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Duke Heller,
DDS, FAAID, DABOI/ID
2021 AAID President

PRESIDENT'SMESSAGE

Why Being a Member of AAID Is Important to Your Practice and to You Professionally

Oliver Wendell Holmes said, "Man's mind, once stretched by a new idea, never regains its original dimensions."

As I mentioned before, 2021 is the year of AAID Education and the creation of a revolution. We are at the tip of creating multiple programs to meet the needs of different types of learners.

The AAID leadership is leading the way but, we need YOU to make it happen. This initiative will help change the course of dental implant education forever. I believe in this movement and continue to be an active participant.

What is it?

The AAID's goal has expanded to standardizing post-graduate dental implant education.

The AAID continues to work toward specialty status. We've had several successful legal cases on the journey to becoming recognized as a specialty. But we need to expand into formal education to make specialty recognition a reality. One way to get there is to provide dentists with landmark implant education with a means to earn a master's or advanced education degree. This year we have focused on program design.

With the program almost finished, we are focused on "Education in Dental School Settings" and reaching out to dental schools and other higher educational programs.

AAID is supporting implant dental education with the following initiatives:

1. Post-Graduate Education in Dental Schools: The AAID has been developing a standardized curriculum for oral implantology programs conferring degrees. There are two to four Dental Schools that are interested in starting Masters of Art (2-year program) or Masters of Science (3-year program).

2. Full-time, 36-month Comprehensive Oral Implantology Residency Program at Jacksonville University: Sponsored by the Comprehensive Oral Implantology Residency Foundation (COIRF), this program has been led by AAID members and plans to recruit program directors from among the ABOI/ID Diplomates. The students will be enrolled in JU for didactic education with 8 to10 surgical centers where the surgical component will take place. This program will provide a Certificate in Implant Dentistry as well as a Masters in Science in Dentistry.

As these programs continue to develop, the AAID will provide these areas of post-graduate education for you at the annual conference, district meetings and new regional events.

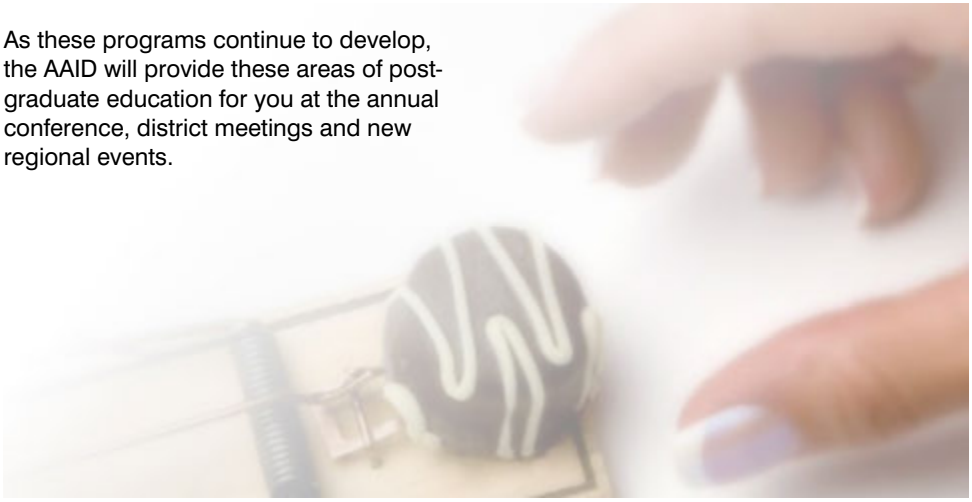
Ben Franklin said, "An investment in knowledge pays the best interest."

It has been said that the "free" lunch is in a mousetrap. There is no "free education" available in implant dentistry.

"Mice die in mousetraps because they do not understand why the cheese is free"

We have made so much progress over the last few months. Hopefully when we look back, 2021 will be looked upon as the year that Implant Dentistry Residency programs got their start in the dental schools.

Look for continued updates on the AAID's initiatives for graduate implant education—all in hopes of leading to specialty status for implant dentistry. Share your thoughts with me about this program. Email me at *president@aaid.com*.



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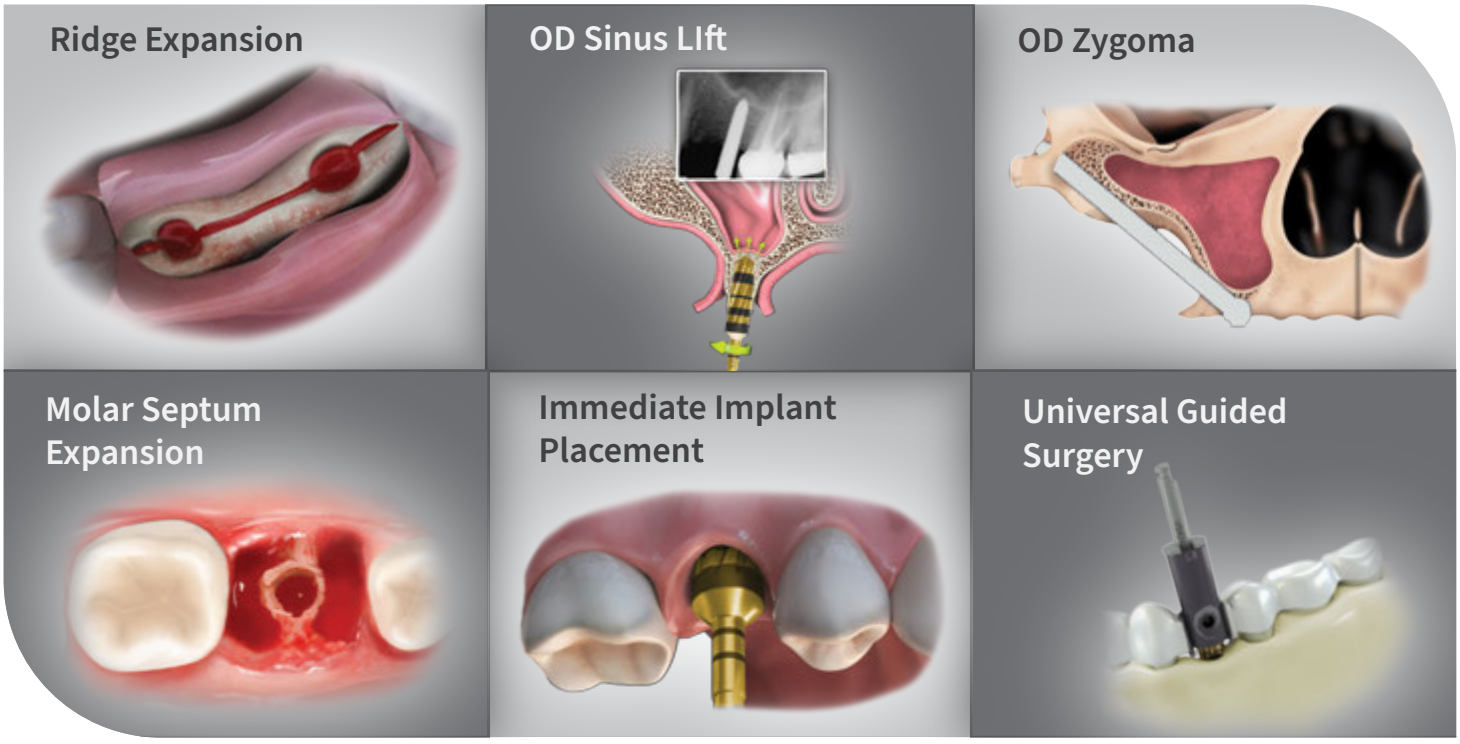

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Choosing Your Payment Philosophy

By Bonnie Litch

In *AAID News* Issue 3, 2020, we interviewed several dental practice experts on the importance of dental insurance to your business. The article "Playing the Insurance Game: Understanding the Business of Running a Dental Practice" highlighted one of the greatest challenges facing dental practices today. According to the National Association of Dental Plans, 80% of the United States population has a dental benefit. Therefore, dental practices need to take a more strategic approach to dealing with insurance carriers. In this current issue, we have gone back to the same experts to delve more deeply into how you can evaluate and optimize your insurance participation.

Insurance companies have mountains of data and teams of people dedicated to analyzing, scrutinizing and managing benefit design, claims, and reimbursement rates. Dental practices do not. As a result, Nicholas Partridge, founder and CEO of Five Lakes Dental Practice Solutions, built a comprehensive Insurance Analysis to help dentists think more strategically, make more informed decisions, and level the playing field in terms of taking an analytical approach. Experts in the field offer a variety of solutions to help dental practices evaluate their insurance participation through practice analyses or insurance audits.

Similarly, Roger Levin, DDS, founder and CEO of the Levin Group in Ownings Mills, Maryland, states "a dental practice is a business, and businesses need to do financial modeling to determine the best direction to meet their goals." He notes that "every practice needs to define its philosophy toward payment procedures: fee-for-service versus accepting insurance disbursements. Currently, fewer than 10% of practitioners solely rely on fee-for-service (FFS), and the number of dentists who do so decreases every time our nation faces a crisis." He cites circumstances like recessions and a pandemic as perfect examples. "The problem is that these dentists sign up with insurance companies as a knee-jerk reaction to the situation without thoroughly considering what is best for their business."

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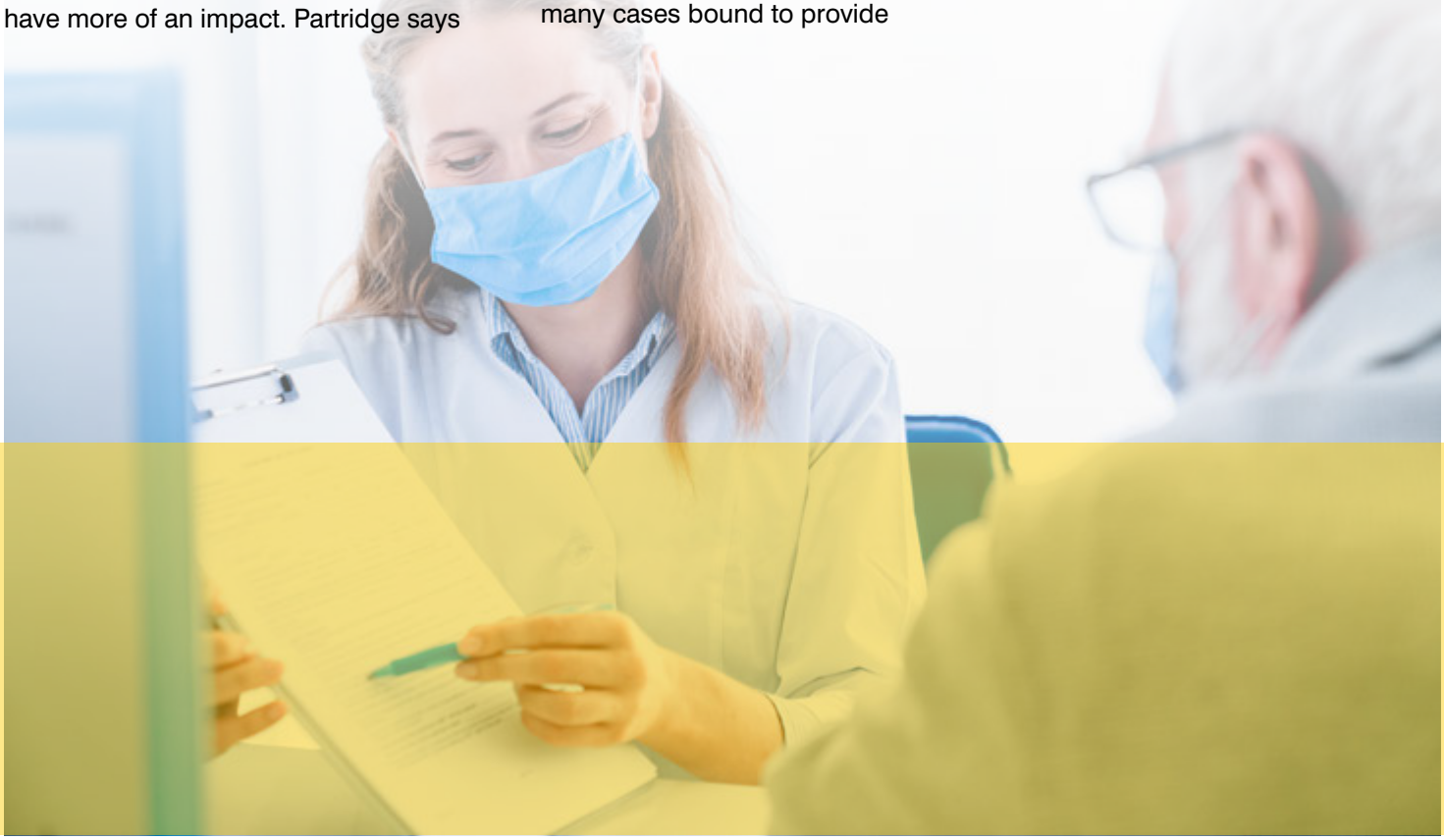
Market analysis

"Terminology is really important," says Partridge. "When reviewing insurance contracts, many practices call that process an audit. We don't conduct insurance 'audits' for our clients; insurance companies perform audits. What we do is analyze the three key components to a successful strategy: your market, your practice, and the PPOs doing business in your market."
What should you be reviewing? "We have access to a treasure trove of data in your target area and we use that data to develop realistic goals for our clients," continues Partridge. While it is possible for you to perform this analysis in-house, the detail necessary to uncover and analyze this data suggest that bringing in outside experts might have more of an impact. Partridge says that his firm reviews the following within its analysis of the market:

1. **Examine the demographics around you:** "We have access to a complete demographic profile of residents in your target area, including forecasts looking five years into the future, a psychographic profile, consumer spending, traffic counts, and more." When analyzing your market, you will also want to consider factors like daytime or seasonal population, education, income, ethnicity, etc. Each of these factors affect scheduling, pricing, and other key inputs to your practice.

2. **Check out your competition:** "Insurance companies are in many cases bound to provide a certain number of providers within a specific distance of a key employer. As such, geographic advantages—while increasingly rare—are increasingly valuable," says Partridge. Further, understanding the population-to-dentist ratio in your area is important to get a sense of the degree of competition in your market. Lastly, understanding more about competing offices is critical. "Are these competitors part of a DSO or a solo practice? What are their dental specialties? With which insurance companies are they contracted?" The latter question is a perfect example of why you might hire outside experts to conduct your analysis as they have better access to such information.



3. **Research the potential employers in your area:** Look at a cross section of employers in your geographic area. Perhaps you have the headquarters or regional office of a Fortune 500 company nearby. Which insurance plans do these companies offer to their workers? What about that 50-employee accounting firm down the street? Understanding which companies offer dental benefits and which carriers are most prevalent is critical to developing goals for the practice.

4. **Review your own office fees:** Understand your pricing compared to your competitors in your market and to insurance reimbursements. How do your fees hold up against the Usual, Customary, and Reasonable (UCR) fees as set by the insurance companies?

Internal review

"Reviewing your revenues to optimize insurance disbursements is like peeling back the layers of an onion," states Levin. "Many practices have not taken a look at their fee schedule and their insurance contracting agreements in a long time. They may be operating on out-of-date data. This step is critical to the process of developing your business plan."

Levin sits down with clients and asks the following questions to help them set their strategic goals:

1. How many of your active patients are covered by insurance?

2. What is the percentage of the insurance patient revenue to the total revenue?

3. What is the percentage of each insurance plan revenue to the total revenue?

4. What percentage of your patients are in each plan?

5. Which plans should I keep and which should I not? Gather the discounts of each plan and then rank them from best to worst. If your worst plans are small percentage of your revenue, you could choose to exit them. If they are a large percentage, you probably should stay with that contract. If you choose to exit a plan and communicate that exit properly with your clients, you may only lose half of the patients. This loss may be eradicated with growth from adding a different, more popular carrier to your portfolio.

According to Levin, "Some people believe that working with a certain insurance company may be an emotional or ethical decision. In reality, it is a business decision. Ask yourself: If I enroll in this plan, will it bring in more patients? Ultimately, what is the practice production goal?' If you want to do $1 million net production and collections, build your model on achieving the goal—not based on total production. There are multiple ways to bring in revenues."

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"Some people believe that working with a certain insurance company may be an emotional or ethical decision. In reality, it is a business decision. Ask yourself: If I enroll in this plan, will it bring in more patients?"
— Roger Levin, DDS

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Implementing the results of your analysis

Many dentists already do this type of analysis as a part of their regular business practices. However, experts like Partridge and Levin note, it can be difficult for practitioners to conduct such a study in-house. "Insurance is where marketing and finance meet," states Partridge. "Accountants are really good at helping practices manage expenses, so we focus on maximizing revenue. We help develop an integrated business, marketing, and insurance strategy that brings together patient attraction, retention, and pricing." He also cautions that, because insurance companies are constantly evolving, practices need to re-evaluate their contracts and fee schedules on an ongoing basis.

"The average practitioner contracts with more than 11 networks and it is hard to keep up with all of these carriers. We keep our fingers on the pulse of change so we are able to put the most up-to-date information in the hands of our clients while allowing them to concentrate on providing dental services to their patients," continues Partridge. "Insurance companies are a moving target. We review where you are contracted and where you are not; we evaluate other plans and the cost/benefit of joining their plans vis-à-vis how many patients you may gain or lose in signing on with any given company; and we look for ways you can get involved with other companies through their partnerships with other carriers. For example, Ameritas and Aetna partnered together last year. When that happened, we sent more than 800 letters on behalf of our clients to either get into or out of that new relationship, depending on what worked best for them. We saved one client more than $100,000 through this process."

According to Partridge, "You can't take too lightly the importance of dental insurance on your practice. We work to find the optimal plan so that your business can achieve its goals. These companies are aware of what others are doing in their industry, putting dentists at a disadvantage. We help peel back the curtain and show dentists how this all works and work to negotiate on their behalf."

Whether you are a newly minted dentist or one who has been licensed for decades, your understanding of dental insurance and the companies that provide coverage can mean everything to the success of your practice.

Bonnie Litch is a freelance writer in Northbrook, IL.

"Accountants are really good at helping practices manage expenses, so we focus on maximizing revenue. We help develop an integrated business, marketing, and insurance strategy that brings together patient attraction, retention, and pricing."
— Nicholas Partridge

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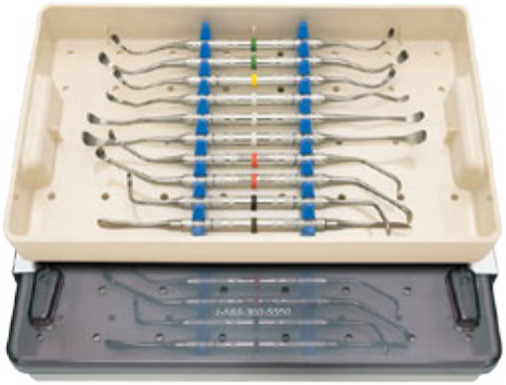

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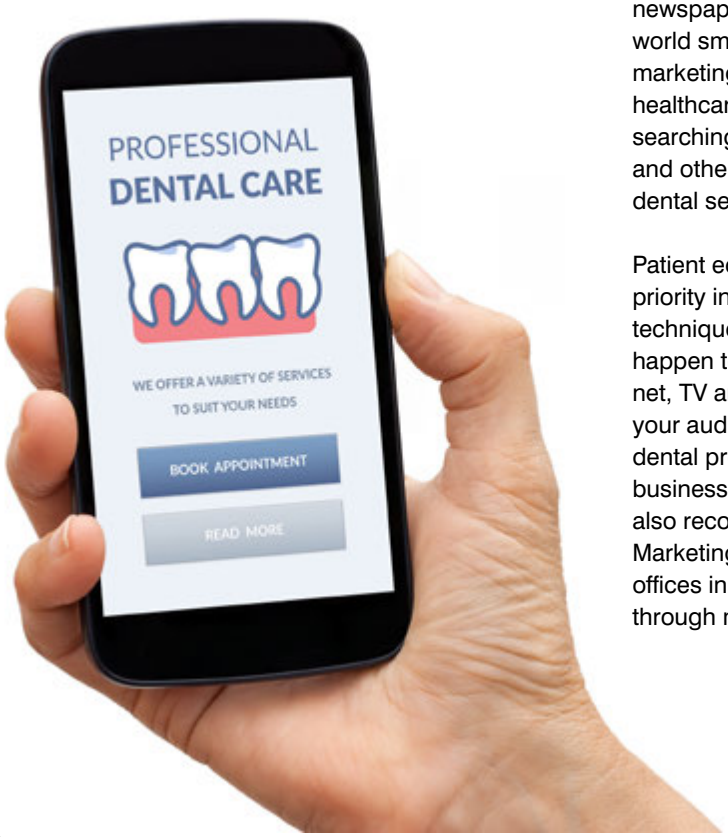
By Bobbi A. Stanley, DDS

Growing Your Dental Office: Finding the Marketing Mix

New clients function as the lifeblood of any small business. As small business owners, dentists must be focused on practice growth via new patients in order to continue to help their businesses thrive in an increasingly saturated market of dentistry. New patients provide growth for dental offices, and marketing is one of the many necessities required for this growth. Many dental professionals feel that marketing can be unethical and unprofessional; however, many misconceptions exist about what "marketing" really is.



What is marketing in the field of dentistry?

Marketing has been misunderstood as selling when, in reality, it is educating. It is imperative that dentists educate their new and existing patients about dental techniques, services, and technologies, as well as the uniquenesses of their particular office.

Prior to the advent of the internet, marketing in dental offices was limited to a simple listing in the Yellow Pages or a newspaper ad. As the internet made our world smaller and more competitive, marketing became more crucial for small healthcare businesses. Patients are searching the internet, social media, and other outlets for information about dental services and providers.

Patient education has always been a top priority in the dental field; the tools and techniques of patient education now happen to include social media, the internet, TV and other outlets for reaching your audience. As small business owners, dental professionals must keep their businesses lean; however, dentists should also recognize the value that a true Marketing Director can provide to their offices in increasing patient education through marketing techniques.

As small business owners, dental professionals must keep their businesses lean; however, dentists should also recognize the value that a true Marketing Director can provide to their offices in increasing patient education through marketing techniques.

Why do I need a Marketing Director?

Dentists do not have time to be the Chief Marketing Officer (CMO) of their practice. Oftentimes, the marketing of the business falls to the responsibility of the office manager, who may or may not be equipped to handle such a role. The dentist should be focused on dentistry and the office manager should be focused on the customer experience in the office. Trying to market the dental practice around the daily rhythms of the office without a dedicated team member often leads to frustration and confusion for both the office manager and the dental professional. It can create limitations to your marketing efforts; marketing is too important to make it a second hand duty of another team member.

Conversely, a Marketing Director is focused 100% on practice growth, as well as the results of various marketing initiatives, both internally and externally. Their primary goal is to make the dental practice successful by educating the public about dental procedures in the dental office. Keeping your expertise in front of potential new patients is a primary goal of marketing, and as a practice owner you are making an excellent investment in the growth of your business and team by recruiting a Marketing Director to manage your practice growth and patient education.

What does marketing in the dental office look like?

Before hiring a marketing professional to assist you in patient education and practice growth, practice owners and dentists should consider what the role of a Marketing Director might look like in their office.

Define your goals

Make sure you are clear on your goals prior to hiring a marketing professional. You will need to share these goals with them to give them a clear path towards growth. These can be simple or complex, and should encompass both short-term and long-term goals. The following are some examples:

- Increase following on social media platform X
- Increase total patient numbers, year over year
- Increase practice Google reviews by Y
- Better Google placement/ improved SEO

Set KPIs

KPIs, also known as key performance indicators, provide a gauge for the Marketing Director to measure their success. KPIs may include numbers like a monthly new patient number or increased treatment acceptance for a particular dental service. They may also include daily, weekly, monthly or yearly measures which may be reviewed for success or failure.

What does a Marketing Director do?

Of course, the Marketing Director is responsible for all marketing efforts, both internally and externally, for the business. However, they can do far more—even change the appearance of your practice inside and out. One important part of marketing is creating a brand—what do you want your image to be to the rest of the world? Marketing professionals are tasked with choosing color palettes, fonts, and images that evoke the emotions of the dental practice, and the brand will be displayed online in your website, social media, and in person in the office through posters, flyers, and brochures. The image of the doctor, the team, and the dental practice is important in marketing, and a Marketing Director should be creative enough to direct and help the doctor create a true brand for the practice that reflects the practice's personality.

Additionally, a great Marketing Director should create a marketing calendar with all marketing campaigns listed for the year in order to be able to encourage providers and practitioners in the office to educate new and existing patients on services, techniques, and specials. For instance, January may be designated as "New Year's Resolutions Month" and focus on cosmetic

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The image of the doctor, the team, and the dental practice is important in marketing, and a Marketing Director should be creative enough to direct and help the doctor create a true brand for the practice that reflects the practice's personality.

dentistry for that new smile. February is National Children's Dental Health Month, so a marketing plan could include a focus on first-time dental visits for children. The summer may be focused on families through local or national holidays. Your Marketing Director's goal should be to use existing events, holidays, and services to increase practice growth and find laser-focus in increasing new patient numbers in specific areas of the practice.

How do I find the right team member?

Finding the right Marketing Director for your office can feel like an overwhelming challenge. However, there are five important skills you should consider when hiring for this position:

1. **Initiative—**They must be able to independently create, manage, and execute tasks without interrupting the dentist and practice owner. A marketing calendar can be established and approved by the dentist, but the Marketing Director should be able to create campaigns and ads for all marketing platforms, and be able to work self-sufficiently in order to grow the business effectively.

2. **Creativity—**Creative ad campaigns engage customers more effectively than the run-of-the-mill promotional flyers that many dental marketing companies offer. Ideally, your next Marketing Director must be able to use their own creativity to create promotional and educational content for the dental practice.

3. **Tracking of KPIs—**The Marketing Director should track every marketing campaign to see how many potential new patients are viewing it and how many new patients it is bringing into the practice. Tracking the effectiveness of marketing efforts allows them to reassess what is working and not working so they can make corrections if needed.

4. **Understanding of basic SEO—**SEO, or search engine optimization, is the best way to improve your standing with Google. If your practice website ranks on the second or third page of Google when potential clients search for "nearby dentists," then you may never reach your new patient goal. A Marketing Director needs to be able to optimize your website by regularly adding fresh, engaging content and building quality back-links.

5. **Understanding of analytics—**Tracking the analytics of your website and other marketing ventures is important to understand if your goals are being met. The Marketing Director should be looking at the analytics on a regular basis so they can improve your marketing to the current marketing trends and compare trends to other dental offices in the area. A top-tier marketing director will be able to understand Google Analytics and be able to show how their efforts affect website performance and new patient numbers.

6. **Social media savvy—**Social media has become imperative for dental marketing. The Marketing Director must be familiar with all existing and breakout social media outlets, and be able to create and manage content on those platforms.

What is the advantage of an in-office Marketing Director?

Perhaps you have decided you need a Marketing Director, but may be considering hiring a virtual one or a dental SEO company. An off-site marketing source may be a good fit for some offices; however, an in-office person carries some distinct advantages over their virtual counterparts.

- They can easily communicate with the doctor and get approval for new ideas more quickly than an out-of-office marketing firm, which may have a difficult time making space to speak with the practice manager or owners.
- An in-house Marketing Director often understands the brand better than a marketing firm that has countless other clients. Their marketing should have a uniqueness that speaks to your practice in particular.
- Your Marketing Director can help with videography and photography. The majority of the internet and social media is made up of video content —if you do not have videos showcasing your office and services, you may be missing the boat. Having someone comfortable with taking video in your office is a strong asset to your business.

How do I begin marketing my business?

Marketing answers real-world questions by educating current and prospective patients on the various aspects of the dental field related to their health and well-being. If you are new to marketing your practice, start with this mix to begin the process:

- Lay out clear goals and objectives for the practice in terms of new patient growth, patient retention, and other long and short-term vision.
- Cultivate KPIs to match those goals that can be delegated to the appropriate team members.
- Begin the process of hiring an in-office Marketing Director to create, manage, and execute on your marketing goals and KPIs.

You are a small business owner; the service you offer is dentistry. Educating your patients and growing your practice through marketing can help your small business thrive and stand out from the crowd of dental professionals. A Marketing Director can take control of this task and perfect it to take your business to the next level.

Dr. Bobbi Stanley has practiced dentistry for more than 25 years. She has established best practices for setting daily, monthly, and annual goals and the team incentives to encourage her staff to meet them. In her Dental Entrepreneur Summit, she details the methods she has used to build one of the oldest and largest comprehensive dental practices in the Southeast.

JOISAMPLER

Editor's Note: Because of busy schedules, you may not have time to read the dozen or so articles in each issue of the *Journal of Oral Implantology*. In this section of *AAID News*, we selected a few articles that have broad applicability to the daily practice and provide a brief summary of key points so you can decide if you wish to read the complete article. The following articles are from Volume 46, Issue 6 (2020).

EDITORIAL

Author Aids for *JOI* Manuscript Acceptance Requirements

The *Journal of Oral Implantology (JOI)* editorial team strives continually to: (1) improve *JOI* for readers, (2) aid authors in submitting manuscripts that meet the necessary requirements for peer-review consideration, and (3) help reviewers perform critically valuable and time-efficient reviews. Dr. Jonathan R. Brown, Senior Associate Editor-in-Chief, in collaboration with the *JOI* editorial team, has produced video and Microsoft PowerPoint instructions for authors and reviewers, in addition to reworking the reviewer scoring rubric for the benefit of all. Authors are encouraged to review the Instructions for Contributors and the reviewer scoring rubric as it will guide them in preparing manuscripts that will meet the criteria put forth by the *Journal*. *JOI*'s editorial goals are to recognize salient author contributions and to help contributing authors publish their research findings. In support of these goals, a presentation has been designed to provide important considerations that occur when a manuscript is submitted for possible publication in *JOI*. The link for the referenced video/PowerPoint presentation is http://www.aaid.com/author_aids_for_JOI_requirements.

Jonathan R. Brown, PhD, Senior Associate Editor-in-Chief, James L. Rutkowski, DMD, PhD, Editor-in-Chief, *Journal of Oral Implantology*. 2021 January; 47(1):1.

CLINICAL ARTICLE

The Effectiveness of L-PRF in the Treatment of Schneiderian Membrane Large Perforations: Long-Term Follow-Up of a Case Series

The Schneiderian membrane (SM) perforation is the most common complication during the sinus floor augmentation procedure (SFA), with a prevalence rate ranging from 3.6% to 56%. Large perforations (.1.5 cm) may occur because of operator error, thin-membrane manipulation, presence of bone septum or pathologies, and act secondarily to previous surgery. Studies have shown that SM perforations with a range from 2 mm to 1.5 cm can be closed completely without interfering with bone formation or implant success. In this condition, the SM perforation is usually closed by using a collagenous membrane, fibrin adhesive, or oxidized regenerated cellulose and a block graft; however, in some cases of SM large perforations in which the repair does not seem to be sufficiently possible, the procedure needs to be interrupted to avoid graft contamination or migration, which could lead to postoperative sinus infection. Although several techniques have been proposed, no recognized method has

been recommended for repairing SM perforations. In this context, the leukocyte and platelet-rich fibrin (L-PRF) membranes are an alternative in the treatment of SM large perforation. The L-PRF is a fully autogenous material capable of releasing cytokines and growth factors favorable to the patient's healing and immune response. During L-PRF centrifugation, fibrin network polymerization occurs naturally and slowly, which promotes a high-resistance structure that can avoid graft particle migration into the SM. Nonetheless, evidence regarding the use of L-PRF to manage sinus membrane perforations is limited. Therefore, this case series aimed to evaluate the use of L-PRF in the treatment of large SM perforations in 9 clinical cases with 2–5 years of follow-up.

Carolina Mendonça de Almeida Malzoni, DDS, Lélis Gustavo Nı´coli, PhD, Gustavo da Col dos Santos Pinto, PhD, Suzane Cristina Pigossi, PhD, Vinicius Aparecido Zotesso, MsC, Mario Henrique Arruda Verzola, PhD, Cláudio Marcantonio, PhD, Victor Gonçalves, DDS, Daniela Leal Zandim-Barcelos, PhD, Elcio Marcantonio Jr, PhD, *Journal of Oral Implantology*. 2021 January; 47(1):31-35.

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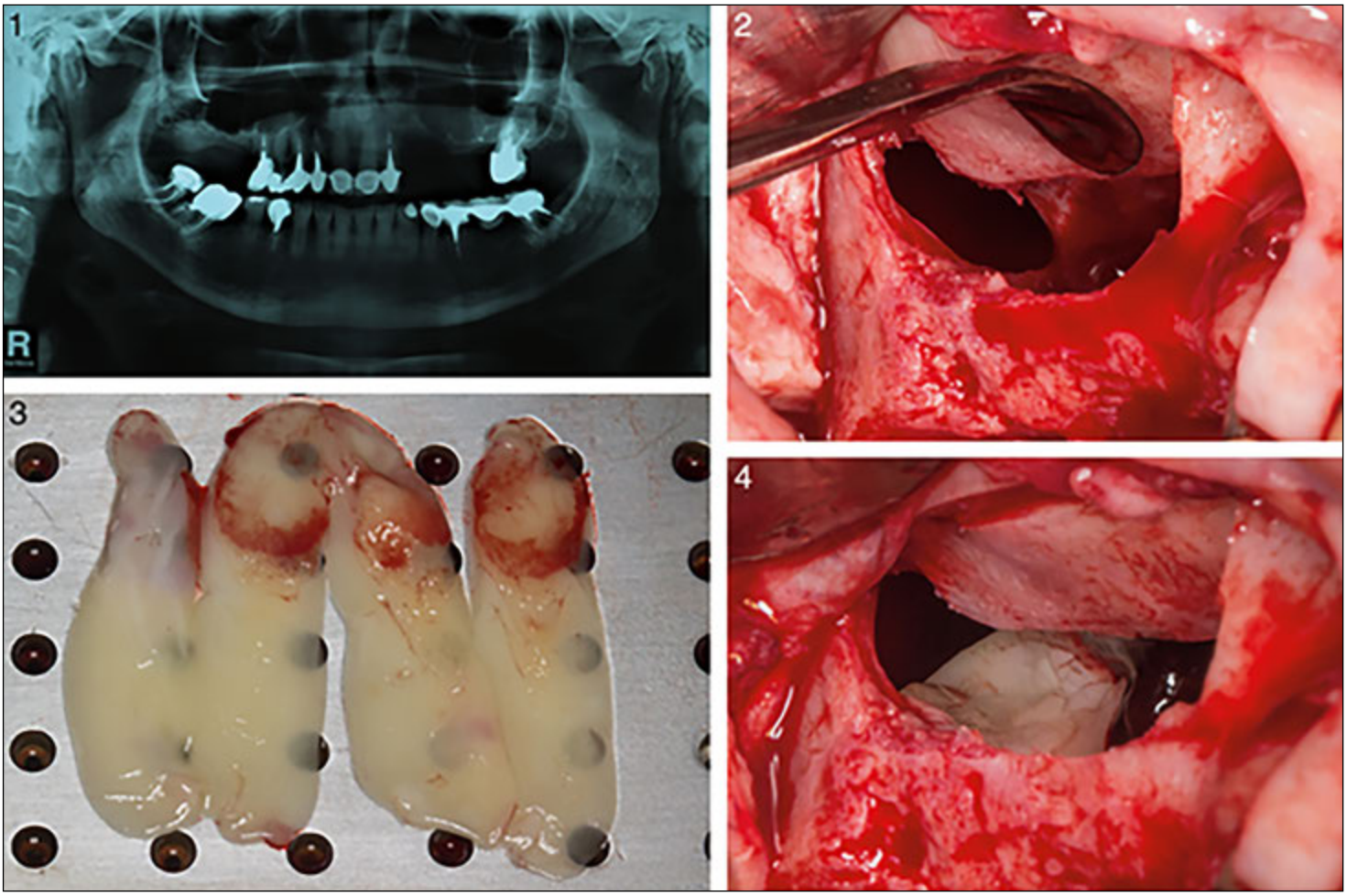

FIGURES 1–4. FIGURE 1. A representative case illustrating the initial panoramic radiograph indicating the need to maxillary sinus floor augmentation for subsequent implant placement in the region (case E). FIGURE 2. The large perforation of the Schneiderian membrane detected during the sinus floor augmentation procedure in the right maxillary side (case E). FIGURE 3. Leukocyte and platelet-rich fibrin (LPRF) membranes obtained by centrifuging the patient's blood tubes (case E). FIGURE 4. Interposition of L-PRF membranes on the Schneiderian membrane perforation (case E).

JOI Sampler

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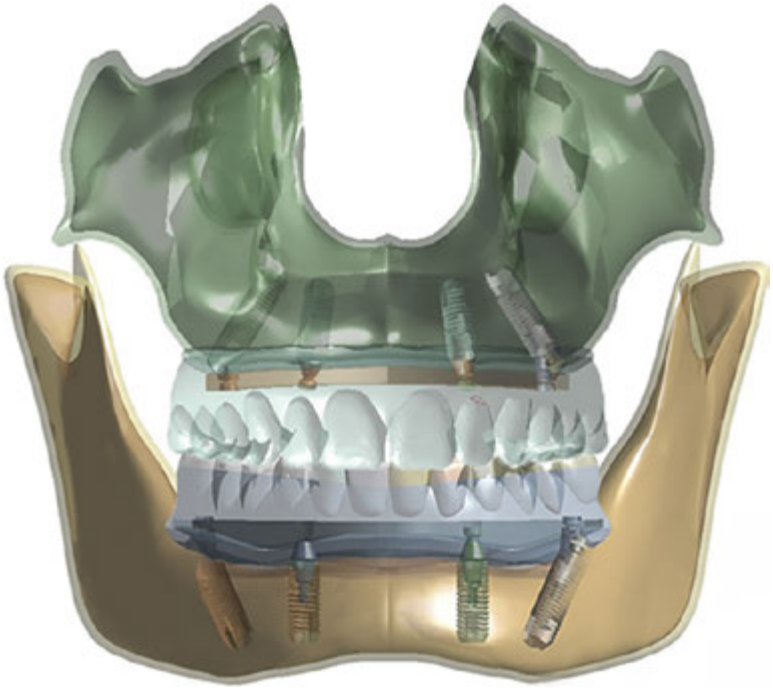
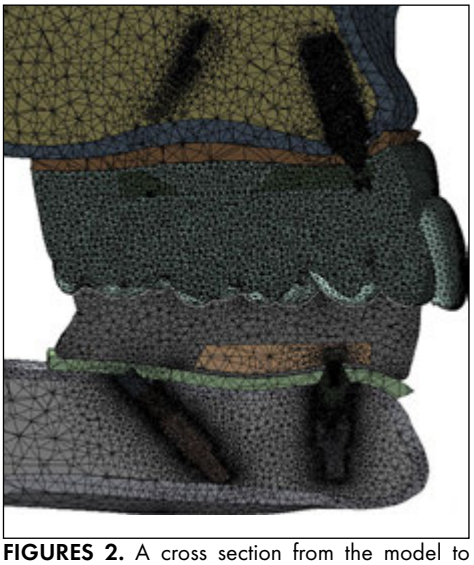
RESEARCH ARTICLE

Effects of Occlusal Scheme on All-on-Four Abutments, Screws, and Prostheses: A Three-Dimensional Finite Element Study

Because of the superior properties of implant applications in achieving aesthetic and functional needs, there has been a burgeoning demand. However, various biological and mechanical problems may arise in implant-supported prostheses. Hyperloading during functioning may cause mechanical complications in the abutments, screws, and prostheses. These complications can be minimized by providing an ideal occlusion that is designed with a sufficient number of implants. However, the type of occlusion to be used in treatment with implants is still not established in the literature. Factors such as deficiencies in bone tissue, the presence of patients in whom complex surgical procedures cannot be performed, the obstacles caused by anatomical formations, and economic reasons have directed clinicians to seek methods performing full-arch fixed prosthetic restorations with fewer implants. Implant tilting suitable for the remaining bone anatomy has been documented by Mattson et al and Krekmanov et al. Malo et al introduced the popular concept called "All-on-Four" that allows immediate function with a complete arch implant-supported fixed prosthetic treatment. In the All-on-Four concept, fixed prosthetic treatment is performed with fewer implants compared with other concepts. Intraoral occlusal loads are transferred to the implants by using fewer abutments and screws, underscoring the importance of distributing occlusal stress equitably in the implant prosthetic design.



FIGURES 1. Maxillary and mandibular models with completed design and assembly.



FIGURES 2. A cross section from the model to which the mesh process is applied.

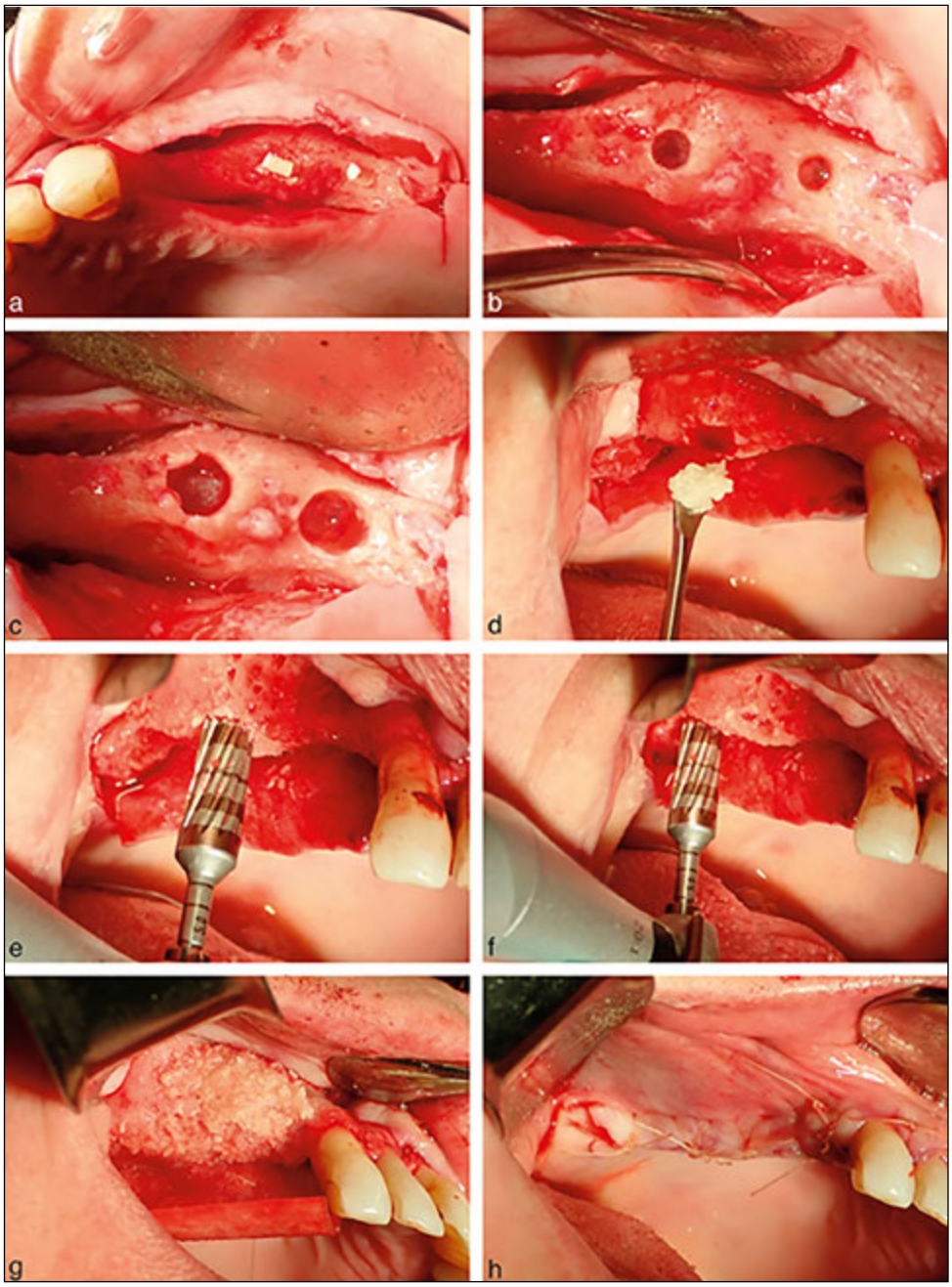
In All-on-Four treatments, it is studied which occlusal scheme is more ideal in terms of the distribution of stresses that will occur in bone tissue. However, there is not any information about which type of occlusion is preferred in the All-on-Four concept to create more ideal stresses in abutments, screws, and prostheses. Thus, the aim of this finite element analysis (FEA) study is the investigation of the different stress distributions on abutments, screws, and prostheses generated by various occlusal schemes, in accordance with the All-on-Four technique on both arches. Three separate models were prepared within the scope of the study: CGO, a model in which the occlusal scheme is prepared according to canine-guided occlusion; GFO, a model in which the occlusal scheme is prepared according to group function occlusion; LO, a model in which the occlusal scheme is prepared according to lingualized occlusion. The methodology of the present study was reviewed by an independent statistician.

Nurullah Türker, DDS, PhD, Hümeyra Tercanlı Alkis, DDS, PhD, Steven J. Sadowsky, DDS, PhD, Ulviye Sebnem Büyükkaplan, DDS, PhD, *Journal of Oral Implantology*. 2021 January; 47(1):18-24.

CASE REPORT

Osseodensified Crestal Sinus Window Augmentation: An Alternative Procedure to the Lateral Window Technique

When assessing a potential future implant site, if the implant does not ''fit'' due to a deficiency of hard or soft tissue, then the clinician and patient must commit to a bone, tissue, or sinus graft to augment that site. The posterior maxilla poses several challenges for the placement of dental implants. Bone and tissue loss from periodontal disease, post-extraction bone atrophy in height and width, pneumatization of the maxillary sinuses, poor bone density, and very high occlusal forces are some factors leading to this difficulty. Bone grafting in the maxillary sinus is the solution to obtain adequate bone volume for implant placement. High-resolution 3D cone-beam computed tomography (CBCT) is the gold standard for imaging and treatment planning dental implants in the maxillary sinus. Multiple factors such as residual bone height (RBH), presence of teeth, size and shape of the sinus, septa, and pathology, must be assessed. The lateral sinus window technique has been the traditional method of choice to augment the sinus in patients presenting with a severely resorbed and atrophied posterior maxilla. The lateral window is the procedure of choice in cases presenting with a larger edentulous region of several teeth, a significant volume of bone grafting required, and a RBH < 5 mm. Implant placement is usually delayed in these cases where the RBH is less than 5 mm. Several of the main disadvantages of the lateral window are the need to raise a large flap, Schneiderian membrane perforation, presence of septa, difficulty in design and preparation of the bony window, thick bony lateral wall, and injury to blood vessels found in the lateral bony wall. The author is proposing a novel transcrestal window sinus lift technique (osseodensification) that bypasses the long established restrictions and disadvantages of transalveolar crestal augmentation.



FIGURES 7. Clinical situation 2: edentulous posterior maxilla with large maxillary sinus and transverse septum compartmentalization. (a) Confirmation of the osteotomy positions (anterior and posterior to the transverse septum) with two gutta percha markers and digital radiograph. (b) Two 3.0-mm osteotomy sites through sinus floor made with Densah bur Ø 3.0. Note intact sinus membrane. (c) Densah bur Ø 5.0 used in osseodensification mode (counterclockwise [CCW]) at 1100 RPM and copious irrigation to advance past the sinus floor in 1 mm increments up to a maximum of 3 mm. (d) Two 5.0-mm osteotomy sites (anterior and posterior positions) through sinus floor with Densah bur Ø 5.0. Note intact sinus membrane. (e) Osteotomy site filled with hydrated mineralized cortical allograft. (f) Densah bur Ø 5.0 used in osseodensification mode (CCW) at low speed (150 RPM) and no irrigation to gently propel the allograft into the sinus up to a maximum of 3 mm past the sinus floor–anterior osteotomy site. (g) Adjunct ridge augmentation graft procedure using mineralized cortical allograft and long-lasting collagen membrane. (h) Primary closure: tension-free 3:0 PGA sutures.

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JOI Sampler

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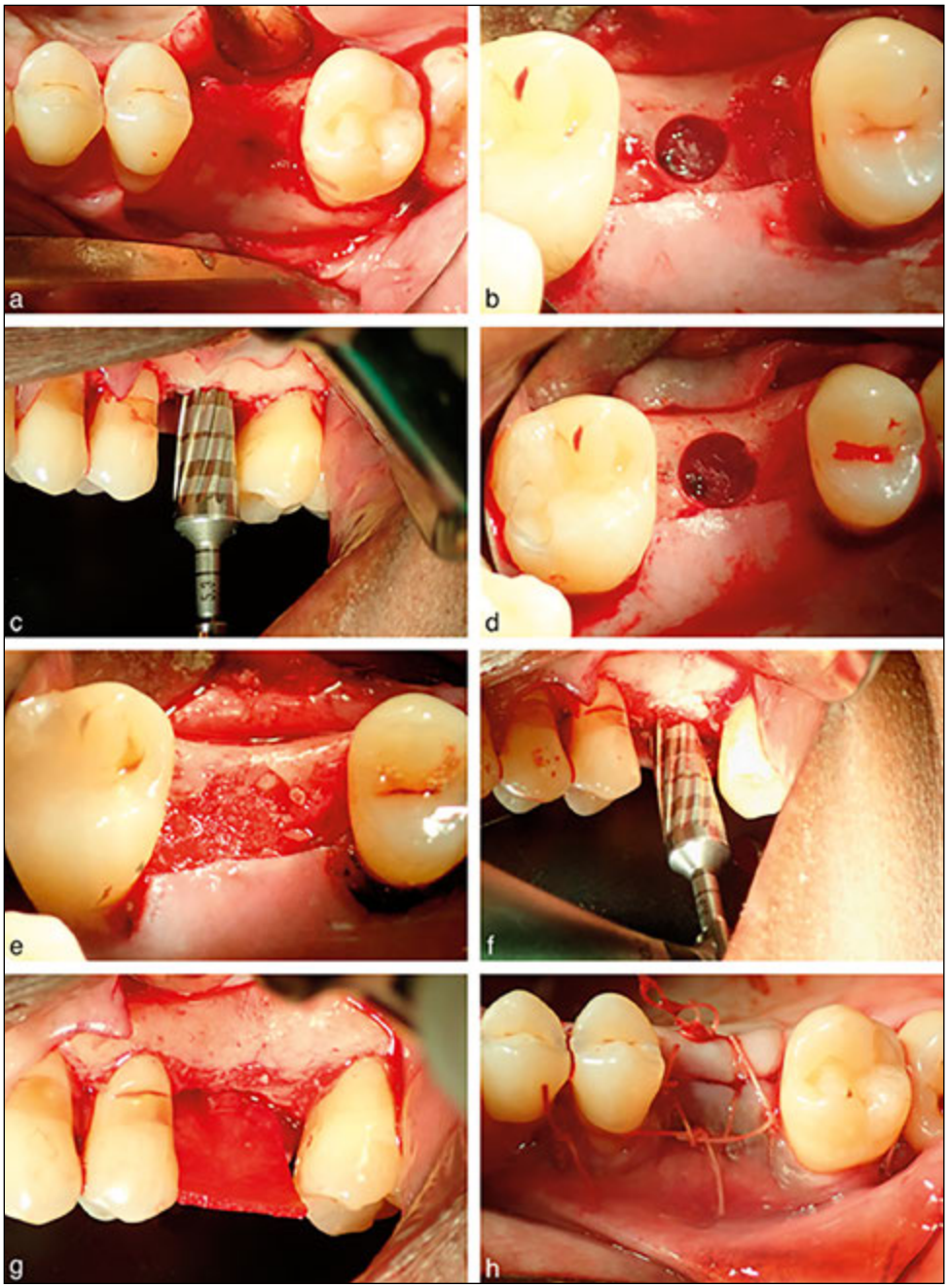
CASE REPORT *(continued)*

The proposed crestal technique is a potentially safe and effective procedure that produces an increase in bone height comparable to that obtained with traditional lateral window procedures. This innovative technique may provide a viable alternative to the rationale for the lateral window approach. Osseodensifying burs are used to densify alveolar bone by rotating in the noncutting counterclockwise (CCW) direction at 800–1200 RPM. Copious amounts of irrigation fluid induce a pressure wave ahead of the bur. This facilitates the autografting of bone particles along the inner surface walls and apex of the osteotomy. This autografting also serves to densify the inner walls of the osteotomy. The sinus floor can thus be penetrated by the CCW nonexcavating bur. The slurry of irrigation fluid and autogenous bone chips creates the gentle hydraulic detachment and elevation of the Schneiderian membrane. The sinus is therefore augmented with a potentially low risk of perforation. This paper presents 3 distinct and difficult clinical situations requiring maxillary sinus augmentation indicated for this procedure having a RBH <1.5 mm:

- Clinical situation 1: edentulous posterior maxilla with large pneumatized maxillary sinus.
- Clinical situation 2: edentulous posterior maxilla with large pneumatized maxillary sinus complicated by transverse septum compartmentalization.
- Clinical situation 3: single missing posterior tooth with severely pneumatized sinus and adjacent roots forming the mesial and distal sinus walls (with a very large and radiographically visible blood vessel present in the lateral wall of the sinus).

Nilesh Salgar, DDS, *Journal of Oral Implantology*. 2021 January; 47(1):45-55.



FIGURES 10. Clinical situation 3: single missing posterior tooth with severely pneumatized sinus and adjacent roots forming the mesial and distal sinus walls. (a) Full-thickness flap. Crestal osteotomy position at the center of the alveolar crest of the missing first maxillary molar. (b) 4.0-mm osteotomy site through sinus floor made with Densah bur Ø 4.0. Note intact sinus membrane. (c) Densah Bur Ø 5.3 used in osseodensification mode (counterclockwise [CCW]) at 1100 RPM and copious irrigation to advance past the sinus floor in 1-mm increments up to a maximum of 3 mm past the sinus floor. (d) 5.3-mm osteotomy site through sinus floor with Densah bur Ø 5.3. Note intact sinus membrane. (e) Osteotomy site filled with hydrated mineralized cortical allograft. (f) Densah Bur Ø 5.3 used in osseodensification mode (CCW) at low speed (150 RPM) and no irrigation to gently propel the allograft into the sinus up to a maximum of 3 mm past the sinus floor. (g) Osteotomy site filled with mineralized cortical allograft. Long-lasting collagen membrane sutured to palatal flap. (h) Primary closure: tension-free 3:0 PGA sutures.

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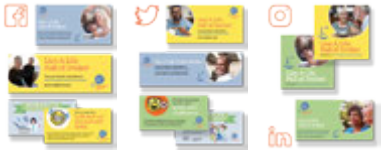

2. Follow *LifeSmiles* accounts on social media and share posts
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Need social media content?

Here are 5 quick ideas:

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4. Share your story and why you became an implant dentist
5. Share a GIF that represents how clients feel after getting implants

Clinical Note

Dennis Flanagan,
DDS, MSc, FAAID, DABOI/ID

HOW WOULD YOU TREAT THIS PATIENT?

When planning for an implant supported prosthesis, it is important to understand that the ultimate bearer of occlusal loading is the bone that contains the implants. This bone can be overloaded and result in a failure.

If this is true, the implant dentist should be aware of the potential load a particular patient would be capable of imparting. This information would give an indication for the supporting implant size and design of the occlusal scheme.

The bite force capability is not the same in any given patient, so the capability of each patient should be measured. Some patients may generate 50 newtons while others may be capable of 300 newtons of load: a six-fold difference. The implant number and size and occlusal scheme of these patients should be different, as well.

Bone quality plays a role here. More dense bone can better resist higher loads. Less dense bone can be densified with bladed burrs or osteotomes to increase supportive qualities (1).

An occlusal scheme that minimizes off axial or lateral forces is appropriate (2).

Masseter thickness is related to bite force capability. The thicker the muscle, the greater the capability (3).

A patient's diet may induce an overload (4). Raw vegetables may cause increased loads on a dental prosthesis and in turn the supporting bone.

A patient with a restored occlusion with implant supported prosthetics can develop an increased bite force capability after approximately one year of function (5). While this increase is not dramatic, it does increase the load on supporting bone. This may cause an increase in bone density, but bone volume may not increase after functional loading (6).

An overload may cause an implant fixture body fracture (PIC). Such a fracture is disappointing for the patient and the dentist, and resolution of this may be costly (7).

Maximum Bite Force Capability

Bite force capability is the only parameter the implant dentist cannot augment or attenuate (8). Bone and gingiva can be augmented, and a prosthesis can be designed to accommodate a variety of oral conditions, but physiologic bite capability cannot be changed.

There are several manufacturers of bite force measuring devices (9). These devices may be used pre-operatively in implant case planning. Manufacturers of bite force measurement devices include TekScan, South Boston, Mass. USA., FU Tech, Ventura, Ca. USA., and Kube Innovation, Montreal, QC, Canada.

Thus, it may be reasonable to preoperatively measure a patient's biting force capability to know beforehand what magnitude of load the supporting bone will be bearing. This allows the dentist to design treatment that may prevent a late failure or a load induced peri-implantitis.

Please email your thoughts about this case to editor@aaid.com. We will be sharing responses.

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Dr. Joe Massad
Dr. Paul Rosen
Dr. Len Tolstunov

GLOBAL PERSPECTIVES
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Dr. Jason Kim
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2022 Slate of Officers

The AAID Nominating Committee, chaired by Bernee Dunson, DDS, FAAID, DABOI/ID, presents the following slate of officers for consideration at the AAID 2021 Annual Business meeting during the Scientific Session, November 10 to 13, 2021.

In accordance with Article IX, Section 7 of AAID's Bylaws, members not nominated by the Nominating Committee may be nominated by petition as follows: "3) Nothing herein contained shall prevent voting members from nominating a candidate provided that the nomination petition is submitted to the chairman of the Nominating Committee or that person's designee at least 30 days in advance of the election at the Annual Meeting for distribution to the voting membership at least 21 days in advance of the election. "4) A nominee not announced by the Nominating Committee must include the signatures of at least 5 percent of the voting membership on the petition. "5) The Committee shall obtain a disclosure statement from each candidate nominated by the Committee or by petition and make this information available to the voting members."

Brian Jackson, DDS, FAAID, DABOI/ID
(Automatic succession from President-Elect)

President-Elect
Shane Samy, DDS,
FAAID, DABOI/ID

Vice President
Edward Kusek,
DMD, FAAID, DABOI/ID

Treasurer
Matthew Young,
DDS, FAAID, DABOI/ID

Secretary
Donald Provenzale, Jr,
DDS, FAAID, DABOI/ID

Meet Donald J. Provenzale Jr., DDS, FAAID, DABOI/ID

Dr. Provenzale joined the AAID in 2000 and has been an Associate Fellow since 2003, an ABOI/ID Diplomate since 2014, and a Fellow since 2015. He received his Bachelor of Science from Benedictine University in 1984 and graduated from Loyola University Dental school in 1988. From 1989 to 1990, he completed a residency in anesthesiology at the Advocate Illinois Masonic Medical Center and a Diplomate on the National Board of Anesthesiology.

Dr. Provenzale has been involved in all ranks of the Central District Officers since 2014 and is currently a member of the Board of Trustees. He has participated on the Legal Oversight Committee and is a *JOI* Reviewer.

Dr. Provenzale practices dentistry in Downers Grove, IL and Phoenix, AZ. His volunteer activities include St. Basil's Free Clinic in Chicago, the Illinois Foundation for the Handicapped, Donated Dental Services, and the Legal Aid Society in DuPage County, IL. He plays trumpet and ice hockey.

Joe Weiss, Advocacy and Governance Specialist, is a recent addition to the AAID staff. He will be monitoring all specialty recognition and advertising issues for AAID members. If you have any questions about how you can advertise your dental services or if you can advertise as a specialist in your state, contact Joe Weiss at *joseph@aaid.com* or 312-625-3705.

The AAID Foundation Seeking Donations for 2021 Silent Auction

For decades, AAID members, exhibitors, and sponsors have supported the AAID Foundation's mission of furthering the science of oral implantology and the delivery of implant care through the Foundation's charitable efforts.

The biggest fundraiser of the year is quickly approaching! The AAID Foundation Board is preparing for the 2021 Silent Auction, which will be held in conjunction with the AAID's Annual Conference at the Hyatt Regency Chicago, November 10 to 13, 2021.

Generous donations to this auction have assisted the Foundation in raising more than $1,000,000 to support research grants and student scholarships, as well as the AAID's Wish-A-Smile and *Smile*, Veteran!™ programs.

Now is the time to donate an educational program, MaxiCourse®, implant materials, instruments, vacation packages, tickets to major sporting events, and more.

To donate, email *foundation@aaid.com* with the subject line "Auction" or call 312-210-8703 with questions. The Foundation will accept donations until October 1, 2021.

Thank You 2020 Committee Members

The AAID would like to thank all our members who have volunteered their time by serving on a committee to better the organization. The following members completed their service in 2020.

Admissions & Credentials Board
Dr. Carlos Alfonso
Dr. Cheryl Pearson

Annual Conference Education
Ms. Karima Bapoo-Mohamed
Dr. Bart Silverman
Dr. John Minichetti

Dr. Rodrigo Neiva
Dr. Andrew Kelly
Dr. Michael Sonick

Education Oversight
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Dr. Joe Orrico

Ethics
Dr. Hamilton Sporborg
Dr. David Hochberg

Honored Fellow
Dr. Joel Rosenlicht

Legal Oversight
Dr. Brian Jackson

Membership
Dr. Danny Domingue
Dr. Hank Long

Nominating
Dr. Duke Heller
Dr. John Minichetti

Advertising Guidance for ABOI/ID Diplomates in Ohio

In 2018, the Ohio Dental Board enacted a rule that limits the recognition and advertising of dental specialties to those recognized by the American Dental Association and the National Commission on Recognition of Dental Specialties and Certifying Boards. The AAID challenged this rule because it violated our Credentialed members' First Amendment rights to be recognized as dental implant specialists. The AAID argued that the ABOI/ID Diplomate credential represents extensive training and education in the implant dentistry field, and that Diplomates are dental implant specialists through recognition from the American Board of Dental Specialties.

Following a lengthy legal process, we are now encouraging all ABOI/ID Diplomates in Ohio to advertise themselves as dental implant specialists. ABOI Diplomates in Ohio should use the language "Specialist in implant dentistry, recognized by the American Board of Dental Specialties" when advertising their services.

The AAID implores all Diplomates in Ohio to advertise themselves as dental implant specialists because it provides the patient with easy-to-understand information about why they should go to an ABOI/ID Diplomate for dental implant procedures. If you have any questions about advertising as a dental implant specialist in Ohio or your state, please contact Joe Weiss, Advocacy & Governance Specialist, at *joseph@aaid.com*.

The AAID Turns 70!

This year, the American Academy of Implant Dentistry (AAID) celebrates 70 years. As members, you are part of a legacy that connects the origins of dental implants to modern day.

While serving as a dentist in the Army during World War II, Dr. Norman Goldberg noticed that metal was used to repair or replace various parts of the anatomy. He wondered if that might offer a solution for those who were edentulous. After returning to private practice, he began developing prototypes and shared this idea with Dr. Aaron Gershkoff. This began a collaboration that, after months of developing and refining their ideas, produced the first successful sub-periosteal implant in 1948 and established the foundation of implant dentistry.

In 1949, Drs. Goldberg and Gershkoff wrote an article published in *Dental Digest* which explained their research and their success. In 1957, they wrote the first textbook on implant dentistry.

In 1951, a group of 13 professionals met in St. Louis to draft the charter for the American Academy of Implant Dentures (now the AAID). The charter was signed by Dr. Norman Goldberg, Dr. Aaron Gershkoff, Dr. Bert Spate, Dr. William Purcell, Dr. Frank Strake, Dr. Phillip Loechler, Dr. William Sone, Dr. Meyer Yallowitz, Dr. Wayne Paullus, Dr. Marshall Mueller, and honorary members Eric Bausch, William Soller, and John Kennedy. Dr. Goldberg became the first AAID president, serving two terms, followed by Dr. Gershkoff.

These pioneers were instrumental in the early development of dental implants. Those who followed them helped define the standard for replacing missing teeth.

Implant dentistry has evolved both formally and informally. Whether you have earned your credential or have attained Diplomate status from the American Board of Oral Implantology/Implant Dentistry, your implant practice would not exist today but for the perseverance of those to share and fight for the acceptance of implant dentistry.

It is impossible to name all the those who, during the last 70 years, have been instrumental in turning implant dentistry to the accepted standard for missing teeth.

A timeline outlining some of the milestones achieved by the AAID since its official incorporation in 1952 follows.

1950–1959

Dr. Norman Goldberg

1951 - Organization Charter

1952 - American Academy of Implant Dentures incorporated in Minnesota with 10 members

1952 - Norman A. Goldberg elected first president

1954 - Volume 1, No. 1, of the *Journal of Implant Dentistry* published

1954 - Requirements for Membership Examination established

1954 - Emory University Dental School sponsored the first course on implant dentures to be given at a US dental school

1957 - Membership reached 100

Dr. Aaron Gershkoff








1960–1969

1960 - American Dental Association (ADA) gave approval to the subperiosteal mandibular implant

1964 - The name of the *Journal of Implant Dentistry* changed to the *Journal of Oral Implant and Transplant Surgery*

1966 - The *Journal of Prosthetic Dentistry* designated as the official journal of the AAID

1966 - Organization renamed to American Academy of Implant Dentistry (AAID)

1969 - American Board of Oral Implantology/Implant Dentistry (ABOI/ID) founded

1969 - AAID submitted first application to ADA for specialty recognition of oral implantology/ implant dentistry

1970–1979

1970 - AAID formed four regions: Southern, Northeastern, Midwestern and Western

1971 - Brookdale Dental Center of New York University and Brookdale Hospital Medical Center began offering the first two-year Fellowship program in oral implantology

1971 - *Oral Implantology Quarterly* named official AAID journal

1972 - Dr. Aaron Gershkoff, AAID founding member, and his wife, Ruth, died in a plane crash on route to Australia

1973 - Aaron Gershkoff Award announced

1974 - AAID Research Foundation established

1976 - AAID held conference on "Status of Human Oral Implants"

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AAID CELEBRATES 70 YEARS








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1980–1989

1982 - At the urging of the AAID, ADA adds implants to list of recognized dental procedures and insurance coding was approved

1985 - *Journal of Oral Implantology* named official publication of AAID

1986 - AAID submitted second application to ADA for specialty recognition of oral implantology/implant dentistry

1987 - MaxiCourse® program for implant education launched with Georgia MaxiCourse®

1987 - AAID submitted third application to ADA for specialty recognition of oral implantology/implant dentistry

1988 - Isaiah Lew Memorial Research Award announced

1990–1999

1992 - AAID hired its first full-time executive director and opened office in the ADA Building in Chicago

1990 - U.S. Supreme Court issued "Peel" decision, ruling attorneys have right to announce specialty even if not recognized by their local legal society. Opened door for AAID to pursue legal strategy to challenge restrictions on announcing implant dentistry credentials.

1990 - *AAID Newsletter* launched

1990 - First examinations for Diplomate status conducted by ABOI/ID

1992 - AAID developed a legal strategy to gain recognition for AAID/ABOI credentials

1992 - Submitted fourth application to ADA for specialty recognition of oral implantology/implant dentistry

1995 - Submitted fifth application to ADA for specialty recognition of oral implantology/implant dentistry

1996 - AAID filed suit in Florida to enjoin state from enforcement of law to prohibit dentists from advertising membership and credentials earned from accrediting organization

1999 - AAID filed first lawsuit in California to overturn law that prohibits dentists from advertising AAID and ABOI/ID credentials

2000–2009

2001 - *Journal of Oral Implantology* expanded to six issues per year

2002 - U.S. Supreme Court denied AAID petition to review Florida court decision that upheld disclaimer language for implant practitioners

2002 - Membership reached 2,400

2002 - AAID files suit in California to allow AAID and ABOI credentialed dentists to advertise their implant credentials

2004 - AAID approved first International MaxiCourse® in India

2004 - AAID adopted the current logo/brand identity

2010–2020

2010 - AAID won victory in Florida when court ruled restrictions on advertising of bona fide credentials to be unconstitutional.

2011 - U.S. Court of Appeals (9th Circuit) upheld AAID's victory in California confirming restrictions on advertising bona fide credentials to be unconstitutional

2012 - Paul Johnson Volunteer Award established. Dr. Johnson and his wife perished in a private plane crash

2013 - AAID launched first patient-focused website: www.aaid-implant.org

2013 - Aaron Gershkoff Memorial Award changed to the Aaron Gershkoff/Norman Goldberg Memorial Award

2013 - AAID Research Foundation removed Research to become AAID Foundation

2015 - *AAID News* launched as the successor to the *AAID Newsletter*

2016 - Terry Reynolds Trailblazer Award established

2016 - AAID Podcast launched

2017 - U.S. Court of Appeals (5th District) upheld AAID victory in Texas eliminating the ADA as the named designator of dental specialties. AAID awarded $270,000 to cover part of costs

2018 - The Amerian Board of Dental Specialties recognized as a specialty body in the state of Iowa, allowing implant dentists to be recognized as specialists in that state

AAID CELEBRATES 70 YEARS

newmembers

The AAID is pleased to welcome the following new members who joined between April 6, 2021, and June 24, 2021. The list is organized by state, with the new member's city included. International members are listed by country, province (if applicable), and city. If you joined the AAID recently and your name does not appear below, it will be listed in the next issue of *AAID News*.

PLEASE WELCOME THESE NEW MEMBERS IN YOUR AREA.

Arizona
Andrew Noble, Sierra Vista

California
Nima Afsari, Moraga
Garrick Denny, San Pedro
Karen Khachatryan, Los Angeles
Desmond Ng, San Francisco
Roberto Savignano, Loma Linda
Charles Smurthwaite, Rocklin

Colorado
Omeed Alkhalidi, Denver
Robert Bull, Colorado Springs

Florida
Akmal Ahmed, Lake Mary
Lauren Alfred, North Miami
Nehal Ali, Weston
Jeffrey Allen, Merritt Island
Joseph Alvarez, Estero
Brenton Assing, Lithia
Vibhor Biker, Coconut Creek
Keya Brown, Cape Coral
Nicholas Castellanos, Miami
Cornelia Dadaciu, Bradenton
Paula De Oliveira, Bonita Springs
Aaron Delgado, Estero
Annie Diaz, Cape Coral
Kim Doan, Jacksonville
Ivonne Duarte, Doral
Jordan Eckardt, Miami
Yelisbet Fernandez, Coral Gables
Luz Natalia Franco, Tamarac
Flavio Fuentes Falcon, Miami Gardens
Alexandre Gaeta, Palm Beach Gardens
Rogelio Garrote, Miami
Juana Geldres, Palm Beach Gardens
Andre Gonzalez, Coral Gables
Jovani Gonzalez, West Palm Beach
Alberto Graupera, Hialeah
Mariano Gutierrez, Hialeah
Rosa Hernandez, Sarasota
Daniel Izaguirre, Cape Coral
Alexander Jelicich, Miami
Chris Keane, Southwest Ranches
Rafael Llanes, Hialeah
Flor Luzardo, Miami
Alejandro Martinez, Indialantic
Yamila Noriega-Abreu, Sarasota
Ricardo Perales, Fort Myers
Annelise Perez, Fort Myers
Reinaldo Perez, Miami Lakes
Sahar Rafiq, Naples
Carlos Rodriguez, Orlando
Luis Rodriguez, Gainesville
Emilio Rodriguez Acosta, Fort Myers
Elizabeth Santiago Torres, Saint Cloud
Ali Ahamed Shaik, Tallahassee
Paola Soto, Miami
Dylan Tagg, Naples
Huy Tran, Viera
Rodolfo Trigueros, Miami
Timothy Turner, Sebring
Jason Vanman, Saint Petersburg
Thomas Veronee, Lake Placid
Lesly Viera, Pembroke Pines
Sandra Wasif, Oviedo
Mohamed Youssef, Davie

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Thomas Angerame, Palatine
Katarzyna Zelichowski, Roselle

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Xena Alakailly, Troy

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David Borata, Brooklyn

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Hal Jeter, South Point

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Barrett Hall, Tecumseh
Daniel Morris, Tecumseh
Daniel Taw, Edmond

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Levi Evalt, Corry
Spencer Grossman, Souderton
Adam Kaminski, West Chester

Texas
Juan Echeverri, Houston
Jennifer Hamorsky, Carrollton

Utah
Bradley Rigby, West Jordan

Washington
Randal Ellis, Bellingham

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IN MEMORIAM

Beverly Dunn, DDS

Beverly Dunn, DDS, passed away Sunday morning, June 6, 2021, in West Palm Beach, Florida at the age of 78 from pulmonary fibrosis.

Dr. Dunn was an Associate Fellow since 1993, a Fellow since 1997, an Honored Fellow since 2004 and Life Member since 2013. He served as AAID President in 2009 as well as many other committee positions, including Bylaws, Nominating Committee, Education Oversight Committee, Public Relations Committee and the Ethics Committee. He served as the AAID Historian for the 60th Anniversary.

Dr. Dunn graduated from the University of Maryland Dental School in 1968. He joined the AAID after taking a course with Dr. Carl Misch. He was drawn by how members of the academy welcomed him with kindness and their willingness to share their knowledge. During his presidency, he was concerned with credentialing and membership involvement.

New Members

continued from page 32

CANADA

Alberta
Eric Tang, Calgary

Ontario
Joseph Adragna, Vaughan
Shane Bot, Barrie
Priyanka Choudhary, Toronto
Adela Coku, Toronto
Niromi Fernando, Burlington
Raghed Hamami, Burlington
Neda Hbibnia, Newmarket
Tarlan Khorram-Nezhad, Innisfil
Jaeseung Kim, Mississauga
Olga Makhanova, Newmarket
Sara Mathew, Brampton
Michelle Mundy, Stoney Creek
Greg Pigeon, Pembroke
Jacklyn Pivovarov, Belleville
Ankur Rampal, Mississauga
Awais Saleem, Mississauga
Natt Shahbaaz, Springwater
Ryan Siciliano, Oshawa
Jeet Toor, Mississauga
Kenneth Urquhart, Toronto

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Hemanshu Mehta
Amitkumar Benjamin

Korea
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Website: www.bostonmaxicourse.com
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Assistant Director: Shankar Iyer, DDS, MDS, FAAID, DABOI/ID
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Phone: 905-235-1006
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Vancouver AAID MaxiCourse®
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Phone: 604-330-9933
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Phone: 404-897-1699
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AAID Active Study Clubs*

United States

AAID Bergen County Dental Implant Study Group
Location: Englewood, NJ
Director: John Minichetti, DMD
Contact: Lisa McCabe
Phone: 201-926-0619
Email: lisapmccabe@gmail.com
Website: https://bit.ly/2rwf9hc

Acadiana Southern Society
Location: Lafayette, LA
Director: Danny Domingue, DDS
Phone: 337-243-0114
Email: danny@jeromesmithdds.com
Website: www.acadianasouthernsociety.com/upcoming-meetings.html

Alabama Implant Study Club
Location: Brentwood, TN
President: Michael Dagostino, DDS
Contact: Sonia Smithson, DDS
Phone: (615) 337-0008
Email: aisgadmin@comcast.net
Website: www.alabamaimplant.org

Bay Area Implant Synergy Study Group
Location: San Francisco, CA
Director: Matthew Young, DDS
Phone: 415-392-8611
Email: young.mattdds@gmail.com
Website: http://youngdentalsf.com

Calderon Institute Study Club
Location: Queens, NY /Oceanside, NY
Director: Mike E. Calderón, DDS
Contact: Andrianna Acosta
Phone: 631-328-5050
Email: calderoninstitute@gmail.com
Website: www.calderoninstitute.com

CNY Implant Study Club
Location: 2534 Genesee street. Utica, NY
Director: Brian J Jackson, DDS
Contact: Tatyana Lyubezhanina, Judy Hathaway
Phone: (315) 724-5141
Email: bjjddsimplant@aol.com
Website: www.brianjjacksondds.com

Hawaii Dental Implant Study Club
Location: Honolulu, HI
Director: Michael Nishime, DDS
Contact: Kendra Wong
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Email: mnishimedds@gmail.com
Website: www.honoluludentaloffice.com

Hughes Dental Implant Institute and Study Club
Location: Sterling, VA
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Contact: Victoria Artola
Phone: 703-444-1152
Email: dentalimplant201@gmail.com
Website: http://www.erhughesdds.com/

Implant Study Club of North Carolina
Location: Clemmons, NC
Director: Andrew Kelly, DDS
Contact: Shirley Kelly
Phone: 336-414-3910
Email: shirley@dentalofficesolutions.com
Website: www.dentalofficsolutions.com

Mid-Florida Implant Study Group
Location: Orlando, FL
Director: Rajiv Patel, BDS, MDS
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Email: drpatel@delandimplants.com
Website: http://www.delandimplants.com/

SMILE USA® Center for Educational Excellence Study Club
Location: Elizabeth, NJ
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Email: dentalimplant201@gmail.com
Website: http://malosmileusaelizabeth.com

Canada

Vancouver Implant Continuum
Location: Surrey, BC, Canada
Director: William Liang, DMD
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Email: andrew@implant.ca
Website: www.implant.ca

International

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Email: hotta-dc@ff.iij4u.or.jp
Website: www.hotta-dc.com

Beirut AAID Study Club
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Phone: 961-174-7650
Email: beirutidc@hotmail.com
Website: http://www.beirutidc.com

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Website: http://www.implanteducation.net/

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Phone: 315-922-2176
Email: education@bostonmaxicourse.com
Website: http://eastcoastimplantinst.com/upcoming-courses/

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Email: learn@pikosInstitute.com
Website: www.pikosinstitute.com/programs-and-courses/coursecontinuum-overview/

Stanley Institute for Comprehensive Dentistry
Dr. Robert Stanley
Contact: Megan Carr, Interim Director of Continuing Education
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Email: megan@stanleyinstitute.com
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Dr. Ron Zokol
Contacts: Barbara Cox and Dr. Faraj Edher
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faraj.edher@ddidental.com
Website: www.ddidental.com

Toronto Implant Academy
Dr. Emil LA Svoboda
Taming The Old Dragons of Implant Prosthetics-3 Part Virtual Webinar Series
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Email: www.reversemargin.com
Link for AAID Group: https://www.reversemargin.com/aaid_guest_ access/
Password: AAID20

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***References:** Accuracy of Edentulous Computer-Aided Implant Surgery as Compared to Virtual Planning: A Retrospective Multicenter Study; R. Vinci, M. Manacorda, R. Abundo, A. G. Lucchina, A. Scarano, C. Crocetta, L. Lo Muzio, E. F. Gherlone, F. Mastrangelo; J Clin Med. 2020 Mar 12;9(3):774. doi: 10.3390/jcm9030774 // Clinical Factors Affecting the Accuracy of Guided Implant Surgery - A Systematic Review and Meta-analysis; Wenjuan Zhou, Zhonghao Liu, Liansheng Song, Chia-Ling Kuo, David M Shafer; pubmed.gov; Epub 2017 Jul 22

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