada, received his dental degree from the University of Toronto, Faculty of Dentistry in 2004. In 2010, he completed the AAID/Ti-MAX Implant MaxiCourse®.



Ahmed Mohamed Matri, BDS, Blacksburg, VA, received his dental degree at the Arab Medical University, Benghazi, Libya, in 2000. Dr. Matri is a 2014 graduate of the Implant Fellowship program at Loma Linda School of Dentistry.



Mutsuhiko Murai, DDS, PhD, Hamamatsu-shi, Japan, received his dental degree from Kagoshima University, Japan in 1989 and a PhD from Hamamatsu University, School of Medicine in 1994. In 2014 he completed the AAID/Korea MaxiCourse®.



Yugo Okamoto, DDS, PhD, Tokyo, Japan, received his dental degree from Tokyo Medical and Dental University in 1996 and his PhD in 2000. Dr. Okamoto is also a graduate of the 2014 AAID/Korea MaxiCourse®.



Rami Salloum, DDS, Bethlehem, PA, earned his dental degree in 2005 from the Loma Linda University and completed the 2013 AAID/Rutgers University MaxiCourse®.



Dr. Hiroyuki Matsuda, Loma Linda, CA, received his dental degree from Nippon Dental University in 2004. He is also a graduate of the Implant Fellowship program at Loma Linda School of Dentistry.



John J. Nazzaro, DMD, Matawan, NJ, received his dental degree from the Tufts University in 1991.



Adam Pite, DDS, Victoria, BC, is a 2006 graduate from the University of Western Ontario, Schulich School of Medicine & Dentistry and completed the 2011 Vancouver MaxiCourse®.



Brendan Selway, DDS, Fremont, CA, received his dental degree from the University of Maryland in 2008.



Yasunori Matsunaga, DDS, Tokyo, Japan, earned his dental degree at Showa University in 1999. In 2014, he completed the AAID/Korea MaxiCourse®.



Mina Nishimoto, DDS, Loma Linda, CA, received her dental degree from Osaka University School of Dentistry in 2002 and completed the Advanced Education in Implant Dentistry Program at Loma Linda University in 2015.



Suresh Sajjan MC, BDS, MDS, Bhimavaram, India, earned both his dental degree (1985) and masters degree (1989) from the Bapuji Dental College and Hospital, India. He is also a graduate of the 2013 AAID/Asia MaxiCourse®.



Samir Shah, DDS, Rialto, CA, received his dental degree in 2000 from the Government Dental College, Ahmedabad, India.



Gary E. Michels, DDS, Greenville, NC, received his dental degree in 1980 from Emory University Dental School and completed the 2012 AAID/Georgia Regents MaxiCourse®.



ByoungChang Oh, DDS, Suwon, South Korea, received his dental degree from Chonnam National University, School of Dentistry and completed the AAID/Korea MaxiCourse® in 2011.



Sho Sakamoto, Sapporo, Japan, completed the Advanced Education in Implant Dentistry program at Loma Linda University in 2015.



Trevor Shew, DMD, Vancouver, BC, Canada, is a 2002 graduate of the University of British Columbia, Faculty of Dentistry Canada and completed the AAID/Vancouver MaxiCourse® in 2011.



Gary Marshall Steen, DDS, Phoenix, AZ, received his dental degree from the University of Washington, Seattle in 1969. Dr. Steen is also a graduate of the 2014 AAID/Loma Linda MaxiCourse®.



Jonathan R. Striebel, DDS, Moraine, OH, earned his dental degree at the University of Illinois at Chicago in 2012 and completed the 2012 AAID/Georgia Regents MaxiCourse®.



MinSeong Suh, DDS, MS, Daejeon, South Korea, earned his dental degree in 1999 from the Kangnung-Wonju National University in Korea and is a graduate of the 2013 AAID/Korea MaxiCourse®.



Afzal Khadir Tharakandathil, BDS, Doha, Qatar, received his dental degree from Bapuji Dental College, India in 1985 and is a graduate of the 2012 AAID/Asia MaxiCourse®.



Jonathan Tsang, DMD, Abbotsford, BC, Canada is a 2008 graduate of Temple University School of Dentistry and completed the 2011 AAID/Vancouver MaxiCourse®.



Patrick Pei-Heng Wu, DMD, Richmond, BC, Canada, received his dental degree from the University of Pennsylvania in 2009. He completed the 2013 AAID/Rutgers University MaxiCourse®.



Huikyong Yang, DDS, Gyeongsangbuk-do, South Korea, received her dental degree from Kyung Pook National University Dental College, Korea in 2014. Dr. Yang is also a graduate of the 2014 AAID/Korea MaxiCourse®.



Hiroshi Yasuoka, PhD, Suita-shi, Japan, received both his dental degree from Osaka Dental College in 2001 and doctorate degree in 2013. He also completed the 2014 AAID/Korea MaxiCourse®.



Lena Zerounian, DDS, Pasadena, CA, received her dental degree at the Herman Ostrow School of Dentistry (USC) in 1994 and completed the 2011 AAID/Loma Linda MaxiCourse®.

2015 Academic Associate Fellow



Khaled Atef Abdel-Ghaffar, BDS, MSc, PhD, Cairo, Egypt, received a dental degree from Cairo University in 1984 and completed a Master's degree and PhD in Dental Surgery. Dr. Abdel-Ghaffar is currently serves as dean of Ain-Shams University Faculty of Dentistry, Cairo, Egypt.



Kee-Deog Kim, DDS, MSD, PhD, Seoul, South Korea, earned his dental degree from Yonsei University, College of Dentistry in 1988. Dr. Kim also received his Master's degree in 1991 and PhD in 1997 from Yonsei University. Dr. Kim currently serves as faculty at the Yonsei University College of Dentistry, Seoul, South Korea.

2015 Fellows



Carlos Alfonso, DDS, MS, New York, NY, graduated from New York University in 1993 and received a post-doctoral degree in Prosthodontics at Columbia University in 1999. In 2014, he became a Diplomate of the American Board of Oral Implantology.



Victor Roberto Camones, DDS, Brea, CA, earned his dental degree at Universidad Peruana, Lima, Peru, in 1991. Dr. Camones then went on to attend the Prosthodontics program at the University of Southern California in 2009. In 2014, he became a Diplomate of the American Board of Oral Implantology.



Hubert W. Hawkins, DDS, MPH, Littleton, NH, is a 2001 graduate of State University of New York at Buffalo, School of Dental Medicine. Dr. Hawkins also completed a General Practice Residency at Erie County Medical Center and is a 2014 Diplomate of the American Board of Oral Implantology.



Dr. Badr Majed Othman, Jeddah, Saudi Arabia, received his dental degree from King Abdulaziz University in 2008. Dr. Othman also attended the University of Pennsylvania, receiving a Master of Science in Oral Biology. In 2014, he became a Diplomate of the American Board of Oral Implantology.



Fawaz Alzoubi, DDS, San Francisco, CA, received his dental degree from Kuwait University in 2007. In 2012, Dr. Alzoubi completed an Advanced Education in General Dentistry program at the University of the Pacific in San Francisco. Dr. Alzoubi is also a 2015 Diplomate of the American Board of Oral Implantology.



Robert Castracane, DMD, New York, NY, received his dental degree from Tufts University and completed a General Practice Residency at Kings County Hospital. Dr. Castracane is a 2014 Diplomate of the American Board of Oral Implantology.



James A. Miller, DMD, Hillsboro, OR, earned his dental degree at the University of Oregon, Health Sciences in 1979 and received his Diplomate credential from the American Board of Oral Implantology in 2014.



Nimesh Patel, DDS, Irvine, CA, is a 2004 graduate from the University of the Pacific, Arthur A. Dugoni School of Dentistry and became Diplomate of the American Board of Oral Implantology in 2014.



Nezih Jajou Bachuri, DMD, Troy, MI, received his dental degree from Tufts University. He became a Diplomate of the American Board of Oral Implantology in 2014.



Joseph Gendler, DDS, Hopkins, MN, received his dental degree from New York University and received his Diplomate credential from the American Board of Oral Implantology in 2014.



James A. Oshetski, DDS, Brunswick, ME, is a graduate of the University of Maryland, School of Dentistry and completed a General Practice Residency at Baltimore VAMC in 2003. Dr. Oshetski is also is also a 2014 Diplomate of the American Board of Oral Implantology.



Donald J. Provenzale, Jr., DDS, Downers Grove, IL, earned his dental degree from Loyola University of Chicago in 1988 and his Diplomate credential from the American Board of Oral Implantology in 2014.



Kaveen Ramnarine, DDS, Curepe, Trinidad & Tobago, received his dental degree from the University of West Indies in 2001.



William N. Tyler, DMD, Mission, BC, Canada, earned his dental degree from the University of British Columbia on 1991 and became a Diplomate of the American Board of Oral Implantology in 2014.



Richard Barry Winter, DDS, Milwaukee, WI, is a 1988 graduate of the University of Minnesota School of Dentistry and earned his Diplomate credential from the American Board of Oral Implantology in 2014.



Inwoo Yi, DDS, Gimcheon, South Korea, received his dental degree from Seoul National University in 1985. In 2014, he became a Diplomate of the American Board of Oral Implantology.

Transfer to Affiliate Associate Fellow Status

General Members who have passed Part 1 of the Associate Fellow examination and have not previously transferred their membership to Affiliate Associate Fellow are reminded to transfer their membership to this new category.

While the Affiliate Associate Fellow category is not a credential, it is a new member type that was created to recognize those who have begun the path to becoming credentialed, and acts as a “stepping stone” to Associate Fellow membership. Affiliate Associate Fellows receive a certificate with the category listed.

There is no additional cost to transfer membership categories, and the annual membership dues are the same as for a General Member. All that is required is the completion of a simple form. If you believe you are eligible and would like to become an Affiliate Associate Fellow, please contact Lisa Villani-Gale, Manager of Member Communications, at 312-335-1550 x226 or lisa@aaid.com. The form is also available on the AAID website — aaid.com — under the Membership section.

An additional benefit of becoming an Affiliate Associate Fellow is that you are granted an extension to take Part 2 of the credentialing exam, regardless of when you passed the Part 1 exam.

For the Part 2 oral/case examinations to be administered in 2016, 2017, and 2018, Affiliate Associate Fellows may apply for Part 2 if they attend one AAID meeting, conference, or education course within three years of the date of the examination.

For more information on the Part 2 examination, contact Carolina Hernandez, Director of Membership and Credentialing, at 312-335-1550 x228 or Carolina@aaid.com or visit the Credentialing section of aaid.com.

Achieving an AAID credential is a considerable accomplishment; it is an excellent way to demonstrate dedication to the practice of implant dentistry. Recently, we sat down and talked with **Dr. Jonathan Bullard**, of Martinez, GA and **Dr. Jennifer Holtzman**, of Sterling Heights, MI, both of whom were inducted as Associate Fellows at AAID's 2015 Annual Conference. Read their thoughts on why they became credentialed and their experiences in pursuing the Associate Fellow Credential.



Dr. Jonathan
Bullard



Dr. Jennifer
Holtzman

Why pursue the credential?

Dr. Bullard:

"Pursuing the credential has forced me to become the dentist I was trying to be all along."

Dr. Holtzman:

"I wanted something to show for all the work I had done, to prove I had learned something. It has also helped me market my practice better."

Preparing for the Written (Part 1) Exam:

Dr. Bullard:

Did an AEGD program. "Before the exam I reviewed a lot of literature, both current and classic."

Dr. Holtzman:

Took the Toronto Maxicourse®, reviewed the Misch textbook

How to prepare for the Oral/Case (Part 2) Exam:

Dr. Bullard:

"Start now by documenting every single case with every photo and x-ray possible, making sure the quality is good."

Dr. Holtzman:

"If you don't know what they are looking for in the case reports, do what it takes to find out. Call the office or look on the website."

Why Is it worth it:

Dr. Bullard:

"Being around people who [practice implant dentistry] every day has been the most valuable part to me."

Dr. Holtzman:

"After you're all done and at the induction, it really is all worth it. I am so proud to be part of a larger group." ●



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The Tatum EZ-Fixation System offers a unique blend of clinical simplicity, advanced features, precision and affordability that is unmatched in the dental market.

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Screw lengths offered - 1.75mm x 8 (Silver), 10mm (Blue), 12mm (Gold), 14mm (Green), and 1.55mm x 15mm, 18mm, 21mm, and 24mm Bone Screws. Kit includes 18 Screws.

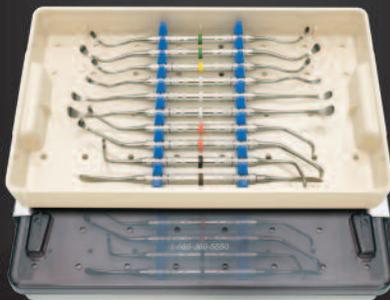
Tatum Sinus Instrument Kit



The Tatum Sinus Instrument Kit is designed to access any anatomical configuration the surgeon may encounter when performing maxillary sinus augmentation.

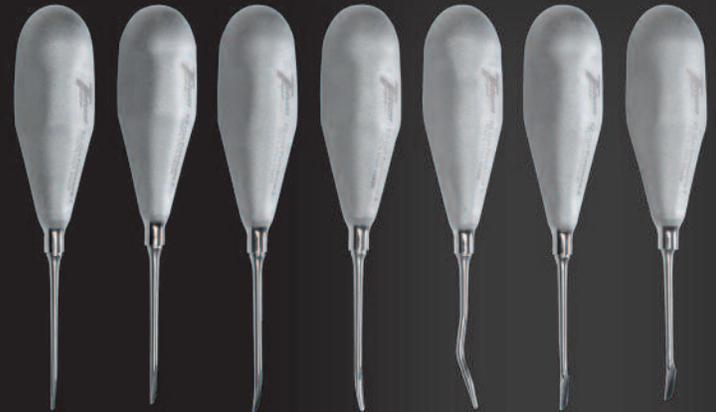
All of the instruments are tempered to permit them to be bent and shaped so that the tip is always touching bone while the curved back of the instrument can always be parallel to the lining it is elevating.

These specialized instruments are ideal to safely elevate the sinus membrane, and allow removal of bone buttresses.



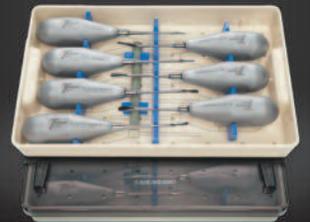
Tatum Tapered Implants

Tatum Surgical offers Traditional Tapered, One-Piece Tapered and Integrity Tapered Implants. They are clinically proven designs that are the result of over 40 years of surgery experience. Dr. Hilt Tatum has developed predictable and successful implant techniques for patient care.



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- Autoclavable Box and Sharpening Stone Included
- "Born and Made in the U.S.A."



ANNUAL CONFERENCE STUDENT/RESIDENT GRANTS AWARDED

AAID recognized outstanding students and residents at the 64th Annual Conference in Las Vegas, Nevada. For the first time, the AAID offered grants to cover the travel expenses for one full-time dental student and one resident who showed an outstanding interest and aptitude in the field of implant dentistry. The Northeast and Central districts provided financial support for this program.



Dr. Jane Shin (left) and Ilene Choal were winners of grants from the Northeast and Central Districts to attend AAID's 2015 Annual Conference.

The Central District awarded a grant to Ilene Choal, a fourth-year dental student at the University of Nebraska. She was first introduced to the AAID at a "Bite of Education" program for Nebraska dental students.

The Northeast District awarded a grant to Dr. Jane Shin, a graduate of Harvard University School of Dental Medicine, and currently enrolled in an AEGD program at NYU Lutheran Medical School.

Both grant recipients attended programs and were able to network with experienced implant dentists. Both reported that they found the conference to be extremely rewarding, and expressed their appreciation to the Northeast and Central districts for their support.

THE AAID STARS AT GREATER NEW YORK DENTAL MEETING



Several of the Academy's members were featured presenters at the 2015 Greater New York Dental Meeting, the largest gathering of dental professionals in the country and second largest in the world. AAID offered three hands-on workshops that were sold out. This marked the second year of AAID's participation at Greater New York as one of

the named sponsors of "Implant World Expo."

AAID presenters at the event included:

- Suheil Boutros, DDS, MS, DABOI/ID
- Shankar Iyer, DDS, MDS, FAAID, DABOI/ID
- Joseph A. Leonetti, DMD, FAAID, DABOI/ID
- John Minichetti, DMD, FAAID, DABOI/ID
- Cheryl Pearson, DMD, FAAID
- Jack Piermatti, DMD, FAAID, DABOI/ID
- James Rutkowski, DMD, PhD, FAAID, DABOI/ID

The Academy also had a presence on the exhibit floor where members and non-members could find more information about the many products and services offered by the AAID and also pick up a free gift for visiting.

AAID MEMBER RECOGNIZED BY GUINNESS WORLD RECORDS™

A Guinness World Record™ was established when **Mayur Mehta, DDS, MDS, FAAID, DABOI/ID**, of Palm Harbor, Florida, placed dental implants on Filomena Battista on December 6, 2012, when she was 100 years, 210 days old.

Ms. Battista continues to enjoy her dental implants and teeth today at the age of 103.

Ms. Battista and Dr. Mehta were recognized and awarded a Guinness World Record™ Certificate at a reception on October 18, 2015.



Filomena Battista (left) is the oldest person to receive dental implants according to the Guinness World Records. With her is Dr. Mayur Mehta who provided the treatment.

UPCOMING KEY AAID DATES

FEBRUARY 2016

- 1 DEADLINE TO APPLY FOR 2016 AAID CREDENTIALING PART 2 ORAL CASE EXAMINATION
- 5-6 ABOI/ID IMPLANTOLOGY UPDATE AND COMPREHENSIVE BOARD REVIEW COURSE
ADA Building, Chicago, IL

APRIL 2016

- 8-9 EXPANDING OPPORTUNITIES: DEVELOPING IMPLANT SITES FOR PREDICTABLE RESULTS
Western and Central Districts Meeting
Westin Bayshore, Vancouver, British Columbia, Canada

JUNE 2016

- 10-11 MANAGING BONE DEFICIENCIES
Southern and Northeast Districts Meeting
Hotel Vinoy, Saint Petersburg, FL

OCTOBER 2016

- 26-29 65TH ANNUAL EDUCATIONAL CONFERENCE
Hyatt Regency New Orleans, New Orleans, Louisiana

Check the AAID Online Calendar using this QR Code for a complete listing of all key AAID dates.



OBITUARY



The American Academy of Implant Dentistry regrets to report that that **Dr. Mira Yasinovsky** of Mexico City, Mexico, passed away on September 1, 2015. She graduated from dental school in 1948, and earned her Associate Fellow in the Academy in 1975, and her Fellow in 1990. She was elected as an Honored Fellow of the Academy in 1995.

ABOI/ID IMPLANTOLOGY AND COMPREHENSIVE BOARD REVIEW COURSE

The American Board of Oral Implantology/Implant Dentistry presents its 3rd Annual Implantology and Comprehensive Board Review Course, February 5 - 6, 2016, in Chicago.

Presenters include:

Barry Barte, MD, DDS, FAAID, DABOI/ID

Nick Caplanis, DMD, MS, FAAID, DABOI/ID

John Russo, DDS, MHS

Natalie Wong, DDS, FAAID, DABOI/ID

Earn 16 hours of implant-specific, ADA CERP approved CE credits.

Registration is available at aboi.org.

AAID MEMBERS FEATURED BY ADA

David Hochberg, DDS, FAAID, DABOI/ID was featured in the June 15, 2015, issue of *ADA News*. He was selected



for an interview because he takes his entire team to the American Dental Association Annual Meeting on a regular basis. He was identified in the article as Treasurer of the AAID, a position he held at the time.

Edward Kusek, DDS, FAAID, DABOI/ID, was a speaker on the use of lasers in dentistry at the 2015 Annual Meeting of the American Dental Association held in Washington in November 2015.



Jaime Lozada, DMD, FAAID, DABOI/ID was a panel member on ADA's Open Forum on the topic of "Root Canals vs. Implants." Others on the panel included endodontists, periodontists, and oral surgeons.



AAID MEMBERSHIP AMBASSADORS

AAID Membership Ambassadors know first-hand how membership in the Academy helps dentists establish or expand their expertise in implant dentistry and encourage their colleagues to join the AAID.

We would like to thank the Membership Ambassadors who have referred colleagues as new members between August 19, 2015 and November 20, 2015.

Thank you for referring two colleagues to the Academy

Todd Engel, DDS, from Cornelius, NC

Thank you for referring a colleague to the Academy.

Nadia Abazarnia, DDS, from Irvine, CA

Barry Barteel, DDS, MD, from Lubbock, TX

Aaron Cruthers, DDS, from Racine, WI

Berneer Dunson, DDS, from Atlanta, GA

Duke Heller, DDS, MS, from Lewis Center, OH

Salah Huwais, DDS, from Jackson, MI

Elliot Koschitzki, DDS, from Cedarhurst, NY

Chad Lewison, DDS, from Canton, SD

Charles Mandell, DDS, from Hollywood, FL

Justin Moody, DDS, from Rapid City, SD

Elzbieta Paul, DDS, from Piscataway, NJ

Dr. John Petrini, from Walnut Creek, CA

David Resnick, DDS, from Ada, MN

Terry Reynolds, DDS, from Atlanta, GA

Lawrence Singer, DMD, from Alexandria, VA

Natalie Wong, DDS, from Toronto, ON, Canada

Encourage your colleagues to join the AAID and offer them a \$50 discount on their first year's membership dues by letting us know you referred them. Do so by November 1, 2016, and be entered into a drawing for 2017 AAID membership dues—up to a \$600 value.

If you would like to request membership applications to share with colleagues, contact the Headquarters Office at info@aaid.com or by phone at 312-335-1550.

2015 AUCTION PARTICIPANTS

The AAID Foundation raised over \$50,000 at its auction held during AAID's 2015 Annual Educational Conference in Las Vegas in October. The Foundation thanks the following individuals and organizations that donated items for the auction.

Donated Educational Courses & Study Clubs

ABOI/ID

Joel Rosenlicht, DMD

John Minichetti, DMD

Richard Mercurio, DDS

Jaime Lozada, DMD

Robert Heller, DDS

Michael Pikos, DDS

Shankar Iyer, DDS

Hilt Tatum, Jr., DDS

Richard Borgner, DDS

Berneer Dunson, DDS

George Arvanitis, DDS, & Roderick

Stewart, DDS

William Liang, DMD



OCO Biomedical

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Piezosurgery, Inc.

Rocky Mountain Tissue Bank

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Sterngold

Unicare Biomedical

Tatum Surgical

Treloar & Heisel

Versah, LLC

SUMMARY OF ACTIONS TAKEN BY BOARD OF TRUSTEES

October 20, 2015, Las Vegas, Nevada

ADOPTED 2016 Budget

DESIGNATED Education Oversight Committee as official committee to maintain and enhance the Dental Campus Clinical Classroom on an on-going basis

APPROVED offering web conference in Dubai for 2016 Oral Case Exam

MAINTAINED dues for General Members at same amount as prior year

APPROVED 2016 Committee members and chairs

Corporate Donors

ACE Surgical Supply Company

Care Credit

Curasan, Inc.

Glidewell Laboratories

H&H Company

Hu-Friedy Mfg. Co.

Impladent Ltd.

Intra-Lock International

KAT Implants

Nobel Biocare

Donated Painting, Luxurious Vacations, and Advertising

Timothy Hacker, DDS

Hyatt Regency New Orleans

Impladent Ltd.

Piezosurgery

Pikos Institute

Quintessence Publishing

Tatum Institute

Unicare Biomedical

Winspire

2015 Annual AAID Business Meeting Summary

The 2015 Annual Business Meeting of the American Academy of Implant Dentistry was called to order at 2:03 pm on Saturday, October 24, 2015, by AAID President, **Dr. John Da Silva** at Caesars Palace in Las Vegas. A quorum was present.

Following is a summary of the activities, actions, and reports at the meeting:

- Inducted 51 new Associate Fellows, 14 new Fellows, and two new Academic Associate Fellows; introduced nine credentialed members as the 2015 Class of Honored Fellows
- Observed a moment of reflection in memory of the following members who had been reported as having passed away since the 2014 Annual Business Meeting:
 - Susan D. Bernstein, DDS, Cincinnati, Ohio
 - Robert Goldman, DMD, Chesterfield, Missouri
 - Don K. Henckel, DDS, Houston, Texas
 - **Joseph R. Pullen, DDS**, Huntsville, Alabama, AAID President in 1983 and Life Member
 - **Paul K. Mentag**, Troy, Michigan, AAID President in 1976



Newly installed president, Dr. Richard Mercurio (left) presents outgoing president, Dr. John Da Silva with a plaque commemorating his service to the Academy.

- Dr. John Da Silva delivered his president's report highlighting the progress made on the pursuing the Academy's strategic plan during the year.
- The Nominating Committee chair, **Dr. John Minichetti**, reported that no further nominations were received. So, the slate of officers for 2016 was elected as follows:
 - President: **Richard Mercurio, DDS**
 - President-elect: **Shankar Iyer, DDS, MDS**
 - Vice President: **David Hochberg, DDS**
 - Treasurer: **Natalie Wong, DDS**
 - Secretary: **Berneer Dunson, DDS**

The following reports were delivered:

- 2015 Annual Conference report by **Dr. Shankar Iyer** noting that of the 1,011 doctors registered for the Conference, 143 were non-members of the Academy, over half of whom joined the AAID.
- Treasurer, **Dr. David Hochberg**, reported that to date, 2015 was another successful year financially.
- Dr. Frank Recker, AAID Legal Counsel, reported on the formation and status of the American Board of Dental Specialties and updated the membership on the lawsuit in Texas challenging the statute on specialty recognition.
- **Dr. Emile Martin**, President of the American Board of Oral Implantology/Implant Dentistry, reported that with the 18 new



A full house participated in the 2015 Annual Business meeting in Las Vegas, Nevada.

Diplomates certified in 2015, the total number of Diplomates is 496, of which 427 are active.

- **Dr. Jaime Lozada**, President of the AAID Foundation, noted that the Foundation's assets have grown to \$3 million and over 39 research grants have been awarded to clinicians and graduate students. The "Wish A Smile" program has over 50 credentialed members who have volunteered to participate and is seeking patients to participate in the program.
 - Dr. Mercurio, Chair of the Bylaws Committee, presented a summary of the amendments to the Bylaws and moved their adoption on behalf of the Bylaws Committee. The Bylaws revisions were unanimously passed and became effective immediately.
 - Dr. Mercurio presented Dr. Da Silva with a Plaque of Appreciation and the Past President's pin. He delivered his inaugural address stating that his vision for the year is to focus on the four remaining goals: Education, Membership, Patient Awareness, and Specialty Status.
- The Business Meeting adjourned at 3:13 pm.

Expanding Opportunities: Developing Implant Sites for Predictable Results

Join your colleagues in Vancouver, British Columbia, Canada, April 8 - 9, 2016, to learn about:

- Principles of bone augmentation
- Hard tissue augmentation for predictable implant placement
- Soft tissue augmentation for function and esthetics
- Success with managing implant complications

Honor **Dr. Tom Chess** for a lifetime of contributions to the field of implant dentistry. A dinner in his honor will be held on Friday evening, April 8, and is included in the registration fee for non-student dentists.

Register by February 29, 2016, and save \$100. More information and links to register are available at AAID's website – www.aaid.com.

The following speakers will cover the following topics:

Why Dental Implants Fail and What

Effect Failure Has on Your Practice
Don Anderson, DMD, FAAID, DABOI/ID

Understanding the Use of Autogenous Bio-Activators: BC-PRP, Injectable PRP, PRF

Jim Rutkowski, DMD, PhD, FAAID, DABOI/ID

Advanced Tissue Reconstruction Using BMPs: Current Concepts and Future Directions

Nick Caplanis, DMD, MS, FAAID, DABOI/ID

Predictable Techniques for Guided Bone Regeneration

Jaime Lozada, DMD, FAAID, DABOI/ID

Got Bone?

Colin Diener, DMD, FAAID

Bone Expansion and Bone Manipulation

Berne Dunson, DDS, FAAID, DABOI/ID

Implants and Esthetics: Reducing the

Risks and Improving the Outcomes
Sonia Leziy, DDS

After 40 Years of Augmenting Maxillary Sinuses, What Have I Learned?

O. Hilt Tatum, DDS, FAAID, DABOI/ID

Restoration of Maxillary Ridges

O. Hilt Tatum, DDS, FAAID, DABOI/ID

Guided Surgery and Guided Prosthetics: An Alternative to Advanced Grafting Procedures

Natalie Wong, DDS, FAAID, DABOI/ID

The Game Changer: Maintenance of Vascularity in Surgical Procedures"

Bill Liang, DMD, FAAID, DABOI/ID

Considerations for Grafting after Dental Implant Complications and Failures"

John Minichetti, DMD, FAAID, DABOI/ID

Avoiding and Treating Neurovascular Injuries"

James A. Miller DMD, FAAID, DABOI/ID

The AAID Western District has arranged very competitive rates at the conveniently located Westin Bayshore, Vancouver—Deluxe Guestroom—\$169 CDN S/D plus tax; Premium Guestroom — \$199 CDN S/D plus tax.

Call Toll Free: 800-Westin-1 or the hotel directly at 604-682-3377 and identify yourself as being with the American Academy of Implant Dentistry or AAID. Or you can reserve your room by email at bayshore.reservations@westin.com.

Expanding Opportunities:
Developing Implant Sites for Predictable Results

Presented by AAID
Western and Central Districts

April 8 - 9, 2016
Westin Bayshore
Vancouver, British Columbia

Visit www.aaid.com for more information or call 312.335.1550.

AAID
AMERICAN ACADEMY
OF IMPLANT DENTISTRY

AAID Annual Conference attracted large crowd

More than 1,700 attended AAID's 64th Annual Educational Conference at Caesars Palace in Las Vegas, Nevada, from October 21-24, 2015.

They heard from **Dr. Carl Misch**, one of the pioneers in implant dentistry as he delivered one of the keynote addresses. Dr. Misch discussed the considerations necessary when making the decision to treat an existing tooth or to extract and replace with an implant. He also delved into considerations for immediate loading. The packed room gave Dr. Misch a standing ovation at the end of his presentation.

Dr. Daniel Alam, who was the leading microsurgeon on the first face transplant performed in the US, inspired attendees with his presentation on Face Transplantation: Past, Present, Future, as the closing keynote speaker of the Conference.

Over the three and one-half days,

world-renowned clinicians reviewed time-honored dental implant techniques and explored cutting-edge



Dr. Carl Misch received a standing ovation after his presentation during AAID's 2015 Annual Conference.

dental implants. Through Main Podium Sessions, seminars, and hands-on workshops, attendees were taught the latest concepts in dental implant treatment planning and reviewed the science and practice of implant dentistry.

A post-conference, full-day course on advanced soft and hard tissue grafting also was offered. This course included hands-on experience on cadaver heads.

Next year's Annual Conference will be held in New Orleans, October 26 – 29, 2016. More information and registration links are available on AAID's website.



Dr. Bruce Freund demonstrated the use of neurotoxins on his wife during AAID's 2015 Annual Conference.



Attendees at AAID's 2015 Annual Conference had the opportunity to visit over 120 exhibitors.

newmembers

The AAID is pleased to welcome the following new members to the Academy. The Following members joined between September 3, 2015 and November 30, 2015. If you joined the Academy recently and your name does not appear, it will be listed in the next issue.

The list is organized by state and then alphabetically by city.

International member list is organized by country, province (if available), and city.

Contact your new colleagues and welcome them to the Academy.



ALABAMA

Christopher W. Baker, DMD
Clanton

ARIZONA

Lance Schneider, DDS
Chandler

Luis R. Meneses
San Luis

Haleh Bazargan
Scottsdale

Reem Kidess, DDS
Scottsdale

Shunyu Nieh, DDS
Tempe

Bruce Butcher, DDS
Yuma

CALIFORNIA

Mohamed Gouda BDS
Bakersfield

Kiran Mistry, DDS
Covina

Medhat Rofael
Huntington Beach

Siamak Abai
Irvine

Rafael Quintero, DDS
Irvine

Cvetan Mechev, DDS
La Mesa

Joseph Levingston
Laguna Beach

Andrew Yang, DMD
Laguna Hills

Charles Ned Sannar
Live Oak

Raunak Singh
Los Angeles

John Row, DDS
Madera

Joseph Alwan, DDS
Marina

Brendan Tully, DDS
Ojai

Maria Lobodzinski, DDS
Pasadena

Alexander Joseph
Magallanes, DDS
Perris

Niraj V. Shah
Rancho Cucamonga

Alejandra Corpus Galindo-
Magallanes, DDS
Redlands

Suraj Pal Sharma, DDS
Riverside

Sahil Sethi, DMD
Sacramento

Sandhya Hegde, BDS, DDS
San Diego

James Lim, DDS
Torrance

Scott Edward Keith, DDS, MS
Walnut Creek

John Joseph Petrini
Walnut Creek

COLORADO

Hanying Wang, DDS
Aurora

Michael D. Doherty
Carbondale

Nina Gomenyuk, DDS
Centennial

Tyler Pickett, DDS
Colorado Springs

Michael Gadeken, DDS
Grand Junction

Derek M Collins, DMD
Loveland

Alex Acevedo, DDS
Westminster

CONNECTICUT

Adauri Soprani, DDS
Danbury

Aynur Ismayil, DMD
Stamford

Oscar Gonzalez, DDS
West Hartford

DELAWARE

Blair Jones, DMD
Lewes

Thomas Kuon, DMD
Lewes

Charles Labin, DMD
Lewes

FLORIDA

Alejandro Piedra, DMD
Boca Raton

C. Nicholas DeTure, DMD
Deerfield Beach

Marissa Matthews, DDS
Deerfield Beach

Alan Davis, DMD
Englewood

Jeremy Gerber, DMD
Fort Lauderdale

Burak Taskonak, DDS, PhD
Fort Lauderdale

Arthur James Mowery, DMD
Gainesville

Ira Goldman, DMD
Hallandale

Mauricio Ramirez
Hialeah

Samir K. Hanna
Jacksonville

Roger Montz, DMD
Melbourne Beach

Raul I. Garcia, DMD
Miami

Raymond Kenzik, DDS
Ormond Beach

Ray A. Morse, DMD
Panama City

Kenyon M. Fort, DDS
St. Petersburg

Renato Aves, DDS
Tampa

Amy Creech-Gionis, DMD
Tampa

James Russell Green
Tampa

GEORGIA

Troy Gibbons, DDS
Alpharetta

Andrew Hamilton, DMD
Augusta

William E. Carroll, DDS, MS
Austell

Randeep S Bhullar
Lawrenceville

Abel Aguilar, DMD
Manchester

Stephen L Matlaga, DDS
Peachtree City

Theresa A Simmons, DDS
Peachtree City

HAWAII

Norman Shi-Ming Cheung
Honolulu

Dino Dee, DDS
Honolulu

IDAHO

Russ Jensen, DMD
Boise

Wayne Peterson, DMD
Moscow

ILLINOIS

Emil Matthew Verban
Bloomington

Louis Kaufman, DDS
Chicago

Kaiyun Chen
Glendale Heights

Ruoyu Pang
Glendale Heights
Subbhashini Marimuthu, DMD
Glendale Heights
Chiann F. Gibson, DMD
Naperville
Rene Tanquilut, DDS
St Charles
Nataliya Korniyuchuk, DMD
Third Lake
Daniel Huh
Wateka
Michael Ted Kostal, DDS
Yorkville

INDIANA

John Pawlus, DDS
Columbus
Scott A Kapers, DDS
St. John

IOWA

Matthew B. Anderson, DDS
Davenport
Jordan Moffitt, DDS
Eagle Grove

KENTUCKY

Cindy Munoz
Lexington
Stephen Remmers, DMD
Louisville

LOUISIANA

Norman Thompson, DDS
Alexandria
Danielle Muse, DDS
Lafayette
Michael Adam Adragna, DDS
Marrero
John Leslie Hobgood, DDS
New Orleans
William E. Kramer, DDS
New Orleans
Bristol William, MSD
New Orleans

MAINE

William Z. Catterton
Auburn

MARYLAND

Jody M. Waddell, DDS
Annapolis
Nahid Shahry, DDS
Bel Air
Cheryl R. Terrell, DDS
Bowie
George P. Harding, DDS
Hyattsville
Aron D Turner, DDS
Pikesville

MICHIGAN

Julianna Hukill, DDS
Grand Blanc
Ray N. McKinley, DDS
Shelby Twp

Kerri L. Millett, DDS
Sturgis

Mehul C Patel, DDS
Trenton

Sonia Kaur Singh, DMD
Warren

MINNESOTA

Rachel Foster Rivard, DDS
Minneapolis
Nana Yeboah, DDS
West Saint Paul

MISSOURI

Billy Ogborn, DDS
Cape Girardeau
Matthew P. St. George, DDS
Fulton

Amirreza Ghassemi, DDS
Saint Louis

NEBRASKA

Billy Chris Nix, DDS
McCook

NEVADA

Kevin Moore
Henderson
Aaron Gubler
Las Vegas
Patrick Kenney
Las Vegas

NEW JERSEY

Daniel Kim, DDS
Cherry Hill
Kessy Lee, DDS
Cherry Hill
Diana Hagan, DMD
Clifton
Mario Fiorentini, DMD
Cranbury
Steven L. Goldberg, DDS
Englishtown
Betzi Arvelo-Delgado, DMD
Fanwood
Alden Kim, DMD
Gloucester City
Priya Sridhar BDS
Harrison

Esteban Chan, DMD
Holmdel

Mumlikat Aziz, DDS
Jersey City

Calogero DiMaggio, DDS
Jersey City

Ronald Katz, DDS
Kendall Park

Abbas Razvi, DDS
Marlboro

Nabil Gerges, DDS
Newark

Mamdouh S. Soliman
North Brunswick

Khalee Alwan, DDS
Prospect Park

Louis Conte, DMD
Red Bank

Haniel C. Rosemond, DDS
South Orange

NEW MEXICO

Joseph Pitluck
Albuquerque
Huan Yang
Albuquerque

NEW YORK

David Cho, DDS
Bayside
Sonali Marfatia
Bellmore
Joseph Lichter, DDS
Brooklyn
Daniel Gregory Miller, DDS
Buffalo
Vincent Ayuko, DDS
Cortlandt Manor
Bart W. Silverman, DMD
New City
David E Azar
New York
Lori Liu, DMD
New York
James Sullivan
Ossining

NORTH CAROLINA
John W. Hooker, DDS
Arden
George Hanna, DDS
Greensboro
Craig Mize, DDS
Raleigh
Hanna Zombek, DMD
Rocky Mount

OHIO
Eric Wissler, DDS
Chillicothe
Drew Meyers, DMD
Cincinnati
Hadie Rifai, DDS
Cleveland
Lee R. Hendricks, DDS
Dayton

OKLAHOMA
Coty Shores, DDS
Duncan

OREGON
Andy Burton
Hood River
Mo Biria, DMD
Klamath Falls
Robert Millard, DDS
Klamath Falls
Earl Jordan Blanche, DMD
Portland

PENNSYLVANIA
Michael Rowland, DDS
Allentown
Riyaz Gangji, DDS
Bethelham
John Whytosek, DMD
Bryn Mawr
David Killian, DMD
Carlisle
Geoffrey Wozar, DMD
Doylestown

Puerto Rico
Lis M Arocho
Caguas

SOUTH CAROLINA
David Decillis, DDS
Heath Springs

TENNESSEE
Andrews Harding Johns, DDS
Cookeville
Charles Ashley Clayton, DDS
Nashville
Kristin Rushing, DDS
Nashville
William Daye Phillippi
Sevierville

TEXAS
James Vu, DDS
Allen
Roberto Velasco, DDS
Houston
Kurt Loveless, DDS
Lubbock
Aaron Christopher Polk, DDS
Nacoqdoches
Bradford Tiner, DMD
Richardson
Andres E. Biaggi, DMD
San Antonio
Richard Bradley Moss
Southlake
Loyd Dickard Dowd
Tyler
Gayle Bradshaw, DDS, MS
Woodlands

UTAH
Randall Kelley, DMD
Salt Lake City

VIRGINIA
Stephen Radcliffe, DDS
Burgess
Neelam Dube, DDS
Chantilly
Ed Akeel, DDS
Charlottesville
Milan Simanek
Fairfax
Eric J. Smith, DDS
Lynchburg

WASHINGTON
Jasmine Kahlon, DDS
Kent
Derek Thomas Wirth, DMD
Oak Harbor

WEST VIRGINIA
Eric R. Brannon, DDS
Spencer

WISCONSIN
Thomas R Henschel, DDS
Brookfield

WYOMING
Joshua G. Wagner, DDS
Riverston
Timothy J. Pieper, DDS
Torrington

CANADA
ALBERTA
Mohammed Ahmed Al Attas, BDS
Edmonton

BRITISH COLUMBIA
Ben Partovi
Richmond

NOVA SCOTIA
Mohamed Al-Janabi
Truro

ONTARIO
Jonathan Dirige Lazaro
Ajax
Gabriel S. Ponce, DDS
Camlachie

CYPRUS
Apostolos N. Eliades
Limassol

INDIA
Deepak G Kulkarni
Pune

JAPAN
Shotaro Takahashi, DDS
Tokyo

MALAYSIA
Yong Chun Jet, BDS
Kota Kinabalu

SAUDI ARABIA
Khalil Aleisa
Riyadh

SOUTH KOREA
Yongsu Ahn
Cheonan-si,
Chungcheongnam-do
Daewoong Hong
Asan-si
Heewon Jung
Seoul
Han Sangyoon, DDS
Seoul
Jiae Yoon, DMD
Seoul
Kyunghwan Yoon, DMD
Seoul
SANG PHIL MOON
Suwon

newmembers

AAID welcomes new student members

It's never too early for dental students to become familiar with the practice of implant dentistry. And there is no better place for them to learn than from the leading organization of dental implant experts in the world. AAID's electronic membership, open only to dental students, has been in place for several years and we currently have over 1,000 dental student members who are entitled to online access to Academy information and resources. The following is the list of new electronic dental student members who joined between August 19, 2015, and November 20, 2015.

University of Alabama

Ashlee Turner

Arizona School of Dent/Oral Health (AT Stills)

Joshua Adametz
Kashif Ahmed
Mykel Anderson
Faith Roselle Barreyro
Christine Castelin
Victoria Chiu
Kara Dragone
Christopher Fisetto
Chad Gidel
Nima Javan
Tyson Jolley
Mabroor Khan
Satbir Khara
Ron Ko
Ghazal Navab
Michael Rosen
Jacob Shelley
Taylor Velasquez
Jaden E. Willard
Jake Zellner

Baylor College of Dentistry

Laura Albarracin

Boston University

Ishita Agarwal
Swati Agnihotri
Rizwan Baig
Dooyong Choi
Vishtal Gohel
Jing Guo
Shawn Jones
Manish Juneja
Bhoomi Kotak
Jon Kuang
David Lane
Sol Lee
Romil Pasrija
Stephen Prieve
Patrick Richard
Shammi Sagar Saini
Lavanya Tortiker

University of California, San Francisco

Yelizaveta Luchkovska

Case Western Reserve

University

Anmol Brar
Ida Ettehadih
Allyson McClendon
Lizzeth Rodriguez
Lynsie Sprouse
Syeda Zafrin

University of Colorado Denver

Tom Fry
Jason Gordon
Mariia Lavnikovich
Ian Lowell
Saniya Setia

Columbia University

Stephanie Bernard
Guy Njewel
Jennifer Tsuan
Benjamin Wang
Gregory Yunov

University of Connecticut

Emily Sachs

Creighton University

Morgan Freilich
Rachel Lewin
Caroline Miller

University of Detroit Mercy

Lauren Ko
Jordyn Winship

East Carolina University

Kaitlyn Anderson

University of Florida

Olivia Bassily
Monique Belin
Carolina Cadavid
Paula Cohen
Matthew Davidson
Mahmoud Mona
Alison Novakovic
Heather Perez
Neal Singh
Michelle Thomas
Daphne Toussaint
Vanessa Vaquer
Sharon Zachariah

Georgia Regents University

Jenna Powell

Harvard University

Tyler Haeffs
Kalie McCulloch

Howard University

Rafil Ali
Sagar Amin
Brandon C. Bean
Gracie Castillo
Adrienne Castro
Rosemary Chaban
Adel El-Deeb
Chris Gavarrete
Elaria Ghobrial
Amanda Golshiri
Robert Gopie
Rabab Hasan
Manjot Kaur
Ariana Moreno
Olubunmi Olusada
Gauri Pande
Bijal Patel
Shital Patil
Josh Philip

LeNeal Powell
Jace Rutledge
Ahmed Saadulla
Mahsa Shahidi
Amber Shaikh
Adrian Soto
Melissa J. Torres
Marion Williams
Jonathan Wu
Joshua Lewis
Jose Liens
Alexandra Schutzb

University of Illinois at Chicago

Daniel Pagel

University of Iowa

Sean Harvey
Shaun O'Neill
Amanda Phan
Tyler Wallingford

University of Kentucky

Dalton Hampton
Hunter Hazle
Tyler Sanslow

LECOM School of Dental Medicine

William Buis
Natalie Hage

Kyle Humphrey
Brantley McCarty
Desiree McMillen

University of Los Angeles

Edwin Eshaghzadeh
Desiree Hsion
Andre LaMothe
Timothy Yu

University of Louisville

Brittany Mckinley

Meharry Medical College

Mo Alamiri
Jordan Olson
Unique Williams

University of Michigan

Julia Duong
Joseph Fazzio
Syed Haider
Andreana Masters
Timothy Obradovich
Nicholas Reece
Madelyn Stumpos
Cassandra Wieckhorst

**Midwestern University,
Arizona**

Olivia Donaldson
Yeri Guak
Brandon Le
Kianna Memaran

**Midwestern University,
Illinois**

Andrew Schwab
Christopher Sprott
Tyler Villiard

University of Minnesota

Nate Caple
Robert Huot
Quentin Knutson
Jane Yang

University of Mississippi

Ronald Young

**University of Missouri at
Kansas City**

Luke Greene
Jeff Johnson
Devon Pucel

University of Nebraska

Ariel Atwood
Kim Barth
Molly Berke

Jeff Blomstedt
Halie Bricker
Levi Brinkerhoff
Roy Burkhalter
Mary Canarsky
Brandon Chapek
Shawn Custer
Keenan Fischman
Stephanie Grogan
Madison Horsch
Claire Konkol
Blake Kopf
Edward Alex Kusek
Bryan Larsen
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Editor's Notebook

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challenging field of implant dentistry were noticeably a "cut above" the average practitioner. Their enthusiasm was contagious; their quest for professional improvement was inspiring; and even their outside personal involvements were frequently exotic and invigorating. Being surrounded by colleagues of this caliber was and remains the best antidote to professional burn-out I have ever discovered.

AAID's recent Annual Conference in Las Vegas was no exception. Sitting in the audience listening to **Dr. Carl Misch** was itself worth the price of admission. He has been facing some major personal challenges and yet handles the adversity in a way that is truly a profile in courage. His presentation, as always, was thoughtful and reflective.

Some have noted that a major transformation is taking place in our profession, which is causing a blurring of the lines that traditionally divide some of the specialty areas in dentistry. It challenges historical divisions as to how we can best serve the interests of the people who truly are the central focus of our profession—the patients.

To no small extent, it is the "special" area of implantology that has given life to this evolution, as it represents an area of practice growth identified by a wide swath of those in our profession. Dr. Misch long ago described implantology as a prosthetic discipline with a surgical component. It's like a chain: It depends substantially on all of its links. The success that can be attained will only be as certain as the weakest component. The debate about how this service is best delivered obviously involves many aspects of our profession. The challenge is to resist misinterpreting any one of the links to be the entire chain. Having a narrow range of expertise can be an advantage, but it also can be a detriment.

Common decency and professional ethics demand that we always focus on what best serves the patient. The AAID, a group comprised of various specialists as well as general dentists with many specialized skills, is at the forefront of addressing many of these critical questions.



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1. Clinicians Report, TRAC Research, July 2014

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