FLORIDA FOCUS

December, 2023

the publication exclusively for the general practitioner

Region 20 Director Dr. Aldo Miranda and Trustee Dr. Andrew Martin at the 2023 AGD House of Delegates

FLORIDA ACADEMY of GENERAL DENTISTRY

FLORIDA FOCUS
DECEMBER 2023

AGD Secretary Dr. Kimberly Wright meets with the Region 20 delegates.

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President's Message

As we approach the holiday season, we also head into a transition period for our organization. Our General Assembly in January 2024 will include some excellent CE as well as the induction of our new officers for the FLAGD Board. It has been an exciting and challenging couple of years as the FLAGD resumed normal operations post COVID.

The strength of our organization is still centered upon high quality CE for our membership. It is only through the hard work of our board and executive director that we can continue the legacy of FLAGD. I encourage anyone interested in organized dentistry to ask about volunteer opportunities. It is important to remember that we are the only organization supporting the general dentist. Thank you to everyone for all the support during my presidency the last two years.

I hope everyone enjoys their holiday season and look forward to seeing everyone at the FL AGD General Assembly in January.

Matthew Scarpitti, DDS

Editor's Note

Our Aspirational Academy

One of the joys of the *Wall Street Journal*'s weekend Review section is "Word on the Street," linguist Ben Zimmer's column on words trending in the news each week. For example, some of his recent columns have explored the origins of "grok," "sarcasm," "turkey," and "tush." Listening to the speeches and discussions during the recent AGD House of Delegates, I thought of Mr. Zimmer's column. I've only attended two of these meetings, but it was difficult to miss this repetition of the one-word, unofficial theme of the HOD. At the 2023 meeting, the word on the street seemed to be "aspirational," although the previous trendy word, "nimble," did spring into the conversation, as well. As I attended the sessions and town halls, I felt that "aspirational" was a perfect description of both the AGD and its individual members.

"Aspirational" is defined as "having a strong desire for success or achievement, marked by... ambition, energy, and inititive" (vocabulary.com). Synonyms include "dedicated, persistant, steadfast, uncompromising, indefatigable, staunch, unflagging" (wordhippo.com). What better description could there be of our Academy with its mission of "advancing general dentistry and oral health through quality continuing education and advocacy"? As the AGD strives to improve the lives of general dentists and the public, our members strive to become the finest dentists possible. As current ADA President and former AGD President Dr. Linda Edgar told the delegates, "This is the organization that trains young dentists to be the best that they can be." In another sense, we could say that aspiration is almost as necessary to our lives as breathing is to our bodies.

To experience this passion for excellence in the AGD more fully, I urge you to attend the next House of Delegates in Chicago in November, 2024. State AGD officers are automatically suggested as delegates, but any member can serve; just contact Florida's Executive Director, Mrs. Patricia Jenkins to request to be one of our state's eleven delegates. Delegates elect new officers, vote on resolutions to improve the AGD, and applaud the outstanding members who have earned the national Humanitarian, Advocacy, and Distinguished Service awards. Of course, there's also the wonderful opportunity to exchange ideas with fellow AGD members.

As always, thank you to the dentists, hygienists, and assistants who contributed their dental wisdom and experience to this issue! In his interview and speech excerpt on pages 6-8, new AGD President Dr. Merlin Ohmer shares his background in dentistry and his goals for our organization. Drs. Margaret Dennis, Craig Hollander, and Elizabeth Simpson and Ms. Amber Riley provide clinical knowledge on facial pain, "Tiny Smiles," and the vital importance of thorough medical and pharmacologic histories. Debra Engelhardt-Nash, Dr. Angela McNeight, and Denise Williams-Jones offer valuable ideas on communication, leadership, and self-care.

Please consider attending the Florida AGD's General Assembly in Orlando on January 12-13, to enjoy continuing education, lunch, award presentations, and the installation of our 2024 Executive Board. Details can be found on pages 10-11, and the form to nominate a fellow member or yourself for an award is on page 8. We hope to see you there!

Thank you to Dr. Scarpitti for his wonderful guidance as the Florida AGD President, and thank you once again for the privilege of serving as your editor. Wishing everyone a safe and happy holiday season!

Millie Tannen, DDS, MAGD
Editor, *Florida Focus*

2023 ANNUAL MEETING
HOUSE OF DELEGATES

Region 20 Delegates, from left: Executive Director Patricia Jenkins, Drs. John Gammichia, Hermenia Rodriguez, Steve Hochfelder, Douglas Massingill, Bipin Sheth, AGD President Merlin Ohmer, AGD Past President Gerald Botko, Niblado Morales, Millie Tannen, and Region 20 Director Aldo Miranda. Not in photo: Delegates Stephanie Mazariegos and Amr Hassan.

Dr. Robert Peskin honored American and Canadian veterans.

Above: Dr. Aldo Miranda, Executive Director Patricia Jenkins, and Dr. Bipin Sheth at the Region 20 Caucus. On right, from left: Drs. Amr Hassan, Stephanie Mazariegos, and Steve Hochfelder participate in the House of Delegates.

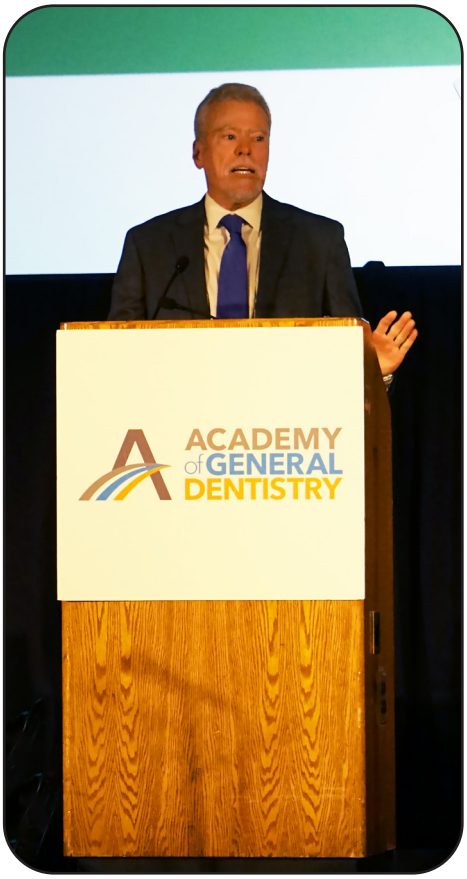
TOWN HALL LEADERSHIP

NOVEMBER 10 – 12, 2023 • CHICAGO

Installation of the Executive Committee, from left: Editor Timothy Kosinski, Speaker Robert Peskin, Secretary Kimberly Wright, Treasurer Joseph Picone, Vice President Marc Worob, President-Elect Chethan Chetty, President Merlin Ohmer, and Immediate Past President Hans Guter.

> "The value of membership comes from the colleague and the person you trust the most, and getting them to understand the value of the AGD."
>
> **- Colleen Lawler, AGD Executive Director**

From top right: Drs. Botko, Hochfelder, Rodriguez, Massingill, and Miranda at the Region 20 Caucus. Center right: ADA President Linda Edgar with Region 20 delegates. Bottom right: Consultant Donna French Dunn of Tecker International led a session to discuss Project Governance, a plan to streamline the AGD.



Florida's Dr. Merlin Ohmer is Installed as AGD President

An Interview With Dr. Ohmer

How did you first become interested in dentistry, Dr. Ohmer?

When I was a kid, my parents made sure I was exposed to different professions along the way. My dad was a professor, and my parents had friends who were dentists, physicians of all sorts, surgeons, and so forth. For some reason, dentistry just appealed to me. I think it's a great profession. I spent many hours standing in operating rooms with some of the surgeon friends, and I thought, I certainly don't want to be doing this at five o'clock in the morning or at ten o'clock at night. Dentistry is a great profession that tends to be more 8:00 to 5:00. It allows you to have a fulfilling profession and also to enjoy some of your own time.

Could you please tell us a little about your career?

I had kind of a weird career when I graduated from dental school. I spent three years on active duty in the Army, went to the National Guard for seven years, and then went back on active duty in the Navy to finish out my 30 years.

Thank you for serving our country! As a Jacksonville resident, I've met a lot of veterans who have incredible leadership skills. How did your Navy service help you become such an effective leader?

Most of the training was trial by fire. You learn a lot of it as you go, studying the climate of the command that you're in and what the mission of that particular group is, and you learn a lot through active mentoring. It seems like every place I went, they gave me a leadership position of some sort, from running the operative dentistry department of five dentists all the way to the COO of Navy Medicine in Hawaii, where we had 550 people assigned to the command. It's like I said, a lot of trial by fire. You do a good job, and they give you a bigger job doing something else. It was a wonderful experience. I wouldn't trade it for anything in the world.

While you were in the Navy, you did a one-year fellowship in oral surgery. What drew you to surgery?

I've always done a lot of dentoalveolar surgery, and when I was in the military in 1993-94, I did a very heavy, clinically based 12-month program in dentoalveolar surgery. The Navy did not have enough oral maxillofacial surgeons to handle the load that needed to be done, and they came up with this idea in the '80s to put general dentists in an intensive one-year program and concentrate on dentoalveolar surgery. So that's what I did, and I loved it. That was one of the highlights of my practice career.

That's wonderful; I didn't realize the Navy had that program. Then you decided to go into private practice.

Something was telling me I should try solo practice, so I did. It was great; I had a blast.

When you were in private practice, you began working with facial injectables. Did that type of esthetic treatment give you a lot of satisfaction?

It did. As I was transitioning from the military, I ran into Dr. Gigi Meineke. I talked to her for about an hour about what she does. I took many, many courses, and it was something that I felt I did well. The patients were very pleased with the results, and it was a very active part of my practice that I thoroughly enjoyed.

With this upcoming position [of AGD President], I knew the time constraints. I started looking for an associate, but I found a doctor who wanted to buy the whole practice. So, I took the offer and now, here I am.

I imagine being President of the AGD is nearly a full-time job.

It's not a full-time job, but it's at least 20 to 25 hours a week of meetings and responding to phone calls and emails. Most of the meetings are at night because most of the members are gainfully employed during the workday. Some of the days get to be very long.

What originally motivated you to join the AGD and to stay involved?

I joined the AGD in 1983, after I left my first stint on active duty. I was interested in furthering my education, and the AGD does a lot of mentoring. It's a great organization; and as most people realize early or sometimes late in their career, we always have to keep learning. If you want to be relevant and if you want to do the right thing for your patients,

you can't stop learning. That's what motivated me to join, and for the first few years, I was just a member getting lots of CE. Then I realized that they have the Fellowship Award. I took the exam about 13-14 years out of school. I got the study guide from someone I was stationed with, and it was, "Oh my gosh, I've forgotten so much!" That really prompted me to study more, to learn more, to stay current, not just on clinical techniques but also the science.

So, I passed my Fellowship exam, then started working on my Mastership, and in July of last year, I became a Lifelong Learning and Service Recipient. It's constant learning, and I just found the awards something to strive for, because the process and the learning that you have to do to get each award just makes you a better dentist that exposes you to new ideas and new techniques and keeps you current. That's why I did it, and that's why I encourage other people to do it. It may look like a big hill to climb, and you go, "What's in it for me?" Well, what's in it for you is, inevitably, it makes you a better doctor.

Dr. Ohmer at the 2023 AGD House of Delegates with AGD Executive Director Colleen Lawler.

Is there anyone that you've worked with over the years who really inspired you?

In the military, after 30 years commission time, you have to retire. I was in Jacksonville, and I knew that was going to be my last duty station and that I was going to be transitioning to private practice. That's when I started getting involved with the Florida AGD. The two people in the Florida AGD who helped push me into the leadership role were Drs. Tony Menendez and Larry Grayhills. They approached me before I retired and said, "We see everything that you're doing. Are you going to stay in Florida? Well, good. Why don't you get involved with us?" So, I did. At the local level, those were the two people who really reached out to me and encouraged me to go down the AGD leadership path, and I haven't looked back. It was great advice on their part.

What are your goals for your term as President of the AGD, and what do you see as the most challenging or urgent issues for the AGD right now?

I have so many goals, but I have to realize that the position is a year's time, and with our government structure the way it is, only being able to pass resolutions once a year, I realize that all I can do is really push for one goal and try for about two more. To make a change, make a difference; but you can't do everything in a year that you would like to do. I've already started working closely with Dr. Chethan Chetty, who's the vice president now. The way to make this happen is we need to have continuance of effort. You can't just decide to change the direction of the ship every year, because nothing will ever get done. Dr. Chetty and I are working very closely to try to have goals that we both will work on together. That way, there's two years' worth of working towards the common goal.

Our main goal is, we need to make the AGD value-added and meaningful for our members. I think we need to reach out to the younger dentists, even those in school, and try to motivate them and make us meaningful to the way they practice now, not the way I practiced in the '80s, but the way anyone has to practice in 2023 and beyond. The world is changing. You could say, "Well, I don't want change," but it's going to change right past you, and I don't want that to happen to the AGD.

One of the other big issues is to work with the Membership Council to establish something meaningful so we can retain our members. We retain members very well once they earn their Fellowship. We don't retain them well within their first five years of graduating. We have to figure out how to retain them and motivate them. Also, I think that we need to look deeper into the international membership because, if you look at our journal, a lot of our articles are written by foreign authors. There's a lot of research being done in the Middle East and in Asia – in Japan and South Korea. They do a ton of research there. If the dentists in those countries are good enough that we use their articles, why aren't they good enough to be members? Of course, we won't change our membership criteria. All the continuing education has to be PACE approved, and the Fellowship exam has to stay the way it is, but we can open ourselves up more to those foreign dentists who want to follow the AGD standards.

The last thing is, membership-wise, we really need to realize now that there are significant populations of dentists who are not in solo practice. We need to make our membership appealing and relevant to those who are working for the government, working in solo practices, working in large group practices, or working in DSOs. They're all dentists, and we want them all to practice to the best of their ability. We need to look at those who are employee dentists and make sure that the AGD has the right offerings to attract them.

Everybody has to remember that the elected officers, the trustees, and the Regional Directors do not have all the answers. We need good

"We all need to be empowered. At the local level, recruit new members and work with your constituents to have great programs and CE. Work to make the AGD the best dental organization in your community. Volunteer! Help your local president, coordinate with your Regional Director and ask what you can do... We all have great ideas. I do not have all the answers; you do. I need your help to make the AGD great."

- from Dr. Ohmer's Acceptance Speech, 2023 AGD House of Delegates

Florida AGD delegates in Tallahassee at the State Capitol building, February, 2020

thoughts, good answers, good ideas to bubble up from the constituent level, because you are living and breathing dentistry every day, and in the AGD, all the good ideas bubble up from the grassroots.

What piece of advice would you give our members as general dentists?

Learn, learn, learn, and then put it into practical use. Always try to remember that we all have bad days when treating patients. We all have our lives, with everything that's going on in the background. But just remember at the time, treat that patient the way you would want to be treated. I think if you always treat the patient as though that was your spouse, mother, or father in the chair, you will provide the best, most ethical treatment that you can. The practice of dentistry is not perfect, and we all end up sometimes with results that aren't optimal, but it's the best we could do at that time on that patient, with the way they presented.

Is there anything else you'd like to share with our members, Dr. Ohmer?

I just want to say thank you for all the support that I've gotten from the Florida AGD. That means a lot to me, and next year, I'll be crawling back to you all, saying "Hey, what can I do now?"¶

At the 2023 House of Delegates, the AGD officers ponder the test results of the new voting system, Election Buddy.

FLORIDA ACADEMY of GENERAL DENTISTRY

It's time to nominate a fellow FLAGD member for one of these membership awards.

Do you know someone who goes on medical missions or spends hours working at free clinics? Consider nominating that person for the FLAGD Humanitarian Award. Or nominate yourself - who knows you better?

The deadline to submit nominations is December 31, 2023.

Please contact FLAGD Executive Director,

Mrs. Patricia Jenkins at flagdinfo@gmail.com.

2023 FLAGD ACHIEVEMENT AWARD NOMINATION FORM

Please consider this candidate for the following Membership Achievement Award:

Please CHECK one

- Continuing Education Award ☐
- Lifetime Achievement Award ☐
- Distinguished Service Award ☐
- Humanitarian Award ☐

Personal:

Nominee:_____
Address_____
City: _____State:_____ Zip_____

Home #: _____ Office #_____
Email address: _____

Description of Candidate's Qualifications: Briefly describe the works for which the individual is being nominated, and for which award _____
_____
_____
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_____
_____

Use additional sheets if necessary.

List of Nominee's other honors and awards: _____
_____
_____ _____
_____ _____
_____

Nomination submitted by:

Name:_____

AGD#:_____

Phone_____

Email:_____

ACADEMY of GENERAL DENTISTRY

AGD2024
THE PREMIER MEETING FOR GENERAL DENTISTRY

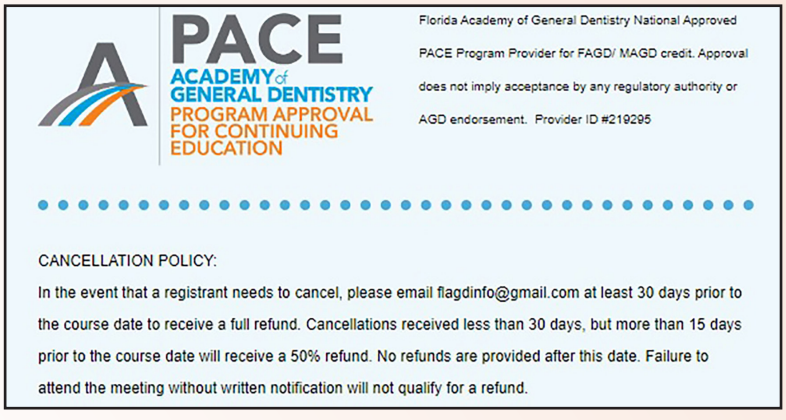
MINNEAPOLIS, MN
JULY 17 - 20
AGD2024.ORG

SAVE THE DATE FOR AN EXPERIENCE LIKE NO OTHER

"Please join me for our award-winning Scientific Session in downtown Minneapolis. You will experience world-class continuing education and camaraderie. Come and bring the family for the CE, fun and beautiful summer weather."

Merlin P. Ohmer, DDS, MAGD
AGD President
Jacksonville Beach, Florida

SAVE THE DATE
agd2024.org



Please Join U
Florida AG

January 13, 2024 - FL
Luncheon a
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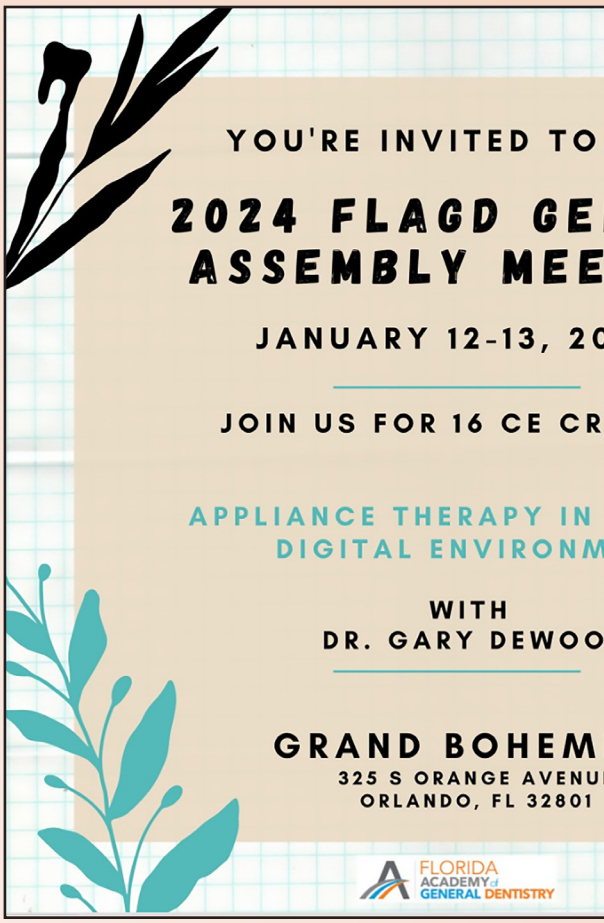
January 12-13, 2024 - App
Digital En
- Dr. Gary



Us for These
GD Events!

AGD General Assembly
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y DeWood

Florida Academy of General Dentistry

You are invited to the 2024 FLAGD General Assembly Meeting!

We're excited to have Dr. Gary DeWood as this year's main speaker. Stay tuned for more CE announcements happening at the GA!

COURSE: Appliance Therapy in Today's Digital Environment

WHEN: January 12-13, 2024
LOCATION: Grand Bohemian, Orlando - 325 S Orange Ave, Orlando, FL 32801
TIME: 8:30 a.m. - 5:00 p.m.
Includes light breakfast, networking lunch, and coffee refreshed throughout the day.

CEUs: 16 (Submitted to AGD and CE Broker)
SUBJECT CODE: 780 – Esthetics/Cosmetic Dentistry (8.0 hours) // 180 – Occlusion Participation (8.0 hours)

AGD Members: $1,295.30
Non-Members: $1,495.30
AGD Student Members: $1,145.30
Staff: $225.30 (Cannot be DDS or DMD)

About the Speaker: Dr. Gary DeWood lives in Phoenix with his wife of 44 years, Dr. Cheryl DeWood. A native of Toledo, Ohio, Gary earned his D.D.S. from Case Western Reserve University in Cleveland in 1980, completed the University of Florida Facial Pain Center Curriculum from 1992 through 1995, and in 2004 earned a Master of Science degree at The University of Toledo College of Medicine. He left full-time private practice in 2003 to serve as clinical director at The Pankey Institute, a position he held until 2008 when he joined Frank Spear in Seattle as the president of Frank's education company, The Seattle Institute. As a founding member of Spear Education, formed by the merger of The Scottsdale Center and The Seattle Institute, he relocated to Arizona in 2009 as Executive Vice-President for curriculum and clinical education. Today he serves as Executive Vice-President for Spear Education. He maintains a limited private practice on the Spear campus and teaches in Spear workshops, Spear Online, Spear Study Clubs, and in Spear Practice Solutions.

Gary has presented to international audiences in the areas of occlusion, temporomandibular disorders, bite splint therapy, restorative dentistry, esthetics, financial management, and practice management.

Enhancing Communication Skills

6 Critical Questions that Will Improve Team Effectiveness

by Debra Engelhardt-Nash

At the heart of a great dental practice is certainly having exceptional clinical skills and the ability to deliver outstanding care. But eighty five percent of the time spent with patients is communicating with them and fifteen percent of time with the patient is spent in clinical application.[1] It's one thing to have the clinical ability to treat the patient. It is another skill to be able to communicate effectively. If we don't communicate effectively from the beginning of the patient engagement, we may never reach treatment acceptance and delivery of our care.

Most patients who call your office have already made the decision to choose your practice. It becomes responsibility of the Team to validate they made the right decision during the first moments of contacting the office. This is the FIRST opportunity to set the office apart and give the patient the right impression of the quality of care and patient experience they will receive.

Award winning storyteller and motivational speaker Kelly Swanson said, "Nobody Notices Normal." Steer away from the standard phone call describing office policies and regulations and asking patients about their insurance coverage. These conversations should happen after you have impressed the patient with your customer service proficiency. Patients tend to be more compliant with your office standards when they feel they are going to be treated well. Avoid making your office rules the focal point of the patient introduction. Replace the questions "What insurance do you have?" or "Do you have a dental emergency?" with:

Question 1: "What Inspired You to Call?"

Initiating the first conversation with this question will immediately set your office apart from other practices and give the patient an opportunity to tell you what motivated them to seek your care. This question also leads the conversation into describing why your practice is right for them. "Based on what you're looking for, I can understand why you would choose us." Informing patients how your practice delivers care and the atmosphere provided to the patients makes the office distinctive within minutes of contact.

It is important that we gather important information from the patient so we can begin establishing their records. Some practices launch into questions regarding personal details before establishing rapport or gaining patients' permission. As a courtesy to patients and to demonstrate your sensitivity to asking them to divulge personal information, it is an extra touch to ask their permission.

Question 2: "May I Ask You A Few Questions?"

This minimizes the patients' perception that you are asking scripted questions to complete a form.

Debra Engelhardt-Nash has presented workshops nationally and internationally for numerous study groups and organizations including the ADA, Hinman, Chicago Midwinter Dental Society, Swedish Academy of Cosmetic Dentistry, and the British Academy of Cosmetic Dentistry. Her articles have appeared in leading dental publications in the US, Canada and England. Debra is a founding member and served three terms as President of the Academy of Dental Management Consultants. She is President of the Academy for Private Dental Practice and a member of Speaking Consulting Network. With her husband, Dr. Ross Nash, they operate the Nash Institute for Dental Learning – a post graduate teaching center focused on Cosmetic and Esthetics Procedures and Full Mouth Rehabilitations as well as Dental Business School located in Huntersville, North Carolina.

Debra has been repeatedly recognized by *Dentistry Today* as a Leader in Continuing Dental Education and a Leader in Dental Consulting. Debra is also on the board of the American Dental Association's Dental Practice Management Advisory Board.

Because of her contributions to the profession of dentistry, Debra received the Kay Moser Distinguished Service Award given by the American Dental Assistants Association. She has also been chosen as one of the Top 25 Women in Dentistry by *Dental Products Report* and is the 2015 recipient of the Gordon Christensen Lecturer Recognition award.

All Team members have the responsibility to create the perception of quality. This happens with everyone on the Team finding opportunities to validate the practice and endorse the doctor. There are several opportunities for the Team to tell their own story of how the office and the doctor are exceptional. Before the Receptionist/Business Coordinator ends the phone call with the new patient, they should share their own endorsement of the office.

Question 3: "May I tell you a little more about our practice?"

Provide statements such as "The doctor has a great chairside manner" or "We will give you all the time you need to help you make the right choices for your care." These comments help the patient feel comforted that they are in the right place for their dental care.

The Dental Auxiliary can also endorse the Doctor and the standard of care provided by the office by telling the patient their "story". Why do they work there? What about the office makes them proud? How do they feel as a member of the Team? These comments establish trust and rapport with the patient and acts as an endorsement of the Doctor and the practice. These remarks must be authentic -not scripted or contrived. This extra step in the patient process only takes a few extra moments but makes a significant difference in communicating well with patients.

Presenting treatment to patients can be challenging. The Doctor's comprehensive treatment plan should be presented after the consultation, diagnostic information gathered, and the clinical examination is performed. Rather than listing what the patients' needs are, and prior to presenting a written treatment plan, ask the patient this important question:

Question 4: "Would you allow me to tell you what I would like to do?"

This question provides the opportunity to present the patient with the Doctor's plan for ideal care. The treatment discussion should be done with great sensitivity incorporating all aspects of excellent communication – body language, tone of voice, pace, and wording. This is not a rushed conversation. It is important to be an intentional listener and convey total engagement. Sitting at eye level, leaning slightly forward visually demonstrates "You have my attention".

The decision to accept treatment is the responsibility of the clinical team- not the financial team. Their responsibility is to negotiate terms of payment AFTER the patient and the Doctor have agreed on the treatment plan.

Avoid giving the patient a "list" of what they "need" and dismissing them too soon to discuss financial arrangements with a Team Member. Speak to the patient – not to the paper.

How much dentistry has been planned but not completed by patients of record? Improving communication skills in the hygiene department will have a dramatic effect on increasing practice productivity. Establishing a way to initiate a conversation with patients about their incomplete treatment plan can boost profitability. It should never be assumed the patient isn't interested in or can't afford their treatment based on past conversations. If the office stops talking about incomplete treatment based on assumptions, the patient will never place importance on the treatment needs not met.

Question 5: "Tell me what has prevented you from moving forward with your care?"

The hygienist needs time to have this conversation with their patients of record. It should happen at the beginning of the hygiene appointment. Here is an example of how this conversation would flow:

"In reviewing your records today, we noticed there is work that Doctor has recommended that has yet to be completed. Tell me (or help me understand) what has prevented you from having this done?"

The patient will probably bring up the following reasons:

1. It's too expensive.
2. It's not bothering me.
3. I don't have time.

Working on communicating with the patients to address these objections will ease the conversation. Here are some examples:

"If cost is a factor, think what it would have cost you if we had done it at the time Doctor first recommended this treatment and think what it might cost you if we wait. It will never cost you less than now. If we can find a way to help this be affordable for you, what other concerns do you have?"

"Our goal is to help you avoid having any dental discomfort or unplanned dental problems. If you wait until it bothers you, it will be more significant treatment and more costly."

"If time is a major concern, it would be best to take care of this now, before it becomes a more significant problem that would require more appointments."

It is also important to remember the reason why that patient is coming to their hygiene visit. Be careful that it doesn't become too "social". Sometimes we become so friendly with the patient, we forget to talk about dentistry. Excellent communications will be a balance of relationship-building and clinical conversation.

Communicating financially with the patient requires confidence and skill and the art of negotiation is required. Patients are not interested in how your financial protocols serve YOU. They are interested in how your financial protocols serve THEM. The office financial standards should be friendly to the patient and healthy for the practice. Written protocols should be established and used as a guideline for financial discussions. Posting them or presenting them in writing diminishes the ability to negotiate your preferred payment options to patients. If the office has several options, but has one they prefer, that is the option that should be presented first. Wait for the patient to respond whether that option will work for them. If doesn't, present the next preferred option. If none of the options you have to offer seem to suit the patient then ask:

Question 6: "Tell me what you had in mind?"

If their preferences do not work with your office protocols, find an affordable solution that will work for the practice and the patient. This is a two-way conversation.

When you begin the financial conversation avoid the statement: "We require". Replace it with: "Most of our patients prefer to take care of their charges…." and describe your preferred method of payment. Give the patient an opportunity to respond. Working in an atmosphere of financial discomfort is not conducive to patient or practice satisfaction. The team presenting financial protocols and negotiating payment terms must thoughtful and professional and comfortable with their skills.

Mastering the art of communication is critical for every member of the Team. A tiny shift in the approach can change the conversation. Dental professionals who excel in communication foster trust, alleviate patient anxiety, alleviate patient anxiety, and contributes to the success of their practices. By asking the right questions, active listening, expressing empathy the team can improve patient outcomes and increase practice productivity.

Providing exceptional dentistry requires skill that is learned and constantly honed. Natural abilities are trained to provide fine work for patients. Providing exceptional communication is also a skill that is learned and honed. Natural abilities are tuned to provide the patient an exceptional experience. The combination of both creates an outstanding practice that is patient care driven and guaranteed to be highly successful. ¶

Reference

1. Waylean, A. The importance of communication in dentistry: *Dental Update* dental-update.co.uk Vol 44/Issue 8: 09/2017; 774-780.

> **"There are several opportunities for the Team to tell their own story of how the office and the doctor are exceptional."**

Leadership In Action

by Angela McNeight, DMD, MS

In today's dental office, leadership takes on many forms. From leading our own team members in the office on a daily basis to our involvement in organized dentistry as well as in our communities, we find ourselves called to be leaders more often than we realize. Effective leaders are passionate, committed, inquisitive, solicitous, and available. They lead with integrity, handling conflict fairly and maintaining confidentiality where required. While some of these qualities are inherent to the individual's personality, many of these traits and abilities can be improved through learning opportunities and practice. At dental conferences, the lectures regarding difficult leadership aspects within dentistry are often more crowded than those about clinical topics.

That is because in the current dental environment, culture is everything. Team members can jump around from office to office, seeking the highest pay and best benefits package. But what makes team members stay at an office is the culture that is created. Office culture begins with our vision– the vision we have for our patients, our practice, and our team. Even just by using the term "team member" over "staff member" can bring that team mentality to the forefront. For our office, our five core values sit at the heart of our office culture. They are posted in our break rooms and are frequently referenced at morning huddles and quarterly team meetings. We invest in our team members - training them, outlining expectations and cultivating problem-solving skills to improve self-awareness. Yearly team member reviews focus on individual goals and provide a space for open and honest conversation. Our team building days outside of the office setting are some of our favorite memories together and help strengthen these relationships. We promote servant leadership, putting the team member first, prioritizing their growth and well-being leading to improved teamwork and collaboration.

"I strive every day to improve my own leadership skills through building relationships, communicating clearly, and showing integrity."

Dr. Angela McNeight is an owner orthodontist at Caudill & McNeight Orthodontics with three offices in her hometown of Brevard County, Florida. Dr. McNeight currently serves as the chair of the Florida Dental Association Leadership Development Committee and the chair of the Southern Association of Orthodontists Leadership Development Committee. Dr. McNeight serves as the New and Younger Alternate Delegate to the Southern Association of Orthodontists and is very involved in her local community with the Junior League of the Space Coast, Inc. She has been awarded both the New Dental Leader of the Year award and the prestigious Leadership Award by the Florida Dental Association. She was recently awarded the Emerging Leader Award from the Southern Association of Orthodontists. In her free time, her favorite thing to do is go boating with her fiancé Adam and their 2 English Bulldogs, Scooter and Dilly.

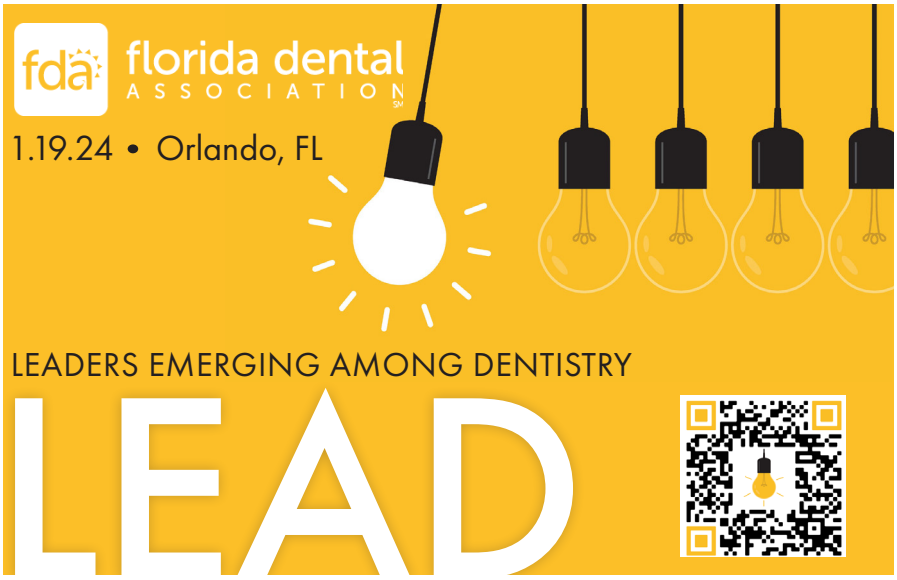
Author and Coach Velma Knowles at the 2022 FDA LEAD event

We as doctors are also constantly trying to improve our leadership skills because leadership within a dental practice is frequently combined with management, and the lines are commonly blurred between the two. By definition, leaders formulate ideas and motivate their team to understand the vision they have set forth. Managers focus on the day-to-day activities, setting measurable goals to report success. In small businesses, these two roles are often combined and frequently overlap. In some offices, the doctor is the manager while other offices may have a true "office manager" who still needs support and guidance from the doctor. While there are countless management structures and organizational hierarchies, it is vital that roles are clearly defined to avoid confusion and blame. Team members are happier and more productive when they understand their roles, have received excellent training, know where to go for support, and are valued and appreciated. When any of these aspects are missing, we have failed our team member and cannot be surprised if they seek a different culture elsewhere.

Leadership outside the office within our communities and professional organizations can be a challenge with a variety of different personalities and leadership styles. Staying positive and focusing on the task at hand are helpful in achieving a favorable result that benefits everyone. At Dentists Day on the Hill each year, I am reminded that community leaders are looking to us for guidance on important issues and actively listening to understand others is the first step in these discussions. One of the most important pieces of leadership in these settings is cultivating personal relationships. Becoming genuinely interested in others and getting to know them on a personal level builds trust and rapport. Aim to bring others into the conversation as much as possible, creating a safe space to voice opinions while encouraging others to listen and reflect attentively. This is especially important in our virtual (Zoom) meeting spaces, where having your camera on, being engaged, staying on time, and calling on those who may be more reserved is essential for ensuring everyone's perspectives are heard and team decisions are made. Keeping lines of communication open and clear is key for effective leadership in today's world.

As the Leadership Development Committee (LDC) Chair of the Florida Dental Association, my charge is to improve leadership within our association. Our yearly **LEAD (Leaders Emerging Among Dentistry)** event is one of the opportunities you can take part in to improve your own leadership skills with seminars related to topics such as public speaking, personality types, and effective meeting management. This year, we are focusing on emotional intelligence – a hot topic in the leadership world. Emotional Intelligence is understanding your own emotions and understanding the emotions of those around you. This translates into discerning your own strengths and weaknesses as well as acting with empathy, seeking to value and appreciate your team members through understanding theirs.

I strive every day to improve my own leadership skills through building relationships, communicating clearly, and showing integrity. Reflecting on your leadership strengths as well as areas of improvement will help you become the best leader you can for your team, your colleagues, and your community.¶



Is Self-Care Important in Dentistry?

by Denise Williams-Jones, RDA

Self-care is a huge topic in today's world. Everywhere you turn, it seems to be what everyone is talking about. It got me thinking about its place in our profession of dentistry. The question I would like to propose is this: Is self-care important in dentistry, or are we different in our profession and do not need to give it the attention that the world is giving it?

What is Self-Care?

Self-care is "the process of taking care of oneself with behaviors that promote health and active management of illness before and when it occurs."[1] Society tells us that performing any sort of self-care is indulgent, unnecessary, weak, or even selfish. Maybe some of us were taught this or even feel this way about these words. Perhaps we feel guilty about practicing different forms of self-care because we are strong, we are tough, and we do not need it. But self-care is not weak or selfish at all; it is quite the opposite.

Practicing self-care requires a very deep and personal understanding of your priorities and respect for both you and the people you choose to spend your life with and do business with. What does that mean? That means yourself, your family, team, and patients.

Self-care encompasses a range of activities and practices that help individuals prioritize their physical, mental, and emotional well-being. However, did you notice that the definition says, "before and when it occurs?" I find it interesting that it says "before." Let's translate that into dental verbiage. We all know what "before" means; it means preventative.

"Self-care encompasses a range of activities and practices that help individuals prioritize their physical, mental, and emotional well-being."

Care Before the Crash

In dentistry, we constantly talk to our patients about preventative care. We encourage them to care for their oral health "before" things happen. We urge them to brush, floss, and have restorations placed before they need crowns. We preach preventative care day and night and get frustrated when our patients do not see the importance of it. Insurance companies even have their category and pay scale entitled "preventative."

Based on all the reasons noted above, we understand the importance of this word. But do we understand it when it comes to ourselves? Are we being proactive in providing preventative personal care before we crash? This is what self-care does. It provides what we need so we do not have the crash. It gives us balance.

Balance

It is tough to be successful in your career as well as balance family time, hobbies, and that oh-so-precious "me time." As we strive to excel in our careers, the challenge of maintaining a harmonious work-life balance remains ever-present. However, we must start exploring strategies to navigate this delicate equilibrium for true success, and the way to do this is with balance. Balance is essential for success because it enables us to effectively manage various aspects of our lives and truly be at the top of our game.

Times have changed. Remember back in the day when everyone would go to the neighborhood dentist? Those days are over. Nowadays, you must have the full package. You cannot count on pure talent. You must be at the top of your game. In turn, you must take a good hard look at the other aspects of your life. You must start to value taking "time out" for self-care as much as you value treating your patients. Why? Because when you feel good, you perform better.

Ripple Effect

This is where the ripple effect comes into play. When you are kind to yourself, it promotes happiness and confidence, because how you treat yourself sets the tone for how you will treat others. This means how you treat your team as well as your patients. When you are kind to yourself and kindly treat your team, they will kindly treat your patients. Thus, the ripple effect comes into play. When you take time out for yourself, you are refilling your cup. When your cup is full, you have plenty to fill others' cups.

Denise Williams-Jones, RDA is a Customer Service Consultant, Speaker, Founder, and Owner of **Next Level to Success**. She started in the dental field in 1995, working in some of the top dental offices in Southern California, with roles including chairside assistant, inventory and supply manager, team trainer, scheduling coordinator, financial coordinator, marketing liaison, community outreach, and front office lead.

Denise consulted for the American Dental Association as part of the Dental Team Hub Advisory Group for Practice Management. She is a Crown Council and Speaking Consulting Network member and has designed continuing education courses for the American Dental Association. She graduated from the Scheduling Institute and ToPs Institute, two highly respected dental practice management training programs. She holds several certifications in Phone Training, Maximizing Patient Flow, Treatment Case Acceptance, and Delivering Exceptional Customer Service concerning patient care.

Denise has a passion and commitment to customer service. She believes results happen when training starts with an organized yet friendly environment and has a track record of noticeable performance growth of the practices she has worked with. Her program is designed to help dental offices improve relationships with their fellow team members and with their patients all while raising their bottom line. Over 28 years of real-life experience in using proven techniques have taken many practices to the **Next Level of Success**.

Next Level to Success

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So, the question is, as you are filling others' cups, are you refilling your own? If not, there will be nothing left to give. If there is nothing left to give, what type of ripple effect will that be? Take good care of yourself first. Fill your cup with proper self-care so that you create the proper ripple effect in your office.

Benefits of Self-Care

When you practice self-care and turn off all the distractions, it allows your body and mind to relax and breathe. When your body and mind relax, several physiological changes occur.

1. Your muscles relax and your heart rate decreases, relieving tension which can improve flexibility and a sense of physical comfort. When you are in this state, it reduces the "fight or flight" response.
2. Your mental clarity is better. Your mind becomes clear and racing thoughts can subside, which leads to improved concentration and problem-solving abilities. Feel-good chemicals like endorphins and serotonin get released and can result in a more positive mood and a reduction of anxiety and depression. It becomes easier to cope with life's challenges and setbacks.
3. You start to sleep better, and your quality of sleep improves. Your digestive health gets better, and you can help alleviate certain types of pain, especially if it's related to muscle tension or stress-induced conditions. You also strengthen your body's natural defense mechanisms, making you more resilient to illness. So, your immune system is stronger.
4. A relaxed state of mind allows for clearer thinking and better decision-making. It becomes easier to weigh the pros and cons and make rational choices when you're not under stress. Your mind is now free to wander and make new connections.

Then you make space. Space for your subconscious mind to expand, thus birthing… creativity.

Creativity in Dentistry

Is this important in our industry? Yes, it is, because having a creative and relaxed mind in the field of dentistry can offer several benefits for the team as well as the patients. Our industry comes with a lot of stress and anxiety. Most people do not like to go to the dentist and often joke about it. You will often hear people say "I would rather... than go to the dentist." We are compared to awful things. Although most people say these things in jest, if you take a look, it is not funny. There is power behind words and there is also a saying "the most serious things are said in jest". So, what people are showing us when they say this type of thing is they are afraid to go to the dentist, and we need to change that.

If we have a relaxed calm demeanor, we can help ease our patients' anxiety and make them feel more comfortable during dental procedures. In turn, this will improve the patient's experience. Patients are more likely to have a positive experience and may be more inclined to return for future appointments.

A creative mind can come up with innovative solutions to complex dental problems. Dentistry often involves diagnosing and treating unique cases, and creative thinking can help find the best treatment options.

A creative mind can also help you communicate effectively with your patients while explaining treatment options, financials, and expected outcomes. It makes complex dental concepts more understandable and relatable.

You start to view your patients as unique individuals with specific needs and preferences. Do you know what happens after that? You give more personalized and patient-centered care.

How To Practice Self-Care

Incorporating downtime into your daily routine through activities like leisure reading, walking, meditation, or just stopping and taking some deep breaths will have a profound impact on your mental and emotional well-being, and this will spill over to other parts of your life, including the office. Remember that we talked about being balanced and how this will have a ripple effect? When you are in the correct mental state, you set yourself up to set an amazing example for your team. Your team looks to you for guidance. You are the leader, and they follow your lead. They will emulate you. When you are calm and in control, they will be calm and in control with your patients.

Another way to practice self-care is to give yourself **guilt-free** time off. You do not have to do anything extravagant, just allow yourself to sleep in, have breakfast in bed, a coffee, and a walk outside in nature. Or a full-on vacation. You choose. The point is to do something that shows how much you care about yourself. Do something that keeps you balanced.

So, let us go back to the original question at hand. Is self-care important in dentistry?

Absolutely! We need it more than ever. I have been in this profession for over 28 years, and we need to change the way we think about these "soft skills" like self-care. Our industry needs to continue to be clinical but allow a balance and make room for self-care. Times have changed and we must change with them if we want to remain on top. If we want to provide the best care to our patients, we must be our best. If we want to keep team members from leaving, we must be our best. If we want to give our best to our patients, we must be our best. This is not a suggestion; this is a requirement. It is what we signed up for, and the only way we can continue to be our best is to be balanced and allow time to recharge our battery.

Self-care is a must in dentistry.¶

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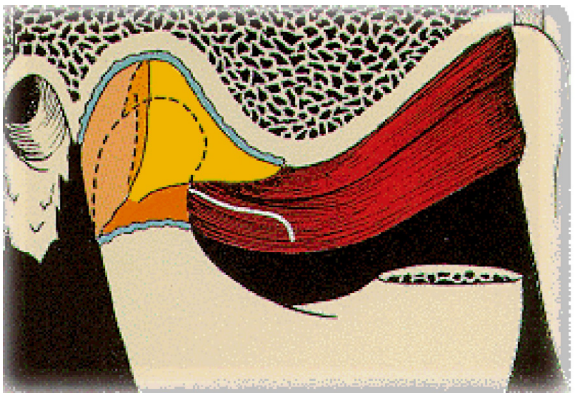
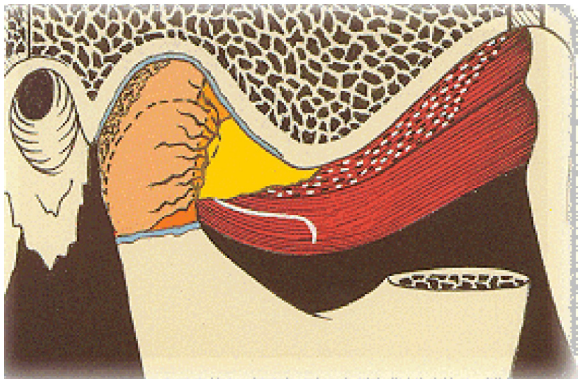
Facial Pain Diagnosis in the 21St Century

by Margaret L. Dennis, D.M.D.

Orofacial Pain Specialist



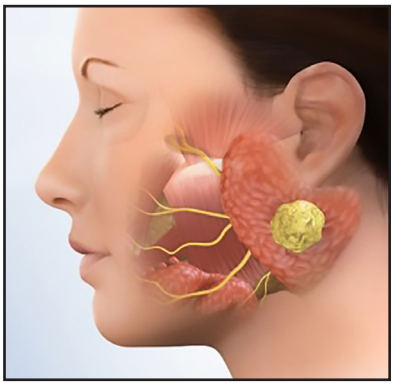


From the Piper Education and Research Center[1]

Are you tired of being confused about facial pain? As a dentist, you are often called upon to diagnose facial pain, but with so many possible causes, it can be overwhelming. But fear not, I'm here to simplify it for you and make it more exciting!

There are nine potential culprits for facial pain, and the most common one is related to teeth and their supporting structures. That's right, those pearly whites can cause you a lot of trouble. From decay and broken teeth to dry socket, periapical abscess, and periodontal abscess, the pain can be excruciating. But don't worry; examination, X-ray, and CT scan can rule this in or out.

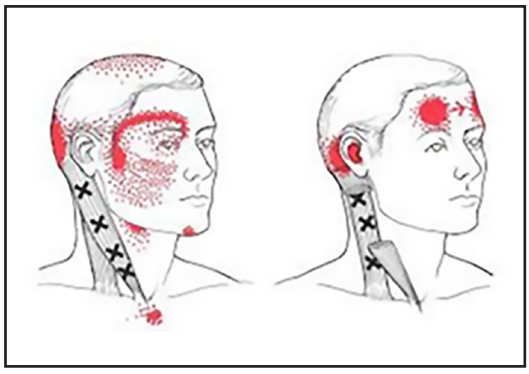
Moving on to the next category, sinus infections and skin disorders can also cause facial pain. Sinus infections can cause aching pain in the masseter and cheekbone areas, as well as in the maxillary teeth. Meanwhile, skin disorders such as acne, dermatitis, hives, chemical rash, and more serious conditions such as Pemphigus vulgaris, Stevens-Johnson syndrome, and skin cancer can also be the culprits. But don't worry, these are generally easier to rule out by their visual presentations, X-rays, MRI, and CT scans.

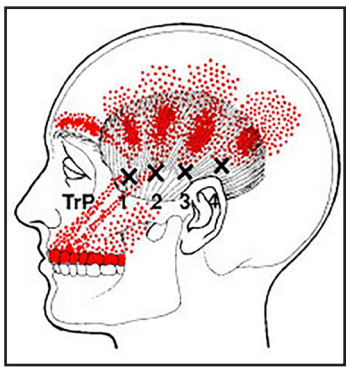


A pleomorphic adenoma, the most common benign tumor of the parotid gland.[2]

Now, let's talk about the more serious causes of facial pain. Brain tumors and soft tissue tumors can cause pain that presents as teeth pain, migraine pain, and facial nerve pain. That's why a thorough brain and facial soft tissue MRI must be done to rule out pathology as a cause of facial pain.

Moving on to the cervical muscles, pain referred from the cervical muscles to the face is often referred to as Myofascial Pain Syndrome (MPS). Myofascial Pain Syndrome is a regional pain syndrome of soft tissue origin that is caused by tender, painful areas of muscle called trigger points. These can be identified by numbing the suspected trigger points, often in the cervical area. It often produces sensory, motor and autonomic symptoms. A common name is "site vs source pain", which means the pain is coming from something other than where the patient feels the pain. If you numb the trigger point area in the neck and the pain in the face resolves, that tells you the facial pain is coming from the cervical muscles. The cervical muscle would need to be treated, not the face. C1/C2 rotation can also cause pain to be referred to the face.





Trigger points[3]

Now, let's talk about the vascular system. The blood vessels can become inflamed (vasculitis) and cause teeth/facial pain, and patients can often have migraine headaches and migraine or vascular toothache.

The autonomic nervous system is the "automatic nervous system", the nervous system that we don't know is working, for instance in blood flow control, blood pressure control, tissue fluid control, etc. Chronic Regional Pain Syndrome (CRPS) is a form of chronic pain that generally develops after injuries. The pain is out of proportion to the severity of the injury and the patients can have tissue discoloration, tissue swelling, and tissue changes. Pateints often describe their pain as a feeling as if "their body is on fire". The closest test we have to a diagnostic test is a stellate ganglion block. CRPS is diagnosed on the history, symptoms and appearance of the patient and response to the block.

Autoimmune disorders such as Lupus, Sjogren's Syndrome, Rheumatoid Arthritis, Fibromyalgia, and VGKC autoimmunity can cause pain from dry eyes and mouth, joint stiffness and swelling, swollen salivary glands, and nerve damage (MS). In general, blood tests will reveal autoimmune disorders, but not always.

Finally, let's talk about the facial muscles. When a person has healthy, stable temporomandibular joints and there is a discrepancy

between the jaw joints, facial muscles, and the teeth, the facial muscles can become overworked and painful. These muscles include the masseter muscles, temporalis muscles, pterygoid muscles and the digastric muscles.

The temporalis muscle is attached to the mandible by the temporal tendon. Temporal Tendonitis is a painful disorder caused by inflammation of the temporalis tendon where it inserts into the coronoid process of the mandible.

Temporal tendonitis may often feel like a migraine headache and causes pain under the cheekbone. We can diagnose temporal tendonitis by palpating the tendon and numbing it with a local anesthetic.

The temporomandibular joints (TMJs) themselves can cause facial pain. But with modern technology such as MRI and CT scans, we can now diagnose temporomandibular joint disorders with ease. Temporomandibular joint disorders is a collective term embracing a number of clinical problems that involve the masticatory musculature, the TMJ and associated structures, or both[4] Temporomandibular joint disorders are often described by using only the term "TMJ" or the term TMD (TMJ Disorder or dysfunction) or TMJ syndrome. I believe these are antiquated terms, developed before MRI and CT. We no longer need to use them when describing facial pain. Just like in any other joint, we can describe what is wrong inside the TM joint by evaluating it with CT and/or MRI. With the knee, you would get an MRI and then say "You have a torn ACL, torn MCL, cracked kneecap, etc." With temporomandibular joints, we can get an MRI and say "You have a growth deficiency of the condyle, a displaced disc, swelling inside the joint, etc." In a normal temporomandibular joint, there is a cartilage disc that is tightly tied down to the condyle with ligaments. Retrodiscal tissue (nerves and blood vessels) lie behind the condyle.

In 80% of the cases of "TMJ" or TMD, the temporomandibular joints themselves are stable. The pain usually comes from surrounding nerves, muscles, tendons and ligaments. Joint health must be confirmed by imaging. The condyle must be of normal size, shape and signal and the disc will be in place at the 1:00 position. Healthy and stable TM joints can be treated with conservative measures to establish a more balanced connection between the joints, the surrounding muscles and the teeth. First by "previewing" the bite correction on a bite guard, then by adjusting the teeth to the comfortable bite.

In 20%, of the cases of "TMJ" or TMD, the joints themselves are unstable due to discal displacement.[5] If the joints are damaged, that disc can be displaced in front of the condyle. The nerves and blood vessels are pulled on top of the condyle. They can be crushed when a person speaks, swallows and chews, causing pain. A healthy temporomandibular joint is a bone-braced joint. When a disc is displaced in childhood, the disc can block the blood flow to the condyle and limit its growth. This causes a condyle/fossa size discrepancy that allows the condyle to be "loose" inside the socket. The facial muscles try to stabilize the joint, making it a muscle-braced joint. Muscles are not supposed to stabilize joints, so they can fatigue, causing pain. Also, if the disc is blocking the blood flow for a long period, the condyle can die. This is called avascular necrosis. Temporomandibular joint pain can come from pain related to the displaced disc and retrodiscal tissue, inflammation in the joint space from the displaced disc, joint capsule pain and bone pain.

Margaret L. Dennis, D.M.D. grew up in Dade City, FL with her sister and "the best parents a person could have." They were public school teachers. She graduated high school in Dade City and earned a BS in Biology at Georgia Southern College. She graduated from the University of Florida, College of Dentistry, in 1987 and opened her general dental office in Jacksonville in 1990. Her sister Jean was her office manager.

In 1995, Dr. Dennis was involved in a motor vehicle accident and injured her neck. She had to stop practicing general dentistry due to hand numbness. At that same time, her sister was having terrible facial pain issues. That's what led Dr. Dennis to explore the world of Orofacial Pain. She was able to treat her sister, and the correct diagnosis of temporomandibular joint damage became her passion. She started to take classes with Peter Dawson, Frank Spear, John Kois, and Mark Piper. She completed the curriculum in both the Dawson Academy and Piper Education and Research Center. Dr. Dawson and Dr. Piper became great mentors in the world of temporomandibular joints and occlusion.

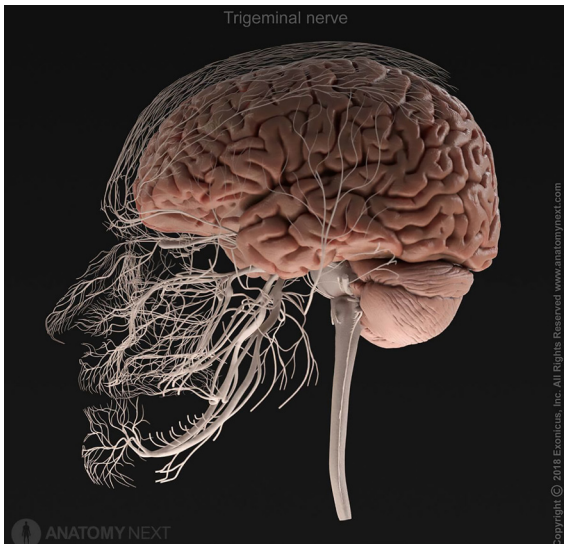
In 2001, Dr. Dennis sold her practice and completed a residency in 2002 at the University of Kentucky, Collage of Dentistry, with Dr. Jeff Okeson. It was a truly great learning experience. She returned to Jacksonville in 2003 and opened The Orofacial Pain Center. Since that time, she has practiced only Orofacial Pain and taught school.

In 2019, a dental school friend who practices in the Villages asked her to come work there. She rents space in his office every other Saturday and sees patients.

Her practice is probably divided into 1/3 nerve pain patients and 2/3 significantly damaged temporomandibular joint patients. She also treats migraine, autonomic nervous system damage, and occlusal issues.

There is a branch of the trigeminal nerve called the auriculotemporal nerve that only goes through the temporomandibular joints. To determine if the facial pain is coming from the facial muscles or the temporomandibular joints, an auriculotemporal nerve block can be done. If the auriculotemporal nerve is numbed and the pain goes away, that tells you the temporomandibular joints themselves are the cause of the pain. If it does not go away, you can then numb the muscle trigger points. If the pain goes away, that confirms the muscles as the source of the pain.

The trigeminal nerve is one of the most fascinating nerves in the human body. It is responsible for providing sensation to the face and motor functions to the muscles of mastication. The nerve has three branches that innervate different parts of the face, making it a complex and intricate system. Understanding the trigeminal nerve can provide insight into how the face functions and can be crucial in diagnosing and treating various facial conditions. A ninth source of facial pain, and a diagnosis of exclusion is pain coming from nerves. Burning mouth syndrome (BMS) is a burning/scalding sensation on the tongue or anywhere in the mouth. Tingling, stinging, numbness, a sensation of dry mouth with a bitter/metallic taste or loss of taste can also be associated. There are no physical findings, no apparent cause, no metabolic disorders present, and it primarily affects post-menopausal women.



Trigeminal Nerve (CN V), Anatomy Next[7]

Trigeminal Neuralgia is a neuropathic disorder of the fifth cranial nerve that causes episodes of intense, stabbing, lightning-like, electric shock-like pain in the areas of the face where the branches of the nerve are distributed. It is often referred to as "the suicide disease" and "the most painful disorder known to man." The trigeminal nerve is the largest of the body's 12 sets of

cranial nerves. It conveys touch, temperature and pain sensations to the face. The trigeminal nerve comes from the base of the brain and fans into 3 main branches. The first branch (V1) is the Ophthalmic or upper branch. It innervates the forehead and eyes and the bridge of the nose. The second branch (V2) is the Maxillary or middle branch. it innervates the maxilla, maxillary teeth, maxillary gingiva, upper lip, cheeks, palate, sinuses, temples and most of the nose. The third branch (V3) is the mandibular or bottom branch. This branch innervates the mandible, mandibular teeth, mandibular gingiva, lower lip, side and front of the tongue and part of the ear. The most common areas affected are the jaw and cheek both (V3 and V2) – 39%, jaw or cheek (V3 or V2) alone - 16%, eyes, forehead and cheek (V1 and V2) – 15%, all branches (V1, V2 and V3) – 13%, forehead and eye only (V1) – 1%. Diagnosis can be difficult because there are no tests available. It is diagnosed on the patient's pain descriptions and symptoms. In an attempt to facilitate diagnosis, The Facial Pain Association has proposed the following classification system:[6]

TN-1 – "Classic TN." Unilateral, with >50% intermittent, sharp, stabbing, lightening-like pain. It is frequently caused by a vascular compression of the trigeminal nerve. The pain typically responds to normal TN treatment. The patient often will not touch the area, won't shave or wear makeup in that area. TN rarely attacks during sleep,

TN-2 – Atypical TN. This is the kind of TN we see mostly in dentistry. It is described as constant burning, dull, aching and stabbing, sharp, boring pain. This pain is generally considered to have no definitive treatment or cure. It is treated most often with medications.

Trigeminal Neuropathic Pain (TNP). Like ATN, the pain is generally constant with no triggers necessary. It is described as dull, aching, burning and boring type pain, but it can also have sharp and fleeting pains. It is due to unintentional injury such as facial trauma from car accidents, nerve injury from difficult dental procedures, complications from sinus surgery or stroke or diabetes and possibly from general dental work.

Post-herpetic neuralgia (PHN). Follows an attack of the shingles, most likely in the eye and forehead (V1). It causes pain, skin sensitivity, itching and a numb feeling. The pain is more constant than classic TN, but often variable. Some describe the pain as sharp, jabbing, burning, deep, aching, dull and boring.

Trigeminal Deafferentation Pain. TN treatment sometimes involves slightly damaging the nerve itself. These are called destructive procedures. If done too often, the nerve is injured to the point where the facial pain is beyond help. *Anesthesia Delarosa* is Latin for pain where there is numbness.

Symptomatic Trigeminal Neuralgia is secondary to another condition like multiple sclerosis (MS) where the myelin protective covering of the nerve is destroyed and appears like a "frayed lamp cord". Nerve impulses do not flow smoothly through the nerve.

The greater occipital nerve is a branch of the cervical spinal nerve II. It arises between the 1st and 2nd vertebrae with the lesser occipital nerve. The greater occipital nerve innervates the skin along the posterior part of the head to the scalp at the top of the head, over the ear and over the parotid glands. Damage to the occipital nerve can cause occipital neuralgia (ON). Patients with ON describe sharp, jabbing pain in the back of the head, along the posterior to the scalp at the top of the head, over the ear, over the parotid glands and the temple area. This type of pain would be diagnosed by numbing the occipital nerve with a local anesthetic.

So, there you have it, folks! These are the 9 potential culprits for facial pain. Don't let facial pain get you down. With the right diagnosis and treatment, your patients can be pain-free and grinning from ear to ear in no time!¶

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Envisioning a Cavity-Free Generation

by Craig S. Hollander D.D.S., M.S.

Diplomate, American Board of Pediatric Dentistry

In May 2000, the US Surgeon General David Satcher released a report entitled *Oral Health in America* which identified the silent epidemic of dental and oral disease that burdened some population groups and called for a national effort to improve oral health among all Americans. Tooth decay was called one of the most common chronic diseases in childhood, 5 times more common than asthma, and 7 times as common as hay fever. More than half of children aged 5-9 had had at least one cavity or filling, and by age 17, 78% percent of children had experienced tooth decay, with more than 7 percent having lost at least one permanent tooth to decay. [1] What has changed? It's been over two decades now, and the CDC published an Oral Health report in 2019 that found that among children with caries, the mean number of affected teeth was 4.3, which represented no detectable change since 1999-2004. Furthermore, although untreated tooth decay in primary teeth reflected decreases in both the 2-5 and 6-8 year age ranges, it still exists. [2] There are new programs like the Alliance for a Cavity-Free Future, which has been committed since 2010 to fighting against the initiation and progression of dental caries, and was formed out of this desire to effect change. They believe that every child born after 2026 should stay cavity-free during their lifetime [3], but how can this become a reality?

The Give Kids a Smile (GKAS) program began in St. Louis in the early 2000s in order to provide free comprehensive dental care during a 2 day event biannually. In order to help the dental volunteers feel comfortable providing treatment, the kids were seen beginning at age 5 up through 8th grade. Unfortunately, since this was the first time many of the kids were seen for a dental visit, the ravages of Early Childhood Caries (ECC) was already evident. ECC occurs in all racial and socioeconomic groups, though it tends to be more prevalent in low-income children, in whom it occurs in epidemic proportions. Studies have shown that 20% of children have 80% of dental caries. Many times, parents have similar experiences with tooth decay, infection and loss of permanent teeth due to infection or periodontal disease. Children can inherit traits like tight contacts or deep grooves in molars, which can make the teeth more susceptible to dental decay. They may share similar feeding habits like consuming carbonated beverages or eating sugary junk foods without brushing well afterwards.

It became evident early on that the only way to make sure that a child is cavity free before they hit the clinic floor was to get the parents before they mess the teeth up. One of the ways to do this is to begin speaking to caregivers about the etiology of dental decay before their child has teeth, or at the very least, perform an oral health screening by age one in order to identify dental problems that already exist. This concept of the age 1 dental visit makes it more likely that tooth decay can be prevented, or at least managed until the child is old enough to cooperate in a dental chair.

Tiny Smiles was developed to bridge this gap, in order to begin counseling parents on the eating and toothbrushing behaviors that could lead to caries development in their child. This educational program, supported by the American Dental Association Foundation, relies on providing information and anticipatory guidance discussions on oral health topics such as bruxism, non-nutritive sucking, soft tissue anomalies, tooth trauma, and potential orthodontic issues through the use of the Tiny Smiles Assessment and Chart[4] which was developed by taking the ADA Caries Management by Risk Assessment form (CAMBRA)[5] and transforming it into a questionnaire. The various headings of the questionnaire allows the health professional to know what factors may be putting that child at risk for developing caries in the future:

Prenatal, Natal, Neonatal History includes whether that child was a result of a risk pregnancy or was born pre-term or at low birth rate.

Developmental History includes the age the first tooth erupted, and whether that child has had multiple ear infections, antibiotics prescribed, or multiple fevers early in life.

Family History will tell a lot about the oral health status of other family members. Finding out about the parent or sibling's rate of tooth decay can allow the interviewer to initiate discussions on the transmissibility of *Strep mutans* and how bad teeth may not run in the family, but poor brushing or eating habits may.

Dental History can investigate topics such as past dental trauma, bruxism, and teething difficulties, and provide the anticipatory guidance needed to resolve these issues.

Oral Habits such as pacifier use and other non-nutritive sucking habits can be discussed, suggestions on how to stop them can be provided to the parent.

Home Care habits such as who is brushing the child's teeth and how can provide the caregiver information that would be important for all of the children in the family. The interviewer can make sure that a fluoridated toothpaste is being used and discuss if a smear or pea size amount is recommended for each individual child.

Water and Fluoride Sources will determine whether the child is receiving the benefits of fluoridation through the halo effect.

Feeding History questions will determine whether the child is at higher risk due to breast feeding habits, bottle use, grazing and snacking frequency, and the availability of gummy type foods or vitamins.

Interviewing the caregivers on the above topics is important so that they receive immediate feedback, instead of just filling out a form. This way, alternatives can be discussed with regard to the oral hygiene and eating habits at home. This discussion may not only benefit the child, but provide the care giver with suggestions that could improve their oral health as well.

Once the interview is complete, the dentist and caregiver can then face each other for a knee to knee lap exam visit so that the child's teeth and soft tissues can be visualized. It should only take a minute or less to "count the teeth", but it is time well spent. The application of fluoride varnish completes the Tiny Smile appointment.

ADA American Dental Association®
America's leading advocate for oral health

Caries Risk Assessment Form (Age 0-6)

Patient Name:				
Birth Date:			**Date:**	
Age:			**Initials:**	
		Low Risk	**Moderate Risk**	**High Risk**
Contributing Conditions		Check or Circle the conditions that apply		
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	☐Yes	☐No	
II.	**Sugary Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes ☐	Frequent or prolonged between meal exposures/day ☐	Bottle or sippy cup with anything other than water at bed time ☐
III.	**Eligible for Government Programs** (WIC, Head Start, Medicaid or SCHIP)	☐No		☐Yes
IV.	**Caries Experience of Mother, Caregiver and/or other Siblings**	No carious lesions in last 24 months ☐	Carious lesions in last 7-23 months ☐	Carious lesions in last 6 months ☐
V.	**Dental Home**: established patient of record in a dental office	☐Yes	☐No	
General Health Conditions		Check or Circle the conditions that apply		
I.	**Special Health Care Needs** (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	☐No		☐Yes
Clinical Conditions		Check or Circle the conditions that apply		
I.	**Visual or Radiographically Evident Restorations/ Cavitated Carious Lesions**	No new carious lesions or restorations in last 24 months ☐		Carious lesions or restorations in last 24 months ☐
II.	**Non-cavitated** (incipient) **Carious Lesions**	No new lesions in last 24 months ☐		New lesions in last 24 months ☐
III.	**Teeth Missing Due to Caries**	☐No		☐Yes
IV.	**Visible Plaque**	☐No	☐Yes	
V.	**Dental/Orthodontic Appliances Present** (fixed or removable)	☐No	☐Yes	
VI.	**Salivary Flow**	Visually adequate ☐		Visually inadequate ☐

Overall assessment of dental caries risk: ☐ Low ☐ Moderate ☐ High

Instructions for Caregiver:

Any noted abnormalities can be charted on the odontogram which is included in the Tiny Smiles Assessment packet. Decalcifications can be identified before the tooth breaks down further, and the parent can be reminded what may be taking place at home that is putting this child at risk for further decay. If larger carious lesions are detected, then the general dentist can refer the patient to their local pediatric dentist for further intervention and treatment. These outside referral sources, called Smile Factories, could be pediatric dentists, oral surgeons, or even endodontists. Once the referred treatment is compete, the patient can return back to your office for their preventive care visits.

A general dentist who provides a dental home for infants and toddlers can literally have a patient for life.

Parents don't know how to prevent cavities in their children until they are taught.

You can be the person who teaches parents how to prevent cavities in their children.

You can be the person who can help create a cavity free generation.

The Tiny Smiles program can help you do that.¶

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4. CAMBRA Attachment

5. Tiny Smiles Assessment and Chart Attachment

Dr. Craig Hollander has been a pediatric dentist in private practice in St. Louis for over 30 years. In his spare time, he teaches at a Graduate Pediatric Residency program as well a General Practice Residency.

He got his dental degree from the University of Missouri in Kansas City, and completed a general practice residency at Miami Children's Hospital in Florida, where he attributes his career choice to his mentor and program director Dr. Mark Webman who encouraged him to become a pediatric dentist. Dr. Hollander was accepted and received his specialty training from the University of Iowa in 1991.

He is a past recipient of the Missouri Dental Association's Dentist of the Year award for his statewide children's oral health initiatives, and in 2008 he received the Greater St. Louis Dental Society's Distinguished Service award for his role in improving access to dental care for the underprivileged children in his community.

Dr. Hollander's leadership roles include being a co-founder of the Missouri Academy of Pediatric Dentistry, and a Fellow of both the American College of Dentists and the International College of Dentists.

Locally, Dr. Hollander is on the Executive Board of Give Kids a Smile where he developed and leads the Tiny Smiles Clinic which provides access to dental care for infants and toddlers.

GKAS Tiny Smiles Assessment and Chart

PATIENT'S NAME_____ AGE_____ DATE_____

NAME of CAREGIVER with the CHILD _____ Mother ❑ Father ❑ Other ❑_____

Prenatal, Natal, Neonatal History	Low Risk	High Risk
High Risk Pregnancy	No ____	Yes ____
Tetracycline Ingestion During Pregnancy	No ____	Yes ____
Pre-Term or Low Birth Weight	No ____	Yes ____

Comments: _____

Developmental History

Age First Tooth Erupted _____months

Comments: _____

Medical History	Low Risk	Moderate Risk	High Risk
Number of Ear Infections	0-1	2-3	≥3
Frequency of Antibiotics Prescribed	None	Low	High
Multiple Fevers Early in Life	No		Yes

Other Childhood Illnesses _____

Family History			
Parents Frequency of Decay	Low	Moderate	High
Siblings Frequency of Decay	Low	Moderate	High

Dental History

Previous Dental Trauma _____

Bruxism (Grinding) _____

Teething Difficulties _____

Oral Habits

Sucks Pacifier	Yes ____	No ____				
Does caregiver clean it in their mouth	Yes ____	No ____				
Does it get dipped in a sugary substance?	Yes ____	No ____	**How Often?**			
Sucks Thumb	Yes ____	No ____	Only at Night	When Sleepy	When Bored	When Nervous
Sucks Fingers	Yes ____	No ____	Only at Night	When Sleepy	When Bored	When Nervous

Home Care

Are teeth being cleaned? No Washcloth Toothbrush **Who is brushing?** Parent Child Parent and child

When are teeth being brushed? Only morning Only night Morning and night After feedings

What toothpaste is being used? None Ingestible (Training) Toothpaste Fluoride Toothpaste

Water and Fluoride Sources

Does your home drinking water have fluoride in it? Yes No Don't Know

Does your child spend time anywhere other than home? Daycare Babysitter Other Caregiver

Does that place have fluoride in the water? Yes No Don't Know

Feeding History

Breast Yes ____ No_____ Until what age? _____

	Low Risk	**Moderate Risk**	**High Risk**
How many times (circle response)	1-3x day	4-6 x day	Over 6 x day
Duration of feeding	< than 15 minutes	15-30 minutes	> 30 minutes

Feeding on demand _____ Feeding over-night in parent's bed_____

Bottle Yes ____ No_____ Until what age? _____

What's in the bottle? Milk Juice Water Other _____

	Low Risk	**Moderate Risk**	**High Risk**
How many times (circle response)	1-3x day	4-6 x day	Over 6 x day
Duration of feeding	< 15 minutes	15-30 minutes	> 30 minutes

Bottle given while lying down Yes ____ No ____

Bottle given as pacifier Yes ____ No ____

Sippy Cup Yes_____ No_____ Until what age?_____

	Low Risk	**Moderate Risk**	**High Risk**
How long does the child have the sippy cup each day?	<15 minutes	15-30 minutes	>30 minutes

Snacking and Grazing

Does your child eat sticky snacks? Yes No Fruit snacks Fruit Roll-Ups Dried Fruit Gummy Vitamins

	Low Risk	**Moderate Risk**	**High Risk**
How often does your child have between meal snacks?	Never	1-2x a day	>3 times a day
How long is each snacking session?	< 15 minutes	15-30 minutes	All of the time

To be Filled out by Dentist

Plaque present on teeth Yes ____ No ____

White/ brown spots or stains on teeth Yes ____ No ____

Decay/cavity present Yes ____ No ____

Has child been to a dentist yet Yes ____ No ____ **Is a Rx required today? Yes _____ No _____**

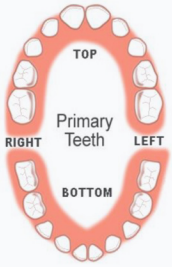
Does this patient require additional treatment today? Yes_____ No_____

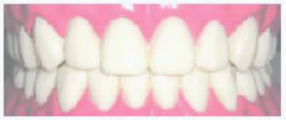
What is needed today? _____

Does this patient require a Smile Factory Office? Yes____ No____ If yes, what treatment is needed?

_____

Dentist's Name _____ Date of last visit _____





Patient Name_____

DOB_____

CHART OF Services for Tiny Smiles Patient Checkout

Dental Code	Services Rendered	YES	NO	Notes
D0145	*Comprehensive Dental Exam (child 0-2 years)*			
D0150	*Comprehensive Dental Exam (child 3-5 years)*			
D1120	*Prophy: Specify in notes (i.e. gauze, TB, etc.)*			
D1206	*Fluoride Varnish Application*			
D1351	*Sealants: (Place Tooth Numbers in Notes)*			
D1330	*OHI Provided*			
OHS	*Oral Hygiene Supplies given to patient*			
D1310	*Nutritional Counseling Provided*			
9999	*Other Services (Explain in Notes)*			

TINY SMILES

Tiny Smiles Assessment and Charting Forms

• • •

For enlarged forms or the forms in Spanish, please email flagdeditor@gmail.com.

The Age One Dental Visit

by Dr. Elizabeth Simpson

When I was asked to write an article for the journal about general dentists doing age one dental visits, I jumped at the chance, because promoting general dentists performing age one dental visits is one of my passions in dentistry. But as I sat down to put pen to paper as we used to say, or finger to keyboard, I grew hesitant. I am under no illusion that most general dentists are discerning with seeing children, let alone toddlers, but I have hope that as members of the Academy of General Dentistry, the dentists who are intentional about having a wide scope of knowledge and skills, that asking this group to add age one dental visits to their everyday practice will be met with open minds. The fact that I was asked to write about this means that perhaps I could say something to persuade some of you to start.

I attended Tufts University School of Dental Medicine for my dental degree where we were taught the age one dental visit as part of our pediatric dentistry curriculum. When we were taught how to do the exams, we weren't taught with the caveat that "well, none of you will actually do this once you get out" or "leave this to the pediatric dentists", we were taught that this was something absolutely in our capabilities and that there was no reason for us not to perform age one dental visits. It was so ingrained in us, or maybe just me, that it didn't occur to me that most general dentists balk at the idea of doing this simple exam.

As someone who has worked in underserved communities for the bulk of my years practicing, promoting good habits as early as possible is part of trying to change the trajectory for many of these patients who have had generations of families with poor oral health. Beyond changing outcomes for our socioeconomically disadvantaged and Black and Hispanic patients (who have higher incidences of early and severe early childhood caries), we are creating better outcomes as well for our kids from more "privileged" backgrounds because they are also still at risk of developing decay because of the amount of fermentable carbohydrates that make up much of the average American diet, particularly the types of snacks that little ones love so much.

A huge push for general dentists doing age one dental visits is because it's a sheer numbers game. In 2022, there were 216,260 live births in the state of Florida. There are 1,144,006 million kiddos aged zero to 4 years old. There are 484 pediatric dentists in the state and around 10,000 general dentists. Simply put, we can't leave it to the pediatric dentists to see all the state's kids! Teamwork makes the dream work. Keep in mind, no one is asking you to do treatment that you aren't comfortable with, but yes, I am asking you to assess the little ones because we can all recognize decay from white spot lesions to severe early childhood caries. We all have the knowledge that our patients need to help families give their kids healthy smiles for life.

One of my favorite procedures to do is full mouth extractions with immediate delivery of dentures. And even though I loved it, it was still work that took up some time and energy. Mixing in a quick toddler visit and educational conversation with their parents was a fun way to add some variety to the day.

A "selfish" reason to do the age one dental visit in whatever setting you practice: it is a practice builder! When I was working at a federally qualified health center a couple of years ago, we hosted a Give Kids a Smile event at our clinic specifically targeting families bringing their toddlers for their first dental visit. Once the parents who didn't have a dental home themselves saw how we treated their children, they signed up to make appointments for themselves.

As far as the actual procedure, when doing age one dental visits, I converse with the parent or guardian before I do the exam. I discuss oral hygiene habits: everything from if baby's teeth are or are not being brushed, to how much toothpaste is safe for use with babies, to not letting baby go to bed with a bottle. I discuss behavioral habits like thumb, digit or pacifier sucking, and bottle or cup usage. And finally, I discuss nutritional habits. Once any questions are answered, and we are ready for the exam, I explain to whoever brought the baby how the exam will go so that we can get our exam done as quickly and as comfortably as possible. I also warn parents that their baby may cry but that helps me see everything better.

For the actual knee to knee exam, we line up my knees to the baby's parent's knees, turn baby to face their parent, and then we dip baby back so that their head is in my lap and parent is holding their arms down and legs are straddling their parent. I quickly assess teeth, their eruption and spacing, lingual and labial frenum and gums. I brush teeth quickly with a prophy angle and prophy paste (I know some practitioners will brush baby's teeth with a toothbrush and toothpaste) and then apply topical fluoride if the parent accepts it.

Patients, Pills and Pathologies

by Amber D. Riley, RDH, MS, FAAFS, CMCPS

Today it is more important than ever to integrate dentistry and medicine and remove patient-perceived distinctions between oral and systemic health. A thorough medical history is the single most important first step to providing comprehensive dental care. Dental emergency management and adverse treatment outcome mitigation begin with preventing either of them from occurring.

Normally, from first contact of a new patient with us, on the telephone or from our website, quickly we glean the most immediately necessary information from them: What kind of dental needs do you believe that you have? Are you experiencing any pain right now? How long have you been experiencing the symptoms? These questions are generally enough to dictate how soon and with which provider, an appointment should be scheduled per the office's standard of care.

When the patient arrives for their appointment, we are more conscientious of what a new patient discloses on the medical history questionnaire, and our line of questioning during our intake interview evidences this. Every practice has its own protocol. Often, it is the dental hygienist making first contact with a new patient and conducting, at minimum, a preliminary medical interview before the doctor meets with the patient. This process of care is certainly much more universal with our established patients in general dentistry, and it is upon them, our established patients, that I wish to cast renewed attention; the patients that have been in our care for years and decades.

Life expectancy has increased and with this longevity we also see the increase in disease incidence and systemic conditions that cause both acute and chronic illness and disability. These result in a medically compromised patient sitting in your dental chair more frequently than you realize. The interrelationship between general health and oral stability does involve most, if not all, organ systems. Hematologic, autoimmune, and infectious diseases strike young and old alike, however as we increase in age, the likelihood of experiencing disease also increases.[1] What is critical for dental providers is that the condition is recognized and managed to avoid or at least reduce complications when providing dental

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She is a Forensic Dental Consultant to the San Diego County Office of the Chief Medical Examiner, a Federal Safety and Occupational Health Specialist & member of the forensic dental unit of the U.S. Government disaster mortuary operational response team, an advisory Board Member to the Oral Cancer Foundation and a professional risk and liability consultant specializing in the dental sciences to national medical/dental liability insurance brokerages and a certified medical cost projection specialist for civil litigation casework.

She is the President of the American Society of Forensic Odontology, Fellow of the American Academy of Forensic Sciences, Member of the International Association of Coroners & Medical Examiners, Member of the California Dental Hygienists' Association and an Associate Member of the American Academy for Oral Systemic Health.

Continued from page 25.

Dr. Elizabeth Simpson is a general dentist from Indianapolis, Indiana. She attended Tufts University School of Dental Medicine for her dental education. After graduation, she did a one-year general practice residency at Meharry Medical College School of Dentistry. After 9 years in clinical practice, mostly working in federally qualified health centers, she joined Indiana University School of Dentistry as a Clinical Assistant Professor and Clinic Director. She is chair of the American Dental Association's Council on Advocacy for Access and Prevention. She is passionate about educating the public about infant oral health promotion and promoting careers in public/community health dental clinics to her dental students.

If I see something suspicious, I may refer to a pediatric dentist, but as I said, as general dentists, we are perfectly capable of assessing toddlers. I would venture to say, the hardest part of the visit is educating families about what will lead to a healthy smile for life for their child. Ingrained beliefs and misunderstandings about oral health and dentistry can be hard to combat. Busy overworked parents can find changing habits challenging. Snacks that are high in refined carbohydrates are generally less expensive than whole foods like fruit and vegetables, not to mention tend to be tastier to immature taste buds. Brushing the teeth (no matter how few there are) can be taxing with a stubborn toddler. But, finding what will motivate these families to make changes can be the difference between some daily frustrations and sedation in the hospital for dental treatment for their little one.

If you still aren't convinced to help close the gap in access for hundreds of thousands of patients by coming alongside our pediatric dental colleagues, at least talk to your pregnant patients, friends and family members, or patients who come in with little ones to take their kids to the dentist by age one! In my humble opinion, the age one dental visit is one of the key steps in helping solve the access to care issue. When we can get more toddlers into the dentist earlier, we can catch potential problems earlier and set them on a path to not only a healthy smile, but to easy and fun visits to the dentist and break generational cycles of poor oral health outcomes and negative feelings.¶

Continued from previous page.

treatment and prescribing drugs. We are ethically and professionally obligated to keep a practical and refreshed working knowledge of the pathophysiology of common medical diseases and conditions, and know the potential risks or complications associated with dental procedures and services.

For instance, fifteen of the top twenty drugs prescribed in the United States list Xerostomia as a side effect.[2] It should be no astonishing revelation to realize that these drugs are used to treat the diseases and systemic conditions occurring the most frequently in adults. Stop for a moment and think of how many times in a week you treat a patient with at least one of these conditions: Hypertension, Hypercholesterolemia, Ischemic Stroke, Chronic Pain, Depression & Anxiety, Insomnia or Gastroesophageal Reflux?

When discussing with your patients about their medical history, ask specific questions such as "Do you take drugs, medicines or pills of any kind?" Patients often do not report OTC drugs and nutritional supplements. The inclusion of these drugs on your medical history can provide clues to unreported medical disorders. Patients frequently respond, "I didn't know that would be important to a dentist", and such a statement is a prime opportunity to explain why first, YES, it is very important, and secondly how the union of dentistry and medicine is inseparable. Follow up this intake process by taking a blood pressure reading on your patients routinely and before the delivery of local anesthetic drugs of any type, and document the reading in the patient record. The ADA recommends deferring elective dental treatment for readings at or above 180/110mmg. It is good practice to make a full written update of every patient's medical history at least every other year but include verbal interviews and updates at every appointment. Keeping a previous medical history form for comparison of changes is a good idea. You may discover a patient with a previous medically managed condition has discontinued taking a prescribed drug (with or without the prescriber's consent) for costs or personal reasons, by questioning your patient about the change you may uncover risks that were previously not as concerning.

The fundamental question we must ask ourselves as providers is "Does the benefit of treatment outweigh the risk of a medical complication occurring either during or as a result of treatment?" When we conclude that yes, benefit outweighs the risk, then we choose what, if any, modifications to treatment planning and treatment delivery should be made. An adjustment to chair position and the use of a plain local anesthetic may be all that is necessary to properly manage a patient living with symptomatic heart failure, more notably one taking digoxin for their chest pains or arrhythmia and non-selective beta-blockers to control the often-associated hypertension.[3] Ask asthmatic patients "What type of asthma do you experience and when was your last asthmatic attack? Do you carry a rescue inhaler, and if yes, do you have it with you right now?" Patients taking warfarin (Coumadin), the anti-coagulant drug indicated for several medical conditions, should not be prescribed metronidazole or fluconazole (Flagyl, Diflucan) for bacterial or fungal infections, as they can have a life-threatening interaction with the liver protein instrumental in metabolism of warfarin. INR levels can rise so high and so fast that even after a single dose of these drugs multiple ecchymoses, swelling, nose bleeds and cerebral hemorrhages have been reported in the literature.[4,5]

Our goals are providing the best treatment to our patients and doing it safely. We not only insulate ourselves from the menace of litigation by taking a few extra minutes to document a comprehensive review of our patient's health status before we begin treatment, but we serve our profession justice by closing the gaps still held in our patient's beliefs that dental care is not health care.¶

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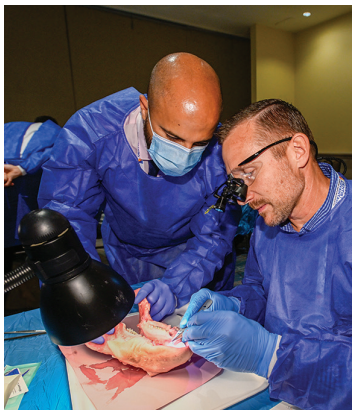

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