UPCOMING COURSES AND EVENTS

JANUARY 14, 2020
Monthly Meeting
Dr. Hal Stewart

JANUARY 17, 2020
OSHA/HIPAA Update
Dr. Dale Martin

FEBRUARY 11, 2020
TDA President Update
Dr. Charles Miller

Register online @ www.fwdds.org
ON THE CALENDAR

2020

SCHEDULE OF EVENTS & MEETINGS

January 14, 2020 Monthly Meeting
Dr. Hal Stewart

January 17, 2020 OSHA/HIPAA Update
Dr. Dale Martin

February 11, 2020 TDA President Update
Dr. Charles Miller

March 10, 2020 Monthly Meeting
Dr. Farhad Boltchi

April 10, 2020 Full Day CE Program
Dr. Bill Robbins

April 14, 2020 Monthly Meeting
Dr. Glenn Vo

May 29, 2020 Installation of Officers 2020 – 2021
Colonial Country Club

October 9, 2020 Annual Clay Shoot
Defender Outdoors Clay Ranch

November 10, 2020 Monthly Meeting
Dr. Jacqueline Plemons
(this is a required course for writing Schedule II prescriptions)

WELCOME NEW MEMBERS!

Dr. Uma Potluri
Dr. Yamini Gollapudi
Dr. McKay Sallaway
Dr. Chau Truong
Dr. Kiran Napa
Dr. Miguel Martinez
Dr. So Chung

Dr. Latonia Smith

Welcome to FWDDS!
We are thrilled to have you as new members. Please join us at our next monthly dinner meeting.

Calendar of ADA and TDA Opportunities

2020
May 7-9
TDA Meeting
Boy, I love it when something actually works like it’s supposed to and when I find something that does work, it’s hard to get me to change. A few months ago I talked about new techniques and materials that I learned from our CE speakers that actually work, and work well, in my practice. So today I thought I’d write about another technique that I recently tried, one that’s been popular in the UK, but is gaining traction here in the states. I might be the only dentist that hasn’t been doing it (I am still using copper bands, but that’s another story), but it worked so well, I thought I’d spread the word.

We’ve all had those patients that come in with severe erosion and wear on the lingual of their maxillary anterior teeth, often at a young age. Sometimes the lingual enamel is completely gone, the wear and erosion deep into the dentin, leaving a thin shell of facial enamel. Often the bite has collapsed, making these difficult cases to treat. We know we need to cover and protect the dentin, but there is just no space. Do we reduce the lower incisal edges to gain space to restore the uppers? Do we intrude the anterior teeth, or extrude the posterior teeth with ortho to gain space? Expand the arch? Do we open the bite with a full mouth reconstruction? And when we find the space, do we want to crown 6 anterior teeth, knowing any facial reduction will only leave us less tooth structure on already compromised teeth? Do we place lingual incisal veneers before we know if all the problems that contributed to the erosion are controlled? Like I said, for me, these are difficult cases.

A lot of us have heard of, or used Dahl appliances. They’ve been around for over 30 years. Basically, they are splints that have occlusal contacts with only part of the opposing arch. They can be removable or cemented. For instance, an upper dahl appliance can be made that only contacts the lower anterior teeth, leaving the posterior teeth out of occlusion. This allows the posterior teeth to super-erupt, or the anterior teeth to intrude. After a period of time, the posterior teeth will be in occlusion with the splint in. When it is removed, space has been created in the anterior. That’s what we’re looking for.

Space! Perfect. Wonderful. Fantastic. Except, compliance with a removable appliance and a college student might not always be perfect or wonderful. Removal of a cemented appliance on already thin, weakened teeth might not be fantastic. But now, with improvement in our direct bonding techniques and materials, the Dahl appliances are evolving into the Dahl Concept or Dahl Technique. Let me describe a case.

A 21 year old male patient comes in with severe erosion on the lingual of teeth #6-11. He had severe wear and chipping of the incisal edges of teeth #6-11 and #22-27 resulting in a loss of tooth height and loss of anterior guidance. He was beginning to get wear and erosion of the posterior teeth. The anterior bite had collapsed, so he had occlusal contacts on all teeth.

We explored the possible reasons for the severe erosion, and tried to address those factors. Because of his age, and the uncertainty on whether all the factors involved in the erosion had been completely eliminated, we decided to go with direct bonded restorations to treat the upper and lower anterior. We would replace the lost lingual of the uppers, and the lost incisal length to regain anterior guidance. But we needed space. The patient had an orthodontic consult about gaining space in the anterior. Eventually, we decided to bond his anterior teeth first using the Dahl Technique to open his bite, “trusting” that the posterior teeth would erupt into occlusion over time. If the posterior teeth didn’t come into occlusion, we knew that orthodontics could be done later to erupt them. (OK, I’m more like a “trusting skeptic” who likes to cover his bases).

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So, we bonded his upper anteriors one morning, and brought him back to bond the lower incisal edges that afternoon. We regained length mainly on the uppers. Because we had to anesthetize his uppers and not his lowers, this allowed us to fine tune his occlusion in the afternoon with feedback for him on how his bite felt. When he left that afternoon, none of his posterior teeth were in occlusion.

I’ve included 3 sets of photos. The first set are pre-operative pictures. The second set of photos are immediately post-op, showing the direct bonded restorations and the opened posterior bite. The third set of photos were taken seven weeks post-op. Seven weeks, and the right side posterior teeth were completely in occlusion. On the left side, half the teeth had strong occlusal stops, and half the teeth just had light occlusal stops. To say that I was pleasantly surprised would be an understatement.

A few points to consider. When you add to the lingual of the upper anteriors, you want to make sure you don’t distalize the condyles.

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I built “cingulum stops” into the lingual bondings to keep the occlusal forces through the axial of the teeth. We saw our patient every few weeks to remove any lingual interferences, to make sure no interproximal contacts were opening up, and to make sure his joints were happy. Was I worried about his joints- Yes, but I actually feel his joints are more stable now. He had a slight centric relation/centric occlusion discrepancy pre-op, but the lingual bonds acted almost like a deprogrammer. We adjusted the bonds to CR=CO, and it remained that way as the posterior teeth erupted and we adjusted interferences. Was I worried about him being able to eat? Definitely. But the patient had no complaints about eating, even the first few days afterward. I had read that some cases take 6 months to a year to come into occlusion, and that is what we had the patient prepared for. So seven weeks was a great surprise. I’m sure the patient’s age was a factor, and for once the dental gods were kind to me. I’m not complaining.

I love the fact that this was so conservative and was mainly an additive procedure. And my patient and his family were thrilled with the results. They understand that no restoration lasts forever. In fact, some dentists will call these “interim” restorations, and plan on the definitive restorations after all the contributing factors to the erosion have been reduced or eliminated. But I’m much more confident of the life of these restorations because of improvements in our bonding techniques and materials- micro abrading to improve dentin bond strength, warming composites to improve flow, wetting agents to improve contouring and adapting the composite to the margins. So if anything about this technique interests you, let us know and the FWDDS CE committee will try to bring in a speaker to present a course on the Dahl Technique.

We’ve already got two world class speakers coming next year that will touch on related subjects. On January 14th at our monthly meeting, Dr. Hal Steward will present an hour and a half course that you don’t want to miss. Dr. Steward has integrated airway, joints, occlusion, and conservative dentistry to get a stable system for our patients. He will show how TMJ rehabilitation cases can be built up entirely in composite, which is fantastic in itself. He will also discuss how doing this supports the joints and airway, and how they’re all interconnected. He’s been through all the occlusion, sleep apnea, TMJ and esthetic courses, and he relates and connects them in a way that really makes sense.

On April 10th, Dr. Bill Robbins will come for our full day CE, presenting his “Global Diagnosis” course. How do you treat the esthetic patient who presents with short teeth and excessive gingival display? Are the teeth short because they are worn, or is the gingiva in the wrong place? Is the gingival display because the lip is too short, or is it hyperactive. Have the teeth extruded bringing the tissue and bone with them, or does the tissue show because the middle third of the face is out of proportion? Do we intrude or extrude the teeth? Do we remove gum tissue, gum tissue with bone, or add gum tissue. Is this an ortho case, or an orthognathic surgery case? Botox anyone? I’ve been to many esthetic courses over the years, but Dr. Robbins is the best at giving you a simple, organized system to diagnose these complex esthetic cases. You’ll find his esthetic evaluation worksheet an invaluable aid that you can apply your first day back in the office.

So put both of those dates on your calendar, and look over the other excellent courses we have lined up for 2020. Hope to see you there, and have a great holiday season.

Don’t miss out on new patients!
Update your NEW ADA Find-A-Dentist® profile.

The new Find-A-Dentist tool makes it easier than ever for patients to find you. Take 5 minutes to update your profile with the information patients look for most:

- ✔ Photo
- ✔ Business address
- ✔ Office hours
- ✔ Practice email
- ✔ Payment options
- ✔ Insurance types
- ✔ Languages spoken

To update your profile and access resources to help promote your practice, visit ADA.org/findadentist
What It’s Like To Be “That Mom”

By Dr. Elizabeth Laborde

Many of us who treat a pediatric population know that relationships and communication with our patients’ caregivers is essential. One can imagine that this translates to those who take care of elderly parents or serve as caregivers in any respect. Also, in the digital age of review culture on social media platforms the pressure is greater than ever for these relationships to remain positive. That pressure can create fear, which can evolve into an oppositional relationship with a caregiver who is perceived as an unhappy “helicopter mom” over-protective, seemingly demanding individual.

I distinctly remember our pediatrician visit almost 3.5 years ago with my then 5-month-old twin boys. They were ex-preemies and as it goes with preemies, we had a lot of doctor visits to check their growth and development. I was there alone with my children, and the doctor was running 40 minutes late. I was overwhelmed in that tiny room as I waited. I was afraid the boys would get upset, that we would run into a feeding time and I wasn’t prepared. I rarely slept. I was back at work nearly full-time, which was like a vacation compared to my job at home. At least I knew how to be a dentist. At the time I had a nanny who barely helped me, came only while I worked, let the boys stay in rock and plays all day, and watched TV. She didn’t even wash bottles, let alone help me around the house. I felt guilty that I wanted more help from her because I thought I should be able to handle it. My husband helped me as much as he could, but he often had to work late. At the time he was a new practice owner and he was trying his best to support us. I was often alone with my little babies in the evening, and my poor boys would cry from 6-9 pm every night. I would put one in the baby carrier and hold the other one in my arms to try and walk around to soothe them. I was barely surviving.

After our wait at our doctor appointment that day my boys were weighed and measured and assessed for milestones. I waited anxiously to see how their stats translated to where they stood on the growth curve, and the nurse accidentally dropped my son’s receiving blanket on the ground. She retrieved it and started covering my son with it again. “Well he can’t have it NOW!” I snapped angrily. Startled, the sweet nurse apologized, and I felt my throat tighten. In that one exchange was everything that was unseen, and even though it was

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a verbal communication, it didn’t convey the underlying issue. The rest of the visit went on as usual, and we left.

We have plentiful metrics to assess a child’s progress, yet until we see the mother-child or parent-child dyad as critical to pediatric health and wellness we limit our ability to be of service to our patients. I absolutely believe it is essential to compassionately assess the primary caregiver’s well-being. Kind questions like “are you sleeping?” or “do you ever get a break? even “what kind of support do you have?” I think it’s even better if you feel comfortable connecting a parent in need to resources. These can be a simple as Facebook support groups, babysitter’s clubs, or even counselors and therapists. Most importantly I think it is critical to motivate to parents that they are not alone, parenthood is not instinctual, and that you believe in them. Again, in the digital age of social media platforms, parents like they should have it under control, and that they should instinctually know how to take care of their children, unlike the several years of training we receive to become a dentist. More often than not, parents I speak to just want to be seen and heard. They are usually aware that they are perceived as difficult and that can contribute to a tougher exterior. I believe that they are worried about something larger that their child’s cavities: like finances, if it’s their fault, or if other children will make fun of their child.

Sometimes I can tell a parent is upset, and I used to try and speed through the conversation because I was uncomfortable. That sometimes led to a one-star review, or an angry phone call, but more often, I believe it led to nothing. That an uncomfortable parent left, said nothing, and remained uncomfortable. For me, that is the worst. Since becoming a mother, I have begun to ask if I said something that made them upset and apologize pre-emptively if I had. I have been amazed at how much that scary question “have I said something that has made you upset?” or “how are you doing?” has allowed parents to open up about what is really going on. Establishing that level of communication and trust has grown my practice by leaps and bounds. Most satisfying though is the depth of the relationships I have with the people who come through the door.

I think about the blanket incident each time I’ve returned to the pediatrician’s office. A lot has changed. I’ve grown my frame of reference as a mom, I worry less about my children’s day to day survival, I sleep more, and I let that nanny go years ago in favor of significantly better support. I’ve never said anything to the nurse about the way I snapped at her that day, although she mentioned it once a couple of years later “I remember when I dropped that blanket.” I’ve always been hesitant to bring it up, especially now, but maybe its not too late to bring it up and get that “difficult mom” pop-up deleted from my children’s charts!
“BIOREJUVENATION DENTISTRY: DIAGNOSING & TREATING FROM THE INSIDE OUT”

- The 4 keys to an airway-centric, anterior proprioceptive guided occlusion
- How to identify occlusal disease
- Quick and easy clinical signs/symptoms of sleep disordered breathing (SBD)
- The participants will learn the basic tenants to an airway-centric occlusion and will see several patient cases to help illustrate

Dr. Hal Stewart
January 14, 2020 @ 6PM | TCMS | 555 Hemphill St., Fort Worth, TX 76104

EASY AND PAINLESS COMPLIANCE TRAINING: OSHA/HIPAA (HB300) UPDATE

- Understand the importance of standard precautions and the use of PPE in the dental office.
- Recognize the importance of the CDC’s infection control guidelines and training for the dental health care worker.
- Recognize the role of regulatory and risk management issues in dentistry.
- Identify strategies that can prevent occupational exposures to blood and body fluids.

Dr. Dale Martin
January 17, 2020 @ 8AM | Cook Children’s | 801 7th Ave., Fort Worth, TX 76104

VISIT FROM THE TDA PRESIDENT & ANNUAL BUSINESS MEETING

- Update from Dr. Charles Miller, TDA President
- Legislative Update from Jess Calvert, Director of Public Affairs
- FWDDS Annual Business Meeting

Dr. Charles Miller
February 11, 2020 @ 6PM | TCMS | 555 Hemphill Street
Fort Worth, TX 76104

Jess Calvert
“DIGITAL IMPLANT DENTISTRY - THE NEXT FRONTIER”

- Demonstrate the benefits of a digital implant dentistry workflow.
- Understand the advantages of guided implant surgery over current freehand techniques.
- Outline a fully integrated digital workflow including digital implant planning, digital surgical guide fabrication, digital impressions via intraoral scanning, and digital fabrication of CAD/CAM implant restorations.

Dr. Farhad Boltchi
March 10, 2020 @ 6PM | TCMS | 555 Hemphill St., Fort Worth, TX 76104

“SPENDING MONEY ON WHAT REALLY MATTERS”

- What matters most in your practice: Assess, Invest, Pay Grade, creating opportunity?
- What matters most in your career?
- What matters most to you personally?

Dr. Glenn Vo
April 14, 2020 @ 6PM | TCMS | 555 Hemphill St., Fort Worth, TX 76104

“MAGNITUDE OF PRESCRIPTION NARCOTIC ABUSE IN THE U.S. AND ITS EPIDEMIOLOGY”

- The extent of prescription drugs across U.S. and the effects of addiction on families & society
- Use of Texas Prescription Monitoring program and how you can safely prescribe prescription narcotics in the dental office
- Potential regulatory issues that will likely affect prescription writing in Texas

This is a requirement for writing Schedule II Prescriptions

Dr. Jacqueline Plemons
November 10, 2020 @ 6PM | TCMS | 555 Hemphill St., Fort Worth, TX 76104
The Importance of Time Offstage

By Dr. Caitlin Flosi

The end of the year is here and along with it, the busyness and countless plans and activities that accompany the holidays. The past few months, our offices have received an influx of patients frantic to utilize their insurance benefits; plans have been made to spend time with family and loved ones; not to mention the countless other activities involved with celebrating the holidays and wrapping up the end of the year.

While there is a lot of fun and excitement with finishing up 2019 and starting 2020, stress certainly accompanies it as well. According to Harvard University’s Department of Neurology, over 90% of people feel elevated levels of stress during the holiday season. Many evenings and weekends are filled with plans to celebrate holiday festivities, but packing a full schedule along with busy workdays can lead to fatigue and burnout.

In the dental profession, we spend our workdays “on stage,” always striving to be our best for our patients and team members. There is no down time in dentistry: at work, we are constantly working to perform top quality dentistry, connect with our patients to provide them an exceptional patient experience, prepare for upcoming cases and lab work, and serve as a leader for our teams. As a self-proclaimed perfectionist (for better or for worse), I tend to expect myself to continue this high performance mode during my evenings and weekends as well. When you’re in the mindset of wanting to always stay productive, the biggest challenge can be to take a break. It is so easy to stay busy and keep going, and the busyness of the holiday season can compound this.

Dentistry is a high performance profession “on stage,” and it is easy to stay in this productive mode during our hours off work. However, it is so important to be proactive in planning for time “off stage” for rest and rejuvenation. My challenge for you this holiday season is to find what relaxes and reenergizes you. For almost six years, my husband and I have a weekly date night. No matter what else we have going on in our lives that week, taking that time together refreshes me for the rest of the week. Whether it’s a board game night with your family, eating at your favorite restaurant, or simply ordering in pizza and falling asleep at 8 pm, this time offstage is the key to preventing holiday fatigue and being able to focus on the blessings and joy this time of year.

In light of recent moments, it is crucial to keep in mind what is most important in life. While dentistry absolutely brings a lot of fulfillment, it’s not what you do that defines you, but who you are and how you do it. Take some time this holiday season to be thankful for the blessings we all have, take a break or two, and enjoy time with your loved ones. Happy holidays, and we can’t wait to see you and connect with you at our FWDDS events in 2020!
The UTA Pre-Dental Society met on November 16, 2019.
Our TDA President, Dr. Charles Miller and some FWDDS members including Dr. Dale Martin and Dr. Hank Jacobs were on hand for a Q & A with students.
Thank you to everyone who attended!
This is the time of the year when we have to pay most of our dues. As a result, we are all experiencing what I call “dues fatigue”. Since we all pay dues to our professional organizations it is important that we all understand how our local society is funded and how those funds are spent. I think that the most interesting way to understand the business of the society is to relate it to the business of our practices. Although the dental society is a nonprofit organization there are many costs associated with running the office and creating programs that make the dental society a relevant organization for its members. Therefore, in order to exist in a quality way, the dental society has to operate under sound business principles. The dues that we collect only cover the bare bones of the costs in running FWDDS. The dues “keep the lights on”, but not much more.

In our practices the main source of revenue is from our patients. It is important that we retain as many patients as possible and consistently bring in new patients to maintain and grow our revenues. Likewise, at the dental society our main revenue is from the dues that we collect from our members – and it is important to retain those members and build relationships with new members. Just like in our practices all of our members do not bring in the same amount of revenue. This year we had the same number of members as last year, but our dues revenue was down. How does that happen? Like all professional organizations our demographics are changing and not all members pay the same in dues. When you look at your dues statement notice that the portion of dues that goes to the local society is only $275. The ones who are starting their career and the ones who have finished their career are paying less than the ones who are going full throttle and paying the full $275. So, some years such as the current one we have more members who are new members and pay $0 or a portion of the dues. It’s great to have more new members, but they don’t contribute much in dues. It’s like having more new patients in your practice who only need their teeth cleaned. It’s great to have them, but they don’t contribute much to cover the overhead. Each year our retired member numbers are growing which decreases our overall dues income. Some dental practices are full of patients that have had all of their dental needs met. Again, it’s great to have them, but... Therefore, like in our practices if we want to be financially viable we have to be able to do a few things to make a change. We could increase the number of patients, increase our overall fees, cut costs in the practice or target more profitable procedures. The same practices apply to our dental society.

Visit our website at www.FWDDS.org to see what is coming up and register for CE programs.
Over the past six years your dental society has transformed itself into a highly efficient business entity. It has done this with the talents and energy of the executive director position, many volunteer board members and officers and countless committee members who have been laser focused on creating an organization that is more relevant to the membership and one that meets the needs of its members. One of the primary needs of the members is that we as a society are fiscally sound. That is the main goal of the board. Today, FWDDS is fiscally healthy. However, the dues revenue doesn’t allow us to continue to create an organization that is growing, and provides services that the members want. In order to do that we had to look to the practices that we use in our businesses.

FWDDS has worked really hard to get more “new patients”- more new members. We added 98 new members in 2019. The new dentist committee and the Membership committees have reached out to potential members in a number of ways that have had positive results.

We have already discussed that we have cut our operational costs as low as they can go. We determined that further cost cutting is not an option and would not result in the objective.

We have had some unusual increases in costs this year. Our facility costs for our monthly meetings have increased by 286% and in order to be responsive to our membership concerning food quality at our meetings our food costs have increased by 60%. Everything else has gone up, as well – just as it has in your practice. We considered raising our fees – or raising dues. As a board we are philosophically against raising dues. In fact, last year we wrote a letter to the ADA delegates stating that opposition. But, we couldn’t operate with these increased costs without some sort of change. So, we decided to work the way we would in our practices and target more profitable procedures. Our executive director has leveraged her considerable experience in working with nonprofits to identify quality sponsors who will support us and who believe in the work that we do. This has allowed us to continue with our impressive lineup of monthly programs and CE seminars without incurring a dues increase. Our efforts will be focused in this direction as long as we can. In my opinion, raising dues is a lazy and unimpressive way to solve the issues of an organization that needs more funds to operate in the best interest of its members.

THE BOTTOM LINE IS THIS: What would your practice look like if only 15% of your patients kept their appointments and accepted the treatment that they needed. By increasing the percentage of patients in your practice showing up for appointments you decrease the need to increase the price of the service. Your practice is more viable. The same thing applies to our dental society.

Not participating in all the good things that the dental society has to offer even though you have paid your dues is like joining a country club and not ever going to the club, or paying for college and never attending class, or going to the grocery store to buy food for the week but never cooking a meal.

The key to not having a dues increase at the local level is for more of us to participate in all the good things that your colleagues have worked so hard to make available to you – to have quality CE, to have fun events, to see your friends and make new ones and to strengthen organized dentistry. When organized dentistry is strong your profession and livelihood is protected.

We must have 50 member dentists at each monthly meeting to meet our costs of providing this service to our members. It is up to you. IT IS YOUR BUSINESS.

Join in – Help us and Help yourself – Come to a meeting and bring a friend- let others know how things are changing at the dental society. Help us make your business better. ■

Did you know...you can find past issues of the newsletter on our website? Go to the “News & Information” tab to find archived copies.
I look forward to returning to my home society that I have missed due to my travels around the state. During my travels, I have been able to meet and visit with TDA members demonstrating a deep passion for dentistry and the patients we serve. Certain areas of the state express different concerns and priorities but I have found all members share a common bond in our profession.

At the FWDDS February meeting, Mr. Jess Calvert, the head of the TDA Legislative and Regulatory Department will be joining me to provide an update to our members. Outcomes from the last Texas Legislative Session will be reported as well as what to look forward to in the next legislative session. Other topics that will be covered include an ADA update, TDA Central Office update, communication plan, state board update, and information about the annual session. Medicaid issues will also be covered. Both Jess and I will allow time for questions. This is a great opportunity to learn more about what is happening within our profession at the state and national levels.
Thank You for Your Support of the Silver Lining Fund!

By Mrs. Paula Owens
AFWDDS President

The Alliance would like to thank all of you for your generous bids at the Silent Auction Bake Sale at the November Monthly Meeting. This fundraiser benefits the Silver Lining Fund. The money raised for this fund is given in the form of grants to our dental families when they are faced with a crisis and need help to them get through the challenge. As in past years, our district was generous in supporting the Silent Auction Sale.

If you didn’t attend the November Monthly Meeting or purchase any baked goods, you can still make a tax deductible contribution to the Silver Lining Fund. Please send your donation checks to our Treasurer, Debbie Moore. The check must be made payable to AFWDDS and mailed to Debbie at 2600 W. 7th Street, Unit # 2748, Fort Worth, TX 76107. Thank you again for supporting the Alliance of the Fort Worth District Dental Society.

“There’s just no dentist like ours!”

We provide oral healthcare for patients with special needs.

Our facility offers a comfortable environment specifically designed to meet the needs of disabled, handicapped or challenging patients.

972-296-0101 • disabilitydental.com
Dr. Hal Stewart  
“BioRejuvenation Dentistry - Diagnosing and Treating from the Inside Out”  
January 14, 2020  
It is becoming more and more evident that the root cause of most TMJ Dysfunction, tooth wear, bruxism, and malocclusion is related to airway issues and sleep disordered breathing. In this CE program Dr. Stewart will introduce the principles of Minimally Invasive BioRejuvenation Dentistry. This is a proven method of diagnosing the root cause of TMD and malocclusions and understanding how to treat it successfully from an airway-centric prospective. You and your team will learn how to identify occlusal disease, quick and easy to spot clinical signs/symptoms of sleep disordered breathing, and the basic tenants to an airway-centric occlusion. The presentation will include several patient cases to help illustrate the issues. Join us in January 2020.

Dr. Dale Martin  
OSHA/HIPAA (HB300) Update  
January 17, 2020  
It’s that time of the year. Join us in January 2020, along with your team, for the annual OSHA/HIPAA Update. This program is unique in that our speaker is both a dentist and an attorney and brings both perspectives to his presentation. We will be at Cook Children’s Hospital for this program – stay tuned for more information.

Dr. Charles Miller  
TDA President and Annual Business Meeting  
February 11, 2020  
Get the latest updates from the TDA President, Dr. Charles Miller on issues facing dental professionals. Learn about the work being done at the state level to ensure your voice is heard and that the interests of organized dentistry are represented and preserved for the future. This is your opportunity to hear directly from Dr. Miller as he shares his experiences and insights on what is happening at the state level.

Dr. Farhad Boltchi  
“Digital Implant Dentistry – The Next Frontier”  
March 10, 2020  
The digital revolution in dentistry is progressing rapidly. The translation of digital technologies into the clinical field of implant dentistry has resulted in new treatment modalities at the surgical and restorative level. This CE program will focus on the application of digital technologies in surgical and restorative implant dentistry, including digital scanners and cone beam CT scanners, and how the merging of CAD/CAM and CBCT data will culminate in a guided implant surgery technique and digital implant restorative techniques that can ultimately lead to an increased predictability and efficiency in dental implant therapy.
Dr. Bill Robbins
Full Day CE Program “Global Diagnosis: A New Vision of Dental Diagnosis and Treatment Planning”
April 10, 2020

With the increased emphasis on interdisciplinary treatment in recent years, the deficiencies associated with traditional methods of diagnosis and treatment planning have become more evident and problematic. Historically, the treatment plan was primarily dictated by information provided by study casts which mounted on a sophisticated articulator in centric relation. The treatment plan was simply based on restorative space, anterior tooth coupling and resistance and retention form of the final preparations, with no focus on placing the teeth in the correct position in the face. Practitioners did not have access to advanced periodontal, orthodontic, orthognathic surgery and plastic surgery tools that are currently available. With the advent and common usage of these new treatment modalities, the historical method of diagnosis and treatment planning is no longer adequately serving our profession. It is the purpose of this course to provide a systematic approach to diagnosis and treatment planning the complex interdisciplinary dental patient with a common language that may be used by the orthodontist, periodontist, and oral and maxillofacial surgeon, as well as the restorative dentist. The four Global Diagnoses which dictate all interdisciplinary treatment planning will be defined. A set of questions will then be presented which will aid the interdisciplinary team in the diagnosis and treatment planning of the complex dental patient.

This is a great program for the dentist and his or her team. Special early bird pricing will be available.

Dr. Glenn Vo
“Spending Money on What Really Matters”
April 14, 2020

In less than two years, Dr. Glenn Vo went from a regular dentist to one of the top influencers in dentistry. He is a sought after speaker and has created multiple large Dental Facebook Groups. Dr. Vo has helped dental practices to locate opportunities to save money and implement systems to lower costs.

Dr. Vo and his wife, Dr. Susan Tran have a practice in Denton Texas and are both graduates of Baylor College of Dentistry. Their shared passion for keeping the old tradition of the “family dentist” motivates them to provide individualized care while offering the knowledge, comfort and clinical techniques of today’s modern dentistry.
FWDDS 2019 Christmas Party

Thank you to everyone who attended!
Minimally Invasive Bio-Rejuvenation Dentistry
A Conservative Approach to Full-Mouth Rehabilitation
By Hal Stewart, DDS

INTRODUCTION
Traditional full-mouth rehabilitation for most clinicians implies putting patients through the vigorous and unpleasant process of having most, if not all, of their teeth restored with crowns or onlays (Figure 1). Not only is this very expensive, making the reality of full-mouth rehabilitation cost prohibitive for many people, but it is also extremely invasive (Figure 2). Once a tooth is treated with an onlay or crown, then it is committed to this type of restoration for life. The author is not against the utilizations of crowns all together, as there are instances in which crowning a tooth is the best option. Rather, the author suggests always looking for the most minimally invasive treatment that will not only enhance the patient’s health, function, and aesthetics, but also make it possible for most patients to afford the treatment. Restoring teeth with more conservative methods like direct composite resin bonding provides the patient with a minimally invasive, more affordable option. Preservation of enamel and restoration of the stomatognathic system are accomplished simultaneously.¹

Bio-Rejuvenation Dentistry
Bio-rejuvenation dentistry is based on principles first introduced by Dr. Bob Lee² in 1990 who observed and documented hundreds of patients with biologically sound chewing systems. These systems all exhibited neuromuscular harmony with unworn teeth and healthy, noise-free joints. Lee² observed nature in its optimal form and hypothesized that if these characteristics, or principles, were applied to a patient’s dysfunctional dentition, then it could be made healthy and optimal once again. The author applies Dr. Lee’s principles to his minimally invasive restoration process and he prefers to use the term minimally invasive bio-rejuvenation dentistry to describe the process.

Figure 1. Full-mouth restorations with crowns.

Figure 2. Full-mouth crown preparations.
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Bio-Rejuvenation Dentistry

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Figure 1. Full-mouth restorations with crowns.

Figure 2. Full-mouth crown preparations.

Figure 3. (a) Our 69-year-old male patient. (b) He was self-conscious about his smile.

The bio-rejuvenation approach adheres to Lee’s principles of anterior proprioceptive guidance. It is imperative that the occlusion be restored at a vertical dimension that allows for both proper tooth form and appropriate form of the occluded dentition with the joints seated in their most superior, anterior, and medial position. It has been documented that the activity of the masseter and temporalis elevating muscles can be reduced only when the absence of eccentric interferences to maximum intercuspal position (MIP) is obtained by anterior proprioceptive guidance.3 The characteristics of a healthy functioning condyle/disk complex are as follows:

- Physiologically correct relationship of the condyle/disk assembly with little to no enamel attrition
- Anterior teeth that occlude properly in relation to the stable condyle/disk assembly
- Noninterfering posterior teeth to this physiologically stable position of the condyle/disk assembly
- Release of the inferior lateral pterygoid muscle during elevator muscle contraction and MIP.4

CASE REPORT

Diagnosis and Treatment Planning

A 69-year-old male (Figure 3a) presented with the chief complaint that his teeth were wearing away. He was unhappy with the appearance of his teeth and smile (Figure 3b) and he was finding it difficult to chew and digest his food. He suffered from severe attrition and erosion resulting from years of bruxism and consumption of multiple diet sodas daily. He was concerned about his facial aesthetics and the increasing difficulty in chewing due to the amount of wear present. He also desired to have an attractive smile. The patient reported that he no longer consumed any soda or sugary drinks other than an occasional hot chocolate. He also reported that he was no longer aware of grinding his teeth. However, he did indicate some hypersensitivity to cold food and drinks. He also indicated to be free of headaches and facial pain.
The patient had sought several opinions from different dentists. He was basically given 2 treatment options:

1. Full-mouth crown and bridge, most likely requiring multiple root canals, posts, and build ups, or
2. Full-mouth extractions, implants with hybrid dentures attached.

Both options were viable treatment plans; however, the fees for these treatments were cost prohibitive for the patient. Furthermore, his desire to retain as much of his natural enamel as possible was important to him.
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Figure 6. Panoramic radiograph.

Figure 7. Pre-op models mounted at determined vertical dimension.

Figure 8. (a) Diagnostic wax-up sagittal view. (b) Diagnostic wax-up frontal view. (c) Diagnostic wax-up maxillary occlusal view. (d) Diagnostic wax-up mandibular occlusal view.
After diagnostic records were taken and a comprehensive examination completed, the author recommended a bio-rejuvenation treatment plan that would restore the vertical dimension of occlusion (VDO) with the temporomandibular joints (TMJs) in the centric relation position. Additive adhesive composite resin reconstruction was recommended due to its predictability and minimally invasive nature. It was explained to the patient that by creating an occlusion in harmony with his chewing and positioning muscles with the condyles seated in the centric relation position, it would give him a functioning, comfortable chewing system and would satisfy his desire to have an aesthetic smile and improved facial features. It was also made very clear to the patient that his was an extreme case and that he should expect a certain amount of repair and maintenance throughout the years. This made perfect sense to the patient, and the fact that his mouth could be treated minimally invasively made it even more appealing to him. The fee was within his budget as well.

Examination revealed generalized severe attrition/erosion of the teeth (Figure 4) resulting in a decreased VDO (Figure 5). The TMJ exam revealed comfortable joints (Figure 6) with no noises and no mandibular deviation upon a maximum opening of 58 mm. Loading of the condyles produced no discomfort. There were several teeth with deteriorating amalgams and moderate carious lesions. Tooth No. 19 was missing, as were all the third molars. Tooth No. 30 had been treated endodontically (Figure 6). His periodontal health was excellent with all probing depths within normal limits and plaque and bleeding indices of zero percent. There were no systemic or medical issues that were barriers to treatment.
An open centric bite record was taken with a Panadent (Panadent) bite tray at a vertical dimension that would allow the mouth to be restored with proper tooth form, horizontal overjet, overbite, and centric contacts. Accurate alginate impressions were taken and models were mounted (Figure 7) on an AD2 semi-adjustable articulator (Advanced Dental Designs) utilizing the AD2 face-bow transfer. The diagnostic wax-up (Figure 8) was completed by Dan O’Rourke, CDT (O’Rourke Dental Studio, Lantana, Texas). A bio-rejuvenation “tool kit” (Figure 9) was also included with the wax-up. The tool kit consisted of clear vinyl polysiloxane (VPS) (Lumaloc [Ultradent Products]) stints for accurately transferring the wax-up to the mouth in composite resin. The kit also included acrylic validators for verification of accuracy in the mouth.
Restorative Treatment

The lower anterior teeth Nos. 23, 25, and 27 were restored first. The teeth were micro-abraded (Figure 10a). No enamel was prepped or removed. Next the teeth were etched with Ultra-Etch (Ultradent Products) for 20 seconds and rinsed. Peak Universal primer/adhesive (Ultradent Products) was applied, air-thinned, and light-cured with the VALO light (Ultradent Products). G-ænial Universal Flo (shade A3) (GC America) was carefully placed into the Lumaloc stint and then taken into the mouth. The composite was then cured through the clear stint material using the VALO light. Next, the stint was removed, and these 3 teeth were finished and polished to completion (Figure 10b). G-ænial Universal Flo is a nanohybrid composite with excellent wear resistance, and it is easily polished. The author has found that this unique flowable composite resin material lends itself perfectly to the bio-rejuvenation technique described herein.

Figure 15. Lower arch completed.

Figure 16. Upper arch completed.

Figure 17. (a) Verification of occlusion. mandibular centric contact points. (b) Maxillary centric contact points.
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Next, the rest of the lower anterior teeth were restored in this same manner (Figure 11). Upon restoration of the lower anterior teeth, the acrylic validators were used to verify the accuracy of the composite transfer (Figure 12). Then, the maxillary anterior teeth were restored in the exact same manner as the lower anterior teeth (Figure 13a). Accuracy was validated (Figure 13b) and the occlusion was then verified (Figure 14). The lower posterior teeth were then completed using G-ænial Universal Flo in the same manner with the full wax-up stint. The lower left missing No. 19 was restored with a fiber post (UniCore Post [Ultradent Products]) reinforced composite bridge utilizing the same G-ænial Universal Flo material (Figure 15). Finally, the maxillary posterior teeth were restored (Figure 16), again using the same flowable composite. The old amalgams and carious lesions were removed during this process. The occlusion was verified and adjusted on the posterior teeth (Figure 17) to preserve the VDO, as determined by the diagnostic wax-up (Figure 18). All restorations were polished to completion (Jiffy Polishing Kit [Ultradent Products]).

An acrylic guard was made and delivered to the patient to wear while sleeping to protect his restorations from the effects of nocturnal bruxism.

The Final Restorative Outcome

In this case, the patient was restored to have a fully functioning occlusion, a restored VDO to the face, and much improved facial and smile aesthetics (Figure 19). It is important to note the positive changes not only in the teeth, but in the face and eyes of the patient (Figure 20). Since the occlusion was restored to a stable condylar
position in centric relation at a proper VDO, the teeth look great and, in addition, the facial muscles and muscles of mastication are relaxed and functioning harmoniously. The pressure on the teeth is minimal due to the idealized occlusion which will result in long-term functional and aesthetic stability.

L. D. Pankey’s rules of optimal occlusion\(^5\) state the following:

- With the condyles fully seated in the fossa, all the posterior teeth touch simultaneously and evenly, with the anterior teeth lightly touching.
- When the patient squeezes, neither a tooth or the mandible moves.
- When the mandible is moved in any excursion, no back teeth hit before, harder than, or after a front tooth.

These rules were all met in the restorative outcome achieved in this conservative bio-rejuvenation case.

Figures 21a to 21c. One-year follow-up.

One-Year Follow-Up

After one year, the restorations were holding up very well and the patient was very comfortable and pleased with his new smile (Figure 21). It took him a few weeks to get used to having longer teeth and to develop a more vertical pattern of chewing. He has adapted very well and has had no problems or discomfort.

CLOSING COMMENTS

Preservation of natural tooth structure is of utmost importance, and every clinician should consider this when creating any treatment plan, whether it is for one tooth or for full-mouth rehabilitation as is the case here. One of the most incredible features of this type of treatment is that the patient’s mouth was restored without permanently altering any tooth structure other than the removal of carious enamel and dentin in several of the molar teeth.
The author has been practicing bio-rejuvenation dentistry since 2001. Throughout that time, he has restored hundreds of patients in this manner and has found the results to be functional, durable, long-lasting and aesthetic.6

Acknowledgment
The author would like to thank Dan O’Rourke, CDT (O’Rourke Dental Studio, Lantana, Texas), for the lab work on this case.

References


Dr. Stewart has been practicing restorative dentistry in Flower Mound, Texas, since 1990. He is a co-founder and clinical instructor for The Texas Center for Occlusal Studies and Minimally Invasive Dentistry (txcos.com), and he lectures internationally on occlusion, minimally invasive dentistry, and aesthetic composite resin techniques. He is also a mentor for the Schuster Center. He can be reached via email at hal.stewart@verizon.net.

Disclosure: Dr. Stewart has received honoraria for speaking for Ultradent Products and is also an unpaid speaker for GC America.

Related Articles

The Wonderful World of Teeth Whitening

Rejuvenation Via Biologically-Guided Technology

Bioesthetic Dentistry, Part 1
Slate of Candidates to be Voted for the 2020-2021 Board of Directors

Here is the slate of candidates proposed by the FWDDS Board of Directors to be voted on at the February Annual Meeting.

**Board Members continuing for 2020-2021**
- Dr. Elizabeth Laborde - President
- Dr. Russell Dix - President Elect
- Dr. Karen Neil - Secretary/Treasurer
- Dr. Tim Knight - Immediate Past President
- Dr. Greg Scheideman - Director

**New Board Members for 2020-2021**
- Dr. Terry Drennan - Vice President
- Dr. Nikki Green - Director
- Dr. Francisco Nieves - Director Under 10 Years

**Delegates/Alternate Delegates for 2020:**
1. Dr. John Boyd 6. Dr. Joseph Laborde
2. Dr. Russell Dix 7. Dr. Karen Neil
3. Dr. Terry Drennan 8. Dr. Greg Scheideman
4. Dr. Tim Knight 9. Dr. Saurabh Singhal
5. Dr. Elizabeth Laborde 10. Dr. Eric Wear

**Alternate:**
1. Dr. Tom Samuel
2. Dr. Ron Lee

**Delegates/Alternate Delegates for 2021:**
1. Dr. Elizabeth Laborde 6. Dr. Karen Neil
2. Dr. Amy Bender 7. Dr. Tom Samuel
3. Dr. Terry Drennan 8. Dr. Greg Scheideman
4. Dr. Garrett Johannsen 9. Dr. Ryan Schmidgall
5. Dr. Tim Knight 10. Dr. Saurabh Singhal

**Alternate:**
1. Dr. Ron Lee
2. Dr. Caitlin Flosi
## Fort Worth District Dental Society
### Analysis of Geographical Location of Dentists in District
#### December 2, 2019

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<tr>
<th>Area</th>
<th>Total Dentists in District</th>
<th>Members in District</th>
<th>Market Share by Area</th>
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<td>Area 1 – Central</td>
<td>400</td>
<td>237</td>
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<td>Includes Benbrook, Forest Hill, Fort Worth, Haltom City, Kennedale</td>
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<td>Area 2 – West/Northwest</td>
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<th>Area</th>
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<td>Area 1 – Central</td>
<td>57%</td>
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<td>Area 2 – West/Northwest</td>
<td>62%</td>
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<td>Area 3 – Mid Cities/East</td>
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<td>Area 4 – South</td>
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<td>60%</td>
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<td><strong>Overall</strong></td>
<td><strong>52%</strong></td>
<td><strong>55%</strong></td>
<td><strong>Up 3%</strong></td>
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Market Share by Area is determined by the number of member dentists in an area divided by the total dentists in the area. Area is based on the office location of the dentist.
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“BioRejuvenation Dentistry – Diagnosing and Treating from the Inside Out” presented by Dr. Hal Stewart – 1.5 CE hours.

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“TDA President’s Visit and Annual Business Meeting” presented by Dr. Charles Miller – 1.0 CE hour.

**March 10, 2020**
“Digital Implant Dentistry – The Next Frontier” presented by Dr. Farhad Boltchi 1.0 CE hour.

**April 14, 2020**
“Spending Money on What Really Matters” presented by Dr. Glenn Vo 1.0 CE hour.

**September 8, 2020** – To Be Determined
**October 13, 2020** – To Be Determined

**November 10, 2020**
“Magnitude of Prescription Narcotic Abuse in the U.S.” presented by Dr. Jacqueline Plemons *(this program satisfies the requirement for writing Schedule II prescriptions)* – 2.0 CE hours.

**Early Bird package price through January 13, 2020**
$159.00

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**Fort Worth District Dental Society**  
**2020 Annual Budget**  
**As of December 2019**

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<th>Revenue</th>
<th>Expenses</th>
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<td><strong>Totals</strong></td>
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**Fort Worth District Dental Society**  
**Year End Membership Update**  
**As of December 2019**

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<tr>
<td>Number of Members</td>
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<tr>
<td>Dues Income</td>
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<td>$136,606.25</td>
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Financial Note: While the member headcount has remained relatively flat over the past three years, dues revenue has declined as a result of a higher percentage of members who are eligible for discounted dues programs. This impacts total dues revenue at the national, state and local levels.
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