FLORIDA FOCUS

September 2025

the publication exclusively for the general practitioner

FLORIDA ACADEMY of GENERAL DENTISTRY

(Left to right) AGD Region 20 Regional Director Aldo L. Miranda Collazo, DMD, FICD, congratulates Drs. Trevor L. Williams, Elianne Emma Vazquez, Raul I Garcia, Mine Turhan, and Rachel Awad at the the Montreal AGD Scienti ic Session.

In this Issue....

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SEPTEMBER 2025

Congratulations to FLAGD member Dr. Tony Menendez upon achieving his sixth AGD Lifelong Learning and Service Recognition!

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President's Message

Do you ever wonder why we do what we do? Is it for the glory and honor of being a dental team member? Is it for the money or job security? Even though dentistry is probably the only field where we try to eliminate the work that we do by teaching patients better home care, there will always be crowded arches, energy drinks and bar fights. As a general dentist who recently turned 60, I've been getting questions from my patients about when or if I'm going to retire. My standard answer is that I'm not ready to retire yet, that I feel like I still have a lot of dentistry left in me, or that I'm excited about the changes in the field and I'd like to see what the next level of digital technology comes around for our field. The truth of the matter is that I feel like I was called into the field. When I was in college, I was granted a scholarship to medical school at Loyola in Chicago. All my life I've desired to do something in the biological sciences, and I had aspirations of being a neurosurgeon. The brain has always held a fascination for me. But that wasn't to be my calling. When it came time to make the decision about accepting the scholarship, my mother was terminal with cancer, and my dad and I decided it would be better to keep me closer to home in case she passed unexpectedly. My college advisor helped me with my decision and it turned out that all my prerequisites qualified me for dental school and I was accepted at THE University of Florida College of Dentistry. My dad's instincts were right because my mother passed during my first semester of dental school, just three days before finals. I was able to be there with her in the hospital on her final day.

So why do I do what I do? Certainly, I love the thanks I get from patients when I do my best work. I enjoy running into my patients in WalMart and Culver's and seeing them in a setting outside of the office. I enjoy having patients who are comfortable enough with me to call me by my first name, or to text me to check on me after my rotator cuff surgery or radiation treatment for prostate cancer. But the real reason I do what I do is because of my mother. When I was in my teens, I worked at a grocery store as a bagging clerk and my mom was a cashier. One day, while she was ringing up groceries for a lady in our town, I was bagging the groceries in the old style paper bags that could hold more than a can of soup and a pack of gum. The lady saw me there and asked my mom who was the young man bagging her groceries. My mom replied, "This is my son, the doctor." That response left me more inspired than anything else I can remember.

So why do I do what I do? Because I love how dentistry has changed in the 33 years since I graduated. Because I love doing something different and challenging everyday. Because I love making a difference in somebody's quality of life. Because even though my mother died in December 1988, her inspiration still sticks with me today. I do what I do because I want her trust in me to make a difference.

Why do you do what you do?

Ray A Morse, DMD
Panama City, FL

Editor's Note

One of the most admirable aspects of our profession – and of medicine in general – is the constant, selfless effort to reduce the need for our services, which is one reason the anti-science backlash following the COVID pandemic has been so distressing. Despite eighty years of research supporting the benefit and safety of water fluoridation, not to mention the nearly two centuries of research on vaccines, Americans are urged to distrust the evidence and accept false statements written only to enhance our politicians' careers. As a second-generation dentist, I've always felt proud of our professional organizations, and now I am grateful to the AGD, the ADA, the Florida AGD, and others for continuing to promote the benefit of fluoridation and fluoride drops for infants in communities where water fluoridation is unavailable. Let us all hope this misguided public policy is eventually reversed.

Congratulations to our members whose professional achievements were recognized at the July AGD Scientific Meeting in Montreal! Nine Florida AGD members received their Fellowship Awards, three received their Masterships, and one, Dr. Tony Menendez, earned his sixth Lifelong Learning and Service Recognition award! Dr. Menendez tells me that he has completed the requirements for his seventh LLSR and is working toward his eighth! Please see page 4 for the names of all these dedicated and inspirational dentists.

As always, thank you to the authors who supported the Florida AGD by contributing to this issue. Prosthodontist Dr. David Carroll discusses his experience with the Bioclear Method of composite restoration and shares its many applications. Dr. Charles Reinertsen emphasizes the many ways in which dental disease affects the individual's medical status and urges us to spread the word among physicians and our patients. Mr. Rick Ball of Summit Handpiece Express advises us on handpiece maintenance in "Repair or Replace?," part two of his 3-part series "Handpiece Lifeline: Smarter Care for Longer Service." Finally, our AGD Candidate for Vice President, Dr. Richard Huot, describes his multifaceted career in dentistry; his leadership experiences in the Air Force, the AGD, and the ADA; and his vision for the AGD. We wish you the best in your campaign, Dr. Huot, and lots of health, happiness, and success for our members!

Millie K. Tannen, DDS, MAGD
Jacksonville, FL

FLAGD UPDATE

CONGRATULATIONS TO THE 2025 FLORIDA AGD FELLOWSHIP, MASTERSHIP, AND LLSR AWARDEES!

AGD Region 20 Regional Director Aldo L. Miranda Collazo, DMD, FICD, congratulates Drs. Trevor L. Williams, Elianne Emma Vazquez, Raul I Garcia, Mine Turhan, and Rachel Awad at the the Montreal AGD Scientific Session.

2025 FAGD Awardees

Rachel Awad, DDS, Lake Worth
Sean Bannan, DDS, Daytona Beach
Trevor L. Williams, DMD, Brandon
Elianne Emma Vazquez, DDS, Miami
Mine Turhan, DDS, Bradenton
Jose G. Rodriguez Lantigua, DMD, Orlando
Ly Nguyen, DMD, Davenport
Anne M. Lamb, DMD, Jacksonville
Yosvel Blanco Sanchez, DMD, Orlando

2025 MAGD Awardees

Robert J. Evelyn, DMD, Ocala
Raul I. Garcia, DMD, Miami
Michael J. O'Neal, DDS, Longboat Key

2025 LLSR

Tony Menendez, DDS, MAGD, Port Charlotte

Fellow Florida AGD Members,

Please join us on September 19-20, 2025, in Orlando, Florida, for Botox & Dermal Filler and Dental Applications Training, hosted by DentaSpa, the world's leading training academy for Botulinum Toxin & Dermal Fillers tailored for dental practitioners.

Nationally recognized by both ADA CERP & AGD PACE for 16 CE credits, our 2-day, comprehensive lecture and live patient clinical training will focus on both the dental therapeutic and cosmetic uses of Botulinum Toxin & Dermal Fillers.

Throughout this exciting, private-style training, you will learn how to seamlessly implement the most lucrative, high-demand Botulinum Toxin & Filler treatments into patients' treatment plans to provide comprehensive care and optimize the final outcomes of dental cases.

You may bring a model to participate in the course and receive treatment.

For more information, please contact
Seth Calish, DMD, MS, FAAIP, FICOI
President, Central Florida AGD
cflagd@gmail.com

Can Bioclear *Revolutionize* Your Practice?

by Dr. David Carroll

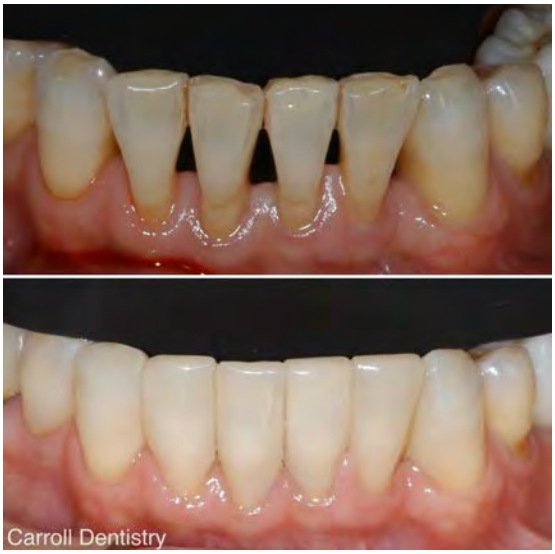


Fig. 1. Black triangle, *pre- and post-op photos*

Imagine if you could learn a method for direct composite-based restorations that would allow you to restore any tooth anywhere in the mouth with a very high degree of confidence - confidence that it would not only look great, but it would also last for many years without breakage or microleakage. Now imagine if the same method would allow you to also approach cosmetic dentistry in a whole new way, where you could literally "crown" teeth without any regard for path of insertion. Does that sound like a dream? Nine years ago that would have been a complete fantasy for me and my practice. Today, thanks to the Bioclear method, it is a reality.

Now, I'm not saying that every direct restoration is going to turn out perfect. We all know that dentistry is not that kind of job, and there will always be that restoration or that one patient that just doesn't go as planned. But what I am saying is that when you have a proven method in your hands, that changes everything!

Eight years ago, when I signed up for my first Bioclear course, I thought I was just going to learn how to close black triangles without cutting down teeth. I had no idea I was starting on a journey that would impact every aspect of my practice. When I graduated from prosthodontic training in 1993 and joined my father in private practice on Miami Beach, I was fairly confident in my abilities to deliver indirect dentistry with a high degree of clinical accuracy. But my direct composite-based dentistry was surely deficient. Class II composites were anything but predictable. Well, actually, it was predictable that each one would be challenging and stressful. My anterior composites were okay but not great, and in general, I didn't really enjoy the world of direct composite dentistry. Today, that part of my practice is so much more satisfying and less stressful.

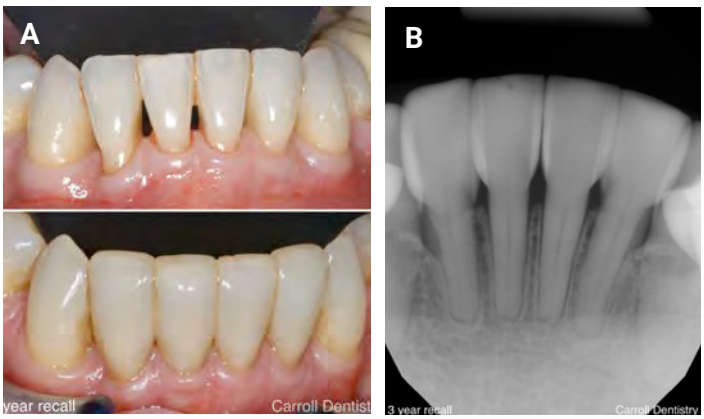


Fig. 2. Black triangle. *A. Pre- and 3-year post-op photo. B. 3-year post-op radiograph.*

In a nutshell, what is the Bioclear Method, and how can it help you to enjoy dentistry more?

The Bioclear Method is a system that allows for injection-molded monolithic composite-based restorations using anatomic matrices. It also includes training on how to properly clean teeth for predictable adhesion, as well as understanding new preparation designs to achieve more favorable biomechanics. Gone are the days of struggling with flat mylar and cutting GV Black-style preparations. There is also no longer a reason to cut all that precious enamel off anterior teeth just to be able to do pretty dentistry. Do I still enjoy doing a nice porcelain veneer case? You bet I do! But there are many patients where it just isn't the best option. Let's look at some examples of cases where the Bioclear Method really shines.

1) **Black triangle cases (Fig. 1 & 2).** Bioclear is absolutely indicated here as my go-to method. Although I will still discuss porcelain restorations as an option with patients, it's mostly just for discussion purposes. I have no intention of cutting down perfectly healthy teeth just to close those spaces. After an objective discussion of the advantages, disadvantages, and risks associated with Bioclear vs Porcelain options, it is rare that any patient selects an indirect method for this situation.

2) **Routine Class III and class IV restorations.** Squeezing flat mylar filled with composite as a form for these is just not the best way to do it, not by a long shot. It makes the cosmetics more challenging and is bad from the biomechanical perspective, as well.

3) **Class II restorations.** This is such a pain point for so many dentists that we actually changed the Introduction course for Bioclear to include more Class II training. The problem with many systems is they just don't allow for anatomically correct contacts, so even if you get it "tight", it's the wrong shape and leads to other problems such as food entrapment.

4) **Diastema closures and other negative spaces in the maxillary anterior segment (Fig. 3).** A good general rule to keep in mind is that if you see negative spaces in a smile, you will generally need to do significant preparation of the teeth

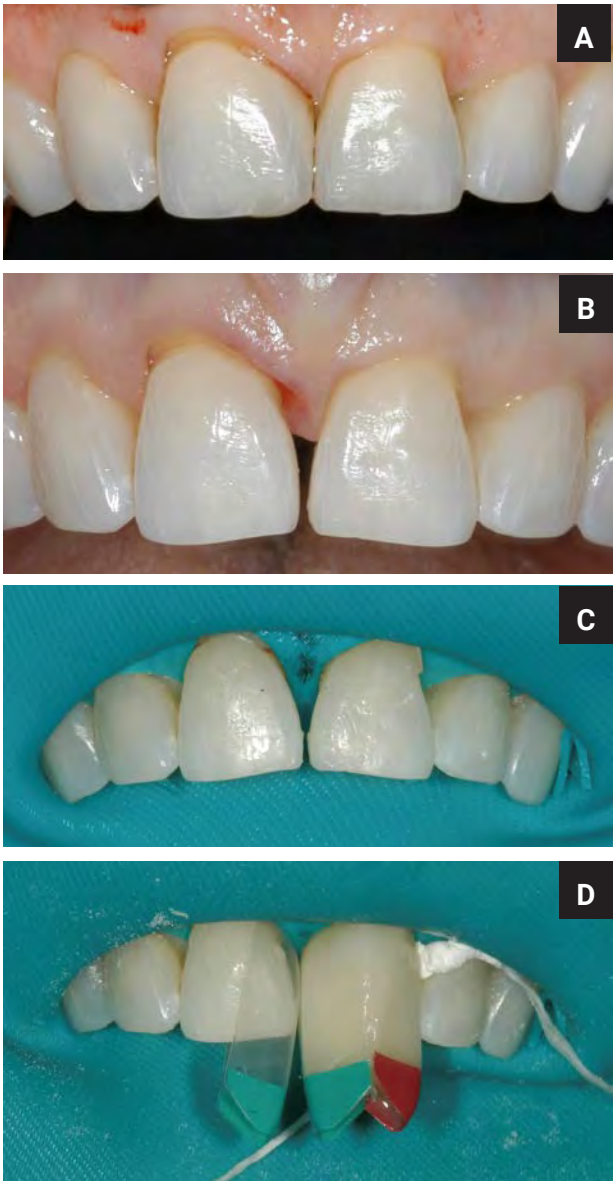
in order to properly close down those spaces using an indirect method. With Bioclear training you can learn how to address these cases without sacrificing healthy enamel, because we are no longer limited by path of insertion issues.

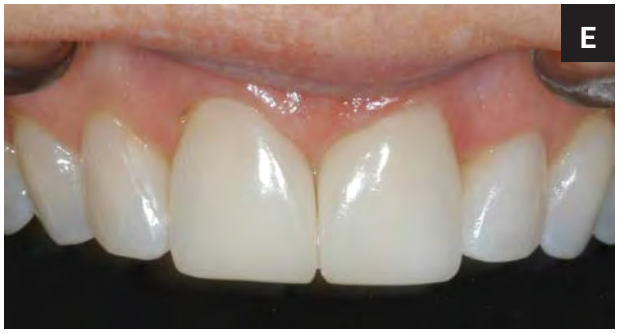
5) **Post adult orthodontic cases (Fig. 4).** Let's face it, most adult patients who have spent the last 6-18 months trying to get their teeth straight will need additional help once the orthodontic phase is complete. They are often very reluctant to allow significant preparation to their teeth to achieve the results they desire, which will commonly lead us towards direct restorations. In my practice, I try to stay as objective as possible and give every patient the option of ceramic-based indirect restorations or direct restorations, most often fabricated via the Bioclear method. A very high percentage of my patients finishing orthodontic treatment will select what they consider to be the less invasive and more conservative method.

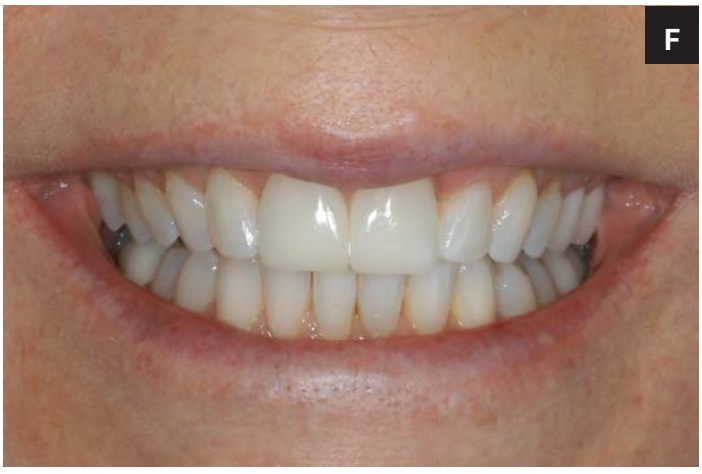
6) **Patients with strong bruxism habits (Fig. 5).** When I rehabilitate patients who are displaying advanced tooth wear for their age, I just assume that they are going to continue to grind away, and they may or may not wear their mouthguard at night. These kinds of patients just make me nervous about going with ceramic restorations. I know zirconium is another option, but I would strongly prefer to not cut down teeth for full crowns, and I have zero experience to date with zirconium veneers. To me, composite-based restorations just make more sense for these patients. I can build facial veneers heavier and incisal edges thicker for these patients, without layering.

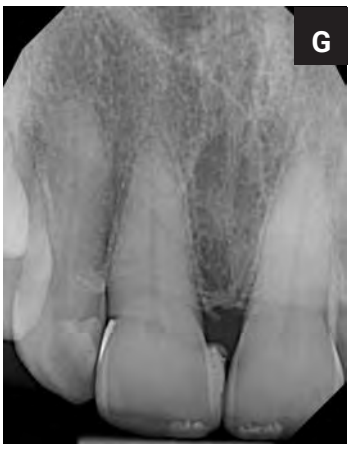
Prior to Bioclear training, I would often layer restorations to mitigate effects of shrinkage or to attempt to improve cosmetic outcomes. Studies have shown little to no real-world benefit to layering composites, except when depth of light penetration is of concern.[1,2,3] Now I find that my restorations are more predictable with less fractures, and cosmetics can be excellent. To date, I have had very good success with these patients using the Bioclear method.

These are just some of the potential uses for the Bioclear method. Bioclear training has influenced nearly every aspect of my practice. I will often approach full mouth rehabilitations from a different perspective now than before my training. For example, instead of increasing the vertical dimension of the case using provisional crowns, I may choose to "shrink









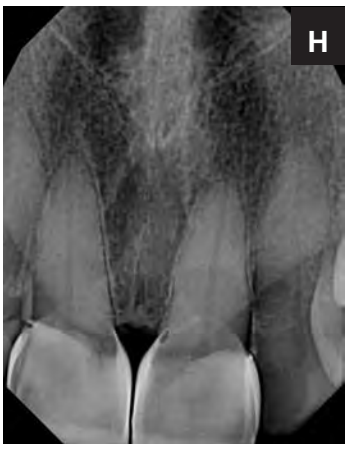


Fig. 3. Diastema closure. *A. Preop photo. B. Old composite removed. C. Rubber dam isolation. D. Black triangle matrices seated. E. Post-op smile. F. Post-op retracted view. G. Pre-op radiograph. H. Post-op radiograph.*

Dr. David Carroll received his medical doctorate and completed his residency in advanced prosthodontics at the School of Dentistry at the University of Alabama in Birmingham and earned his undergraduate degree at the University of Alabama in Tuscaloosa. He's a member of the American Dental Association, East Coast District Dental Society, Florida Dental Association, Florida Academy of Cosmetic Dentistry, and The Seattle Study Club.

He is a frequent guest lecturer for dental study clubs where he practices in Miami Beach, Florida. Dr. Carroll is a second generation restorative dentist with extensive experience in implant dentistry and complex dental procedures. He is adjunct faculty for the Bioclear Learning Center in Tacoma, Washington, and a frequent instructor for Bioclear. When not in his office, he enjoys spending time with family on or near the ocean. He is an avid boater, fisherman, free diver, and conservationist who loves to share his knowledge of the marine environment with kids of all ages.

wrap" teeth with composite, allowing me to preserve enamel and reduce the chances of postoperative sensitivity and/or fractured or dislodged provisional units.

So, what do you need to do to get started and make your days at work more fun and less stressful? Training!

The most important step is to just take the first step and sign up for an introductory course. I have yet to meet the first dentist who has told me they regret taking a Bioclear course or that it had zero influence on their practice. Introductory courses are offered remotely via Zoom, allowing you to stay in the comfort of your own office and get one full day of training under your belt. Following the intro course, I recommend you order the basic supplies needed and get to work and sign up for your next course.

All the best on your journey ahead!

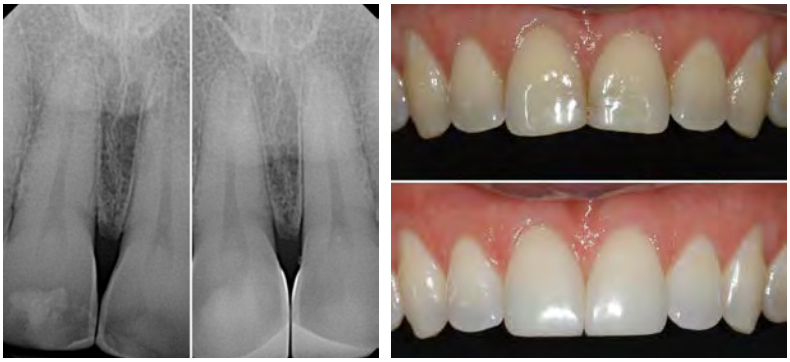


Fig. 4. Orthodontic case, *pre- and post-op radiographs and photos.*

Conflicts of interest:

Dr. David Carroll is a paid Bioclear Instructor and Adjunct Professor for Bioclear.

Eight years ago, when I signed up for my first Bioclear course, I thought I was just going to learn how to close black triangles without cutting down teeth. I had no idea I was starting on a journey that would impact every aspect of my practice.

References:

1. Versluis A, et al. Does incremental filling technique reduce polymerization shrinkage stresses? *J Dent Res*, March 1996: 75 (3): 871-878.
2. Gallo JR, et al. Microleakage and adaptation of Class 2 packable resin-based composite using incremental or bulk filling techniques. *Am J Dent*, 2000; 13: 205-208
3. Campodonic, Carlos E. Cuspal deflection and depth of cure in resin-based composite restorations. *JADA*, October 2011.

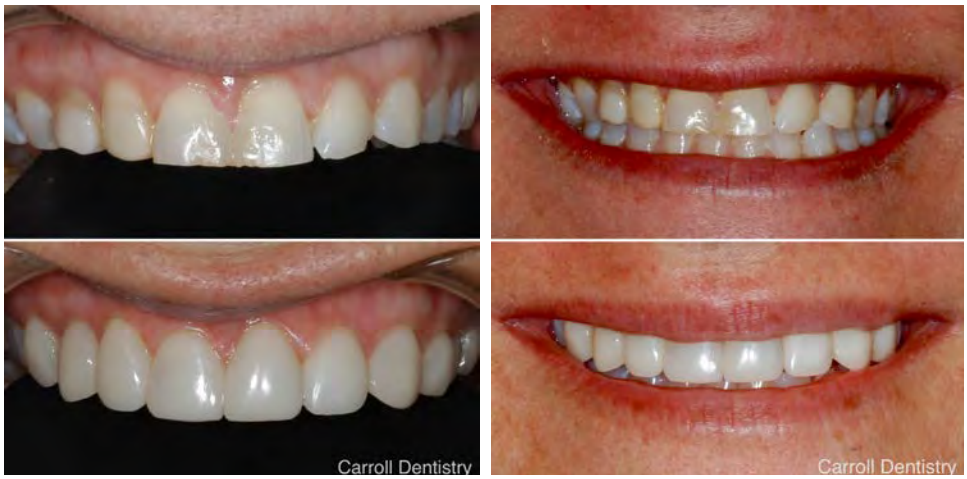


Fig. 5. Bruxism case, *pre- and post-op retracted views and smile photos.*

Dental Infections Have Medical Consequences

Are we telling our patients?

by Charles Reinertsen, DMD

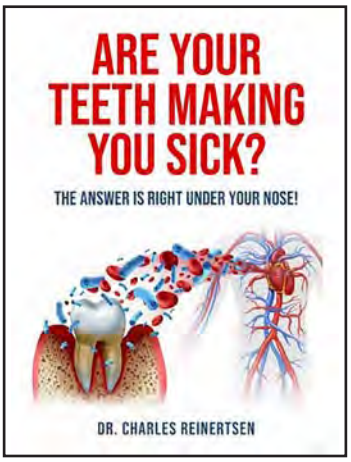
Has your physician ever asked you about your mouth?

Is your mouth part of your body?

Does the same blood that travels through your teeth and gums also go through your heart, brain, and the rest of your body?

Are we, as dentists, informing our patients about the diseases that are caused or worsened by dental infections, even if they have no pain?

Did you know that many dental infections are painless?[1,2] (You probably already knew that!) Periodontal disease can be painless for many years, yet this dental infection is depositing harmful bacteria directly into the bloodstream 24 hours a day, 7 days a week, for many weeks, months, years, and even decades! The patient has no idea because there is no pain.



Did you know that the bacteria in periodontal disease have been proven to be "causative" for cardiovascular disease?[3-5] This is huge! In 2023, 919,032 people died from cardiovascular disease in the U.S., one every 34 seconds.[6] According to Dr. Bradley Bale, a pioneer in cardiovascular care and research and cofounder of the Bale Doneen Method,[7] a heart attack and stroke risk assessment and treatment program, "...the most recent study... implies that up to 50% of acute heart attacks are triggered by oral infection."[8] That means we could have over 450,000 people in the U.S. dying from heart disease triggered by preventable dental infections. And we're not doing anything about it.

In addition to cardiovascular disease, dental bacteria affect diabetes.[7] When periodontal disease is bad, it's harder to control diabetes. When you successfully treat periodontal disease, it's much easier to control diabetes.

Oral bacteria are now known to be associated with Alzheimer's disease[8] and have been found in the brains of Alzheimer's patients.[9] They affect rheumatoid arthritis[10] and pneumonia,[11] and have pregnancy complications from pre-term labor to stillbirth.[12] Some researchers are even showing links to certain cancers.[13,14]

Common sense is so uncommon. Most people know that infections in the arm or leg can enter the bloodstream. Dental infections can also enter the bloodstream. Once in the bloodstream, these harmful bacteria travel everywhere the blood goes. Every organ supplied with blood is at risk of being invaded by harmful oral bacteria.

Are we, as dentists, informing our patients of the diseases that are caused or worsened by harmful dental bacteria?

I found that when I informed my patients of the oral- systemic connection, or how dental bacteria affect your overall health, their home care greatly improved. Once they grasped the connection between dental health and medical health, they had a different motivation for doing their daily home care. Now their daily dental cleaning routine wasn't just for fresh breath, a better smile, to prevent cavities, or to save money. Now it was about their hearts, their brains, their diabetes, their HEALTH!

It's not rocket science. If you have an infection in your arm or leg, can that bacteria get into your bloodstream? Absolutely! If you have an infection in your mouth, can that bacteria get into your bloodstream? Yes! If there is no pain, does that make a difference? Most dental infections have no pain. The patient is completely unaware they even have a dental infection.

The research has already confirmed this connection. In 2017, a peer reviewed study in the *Postgraduate Medical Journal* entitled "High-risk periodontal pathogens contribute to the pathogenesis of atherosclerosis"[3] connected the dots between periodontal disease and cardiovascular disease.

"It is necessary to classify PD due to high-risk pathogens as a cause of ASVD. This type of PD is a medical condition with a dental solution. At present, our dental colleagues have not elucidated a definitive way in which to successfully manage this type of PD. The pathway is clear for justifying that PD due to high-risk pathogens is causal of ASVD."[3] That was eight years ago.

In 2000, the United States Surgeon General wrote in a study, "The major message of this Surgeon General's report is that oral health is essential to the general health and well-being of all Americans and can be achieved by all Americans."[17] That was 25 years ago.

These, and many more reports and studies, only confirm what common sense already tells us. Once harmful bacteria enter the bloodstream, they will have negative effects on our health.

Excerpt from *Are Your Teeth Making You Sick? The Answer is Right Under Your Nose!*©*

How Do We Close the Gap?

Trying to get physicians and dentists to work together has been like herding cats. I attempted to join the staff at our local hospital. My intent was to help identify oral infections so patients could rule out oral bacteria as a possible source of their medical issues.

The hospital staff replied, "We don't want you diagnosing things we can't treat."

I explained that I diagnose things I can't treat every week, so I refer my patients to someone who can treat them.

Their reply was, "We don't want to be in the referral business."

I was floored.

From there, I went to many physicians' offices encouraging them to include the mouth when evaluating a patient's health. I was then told that doctors barely had time to ask the required examination questions, much less the additional ones I was suggesting.

Dentists were not trained to share clinical findings with their patient's physician. Physicians were not trained to request a dental health report from their patient's dentist. The question for you and me isn't who is at fault, but rather where do we go from here. Seeing as physicians say they don't have the time or resources to cover this vital aspect of your health and quality of life, and some hospitals prefer not to, perhaps it is best for you and me to share this information with the world ourselves - one family at a time.

* Reinertsen, C. (2023). *Are Your Teeth Making You Sick? The Answer is Right Under Your Nose!* Higher Life Development Services; p. 44-45.

For tens of millions of Americans, the mouth is a "pus factory" that's depositing harmful bacteria painlessly into the bloodstream. I believe we, as health care providers, have an obligation to inform our patients of the medical consequences of their dental infections, even if they are pain free.

Educating our patients is a team effort! Hygienists and dental assistants have many opportunities one on one with their patients, but the dentist must be the leader.

Do your own research. Search online for "Oral Systemic Connections" or "Periodontal Disease and Heart Attacks" or "Diabetes and Gum Disease." Use multiple search engines as you will get different results, or visit: www.TheDentalMedicalConvergence.org. There you will find many references, videos, links and articles about the oral-systemic connection.

Beginning today, start informing your family, friends, and patients how their dental health affects their medical health. There are many diseases caused or worsened by dental infections. As health care providers, we have the responsibility to educate and inform.

Please share this information with your physicians. They are taught that the dentists' domain is the mouth and that they have the rest of the body, ignoring the fact that the same blood supply travels through the teeth, gums, heart, brain and entire body circulating harmful bacteria everywhere!

In the interest of better dental and medical health,

Charles Reinertsen, DMD

References

1. Gaurilcikaite E, Renton T, Grant AD. The paradox of painless periodontal disease. *Oral Diseases* (May 2017) 23, 451–463. https://doi.org/10.1111/odi.12537

2. Michaelson PL, Holland GR. Is pulpitis painful? *Int Endod J.* 2002 Oct;35(10):829-32. doi: 10.1046/j.1365-2591.2002.00579.x. PMID: 12406376.

3. Bale BF, Doneen AL, Vigerust DJ. High-risk periodontal pathogens contribute to the pathogenesis of atherosclerosis. *Postgrad Med J.* 2017 Apr;93(1098):215-220. doi: 10.1136/postgradmedj-2016-134279. Epub 2016 Nov 29. PMID: 27899684; PMCID: PMC5520251.

4. Gianos E, Jackson EA, Tejpal A, et al. Oral health and atherosclerotic cardiovascular disease: A review. *Am J Prev Cardiol.* 2021 Apr 5;7:100179. doi: 10.1016/j.ajpc.2021.100179. PMID: 34611631; PMCID: PMC8387275.

5. Kotronia, E, Brown, H, Papacosta, AO et al. Oral health and all-cause, cardiovascular disease, and respiratory mortality in older people in the UK and USA. *Sci Rep* 11, 16452 (2021). https://doi.org/10.1038/s41598-021-95865-z

6. CDC Heart Disease Facts: https://www.cdc.gov/heart-disease/data-research/facts-stats/index.html

7. Feng D, Esperat MC, Doneen AL, Bale B, Song H, Green AE. Eight-year outcomes of a program for early prevention of cardiovascular events: a growth-curve analysis. *J Cardiovasc Nurs.* 2015 Jul-Aug;30(4):281-91. doi: 10.1097/JCN.0000000000000141. PMID: 24717191.

8. Quote by Dr. B. Bale. *"Say Ahh - The Cavity in Health Care Reform."* https://www.youtube.com/watch?v=c_yDH28jn8c

9. Borgnakke, WS. IDF Diabetes Atlas: Diabetes and oral health – A two-way relationship of clinical importance. *Diabetes Research and Clinical Practice*, Volume 157, 107839. https://www.diabetesresearchclinicalpractice.com/action/showPdf?pii=S0168-8227%2819%2931261-6

10. Beydoun M, et al. Clinical and bacterial markers of periodontitis and their association with incident all-cause and Alzheimer's disease dementia in a large

Dr. Charles Reinertsen graduated from the University of Florida College of Dentistry in 1979 and was in private practice from 1979 to 2022. As a lifelong learner, he has acquired additional knowledge and hands-on training at the Pankey Institute for Advanced Dental Education and the Great Lakes Education Center for CEREC CAD/CAM training. He attended and successfully completed the Invisalign program for invisible orthodontics along with several levels of advanced aesthetic dental techniques offered through the Nash institute for Dental Learning. Most recently, "Dr. Chuck" completed instruction on use of Tek Scan, digital bite analysis. He feels deeply about giving back by volunteering his time and knowledge to the community and his profession. He has participated in Million Dollar Smiles, Give Kids A Smile, the Florida Dental Association's program for National Children's Dental Health Month. Locally, he has donated his time and skills to Project Dentists Care of Lake County, a volunteer organization dedicated to providing high quality care through the Lake County Health Department Dental Clinic. Dr. Reinertsen served on the Lake County Dental Society's board in various positions most recently as president. In his personal time, recently retired from the dental profession, Dr. Chuck enjoys family time with his kids and grandkids as well as touring the back roads on his motorcycle.

Dr. Reinertsen writes, "After 43 years of experience and observation, I am not the expert, but I can read what the true experts have discovered at the Pankey Institute, the Nash Institute, AAOSH (the American Academy of Oral Systemic Health), and too many CE courses to recall!" He is the author of *Are Your Teeth Making You Sick? The Answer is Right Under Your Nose!©*

national survey. *J Alzheimer's Disease*. 2020;75(1):157-172. doi: 10.3233/JAD-200064.

11. L'Heureux JE, Corbett A, Ballard C, et al. Oral microbiome and nitric oxide biomarkers in older people with mild cognitive impairment and APOE4 genotype. *PNAS Nexus* 4(1), January 2025, pgae543, https://doi.org/10.1093/pnasnexus/p.543.

12. Detert, J., Pischon, N., Burmester, G.R. et al. The association between rheumatoid arthritis and periodontal disease. *Arthritis Res Ther* 12, 218 (2010). https://doi.org/10.1186/ar3106

13. Son M, Jo S, Lee JS, Lee DH. Association between oral health and incidence of pneumonia: a population-based cohort study from Korea. *Sci Rep*. 2020 Jun 12;10(1):9576. doi: 10.1038/s41598-020-66312-2. PMID: 32533077; PMCID: PMC7293333.

14. Clothier, B., Stringer, M., Jeffcoat, M.K. Periodontal disease and pregnancy outcomes: exposure, risk and intervention. *Best Practice & Research Clinical Obstetrics & Gynaecology*, 21:3, 2007, pp. 451-466, ISSN 1521-6934, https://doi.org/10.1016/j.bpobgyn.2007.01.005.

15. Olsen I, Yilmaz Ö. Possible role of Porphyromonas gingivalis in orodigestive cancers. *J Oral Microbiol*. 2019 Jan 9;11(1):1563410. doi: 10.1080/20002297.2018.1563410. PMID: 30671195; PMCID: PMC6327928.

16. Nwizu N, Wactawski-Wende J, Genco RJ. Periodontal disease and cancer: Epidemiologic studies and possible mechanisms. *Periodontol 2000*. 2020 Jun;83(1):213-233. doi: 10.1111/prd.12329. PMID: 32385885; PMCID: PMC7328760.

17. U.S. Department of Health and Human Services. 2000. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: National Institute of Dental and Craniofacial Research.

For more information, watch "Are Your Teeth Making You Sick?," Dr. Charles Reinertsen's webinar for the Florida Dental Hygienists' Alliance at
https://youtu.be/SS8cpQsQJ4Q?si=yB_2IS566yTPdAOQ

Meet Florida's AGD Candidate for Vice President, Dr. Richard Huot!

You've had quite a varied dental career in private practice, the military, consulting, and education, Dr. Huot. What were some of the highlights?

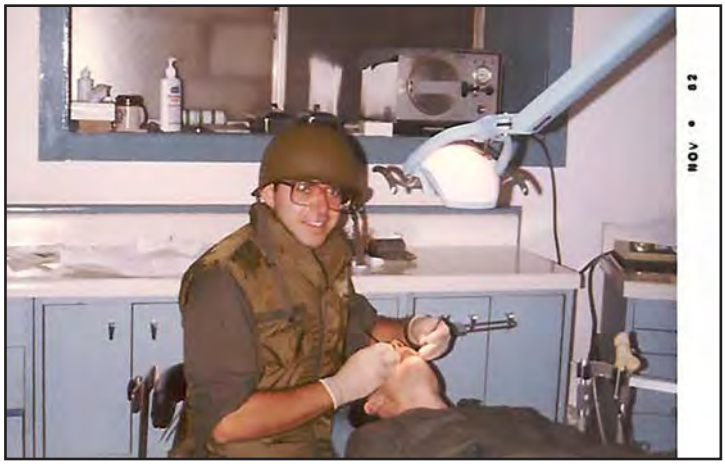
I delayed going into private practice, because I had a commission from dental school to serve in the Air Force for three years of active duty. When I got into dental school, my plans were to go back to my hometown in southern Maine and practice. My uncle was in practice there for forty years, but we never practiced together. I started from scratch. It was a time when you could actually do that. Of course, it's a little bit easier when you have three years under your belt from the Air Force to get your speed up.

Eventually, I moved to Florida and bought an existing practice in Vero Beach. After the initial purchase, I bought three other practices over the course of my 14 years practicing in Florida. When I consult for dentists on practice management, I encourage young practitioners to survey their practice area and see if there are merger or acquisition opportunities, which can lead to rapid growth.

Another highlight of private practice was how I got my start in organized dentistry. In 1986, we fluoridated the water supply of my hometown. Maine is one of four states that require a referendum vote by the public to approve that. It isn't something passed by a City Council. We got enough signatures to put it on the ballot, and we won it by a three to one margin. It fluoridated the homes of 90,000 people. That was a very proud moment and a great team effort.

After 9/11, I was called up to the Surgeon General's office in Washington to provide a private practice perspective on increasing production and modernization of clinics, including a few new construction projects. It was gratifying to increase production up to 40% at some locations and to help them pick out digital equipment, including the concept of lab scanning to a central lab. To this day, the way that the Air Force schedules their patients is very similar to what we were implementing.

Down the road, this eventually led to being selected to work on the Department of Defense project called MHS Genesis, and that's the medical/



"My connection with the AGD began just before graduating from Northwestern University Dental School. A representative visited our senior class to share what AGD had to offer, and it clicked. As a newly commissioned Air Force dentist, I knew my continuing education would mostly come through the military—but AGD offered something more: a community and a voice. I joined, and I've been a member ever since.

"After completing active duty and continuing as a reservist, I earned my Fellowship just four years later—an achievement that reinforced my belief in lifelong learning and professional growth. Since then, I've owned practices in Maine and Florida, and along the way, I've seen how much our profession, and the world around it, has changed.

"As Chair of the AGD Legislative and Government Affairs Council, I've seen firsthand how critical it is to have a strong voice advocating for general dentists. But advocacy isn't just about legislation—it's about communication. We need to become a more connected and communicative organization, especially in today's fast-paced, digital, and increasingly diverse world.

"That means making space for more voices at the table—women, minorities, and professionals from all races, cultures, and practice settings. The next generation of dentists expects not only continuing education and advocacy, but also transparency, inclusion, and opportunities to be heard and represented. If AGD is to grow and lead in the years ahead, our vision must evolve to meet those expectations.

"When elected Vice President, I'll bring a modern, inclusive approach rooted in experience—but focused on the future. I'm not part of the old guard. I believe in building bridges, fostering open dialogue, and ensuring that every general dentist, whether you're starting out, mid-career, or planning your legacy, feels seen, supported, and empowered.

"Thank you for the opportunity to serve. I hope to earn your support as we move AGD forward together."

Respectfully,

Richard A. Huot, DDS, FAGD, ChFC

dental electronic health record. Up to 2015, the medical and dental records of all our servicemen were on paper. I was working on the dental chart and its integration with the medical chart. We needed a combined record. It all came to fruition in 2023 or so. It's now worldwide, everywhere there are medical and dental clinics. Everywhere, including submarines!

In private practice, the fact that the records are not married together still prevents dental care from being seamlessly coordinated with medical care. That's part of my consulting work.

I'm also working for an AI firm now called Velmeni, and we're working to develop an AI system that includes reading CBCTs. We're the only firm in the U.S. that has been FDA-approved to read a panorex. We can read CBCTs now and write a narrative for them, so that dentists can feel more comfortable about taking CBCT's and not missing anything.

When did you know you wanted to become a dentist?

It was in the mid-70s. I wanted to be a pediatrician but after talking to physicians, they weren't excited about private practice and felt the profession was changing. Most dentists that I talked to really enjoyed the work, and they enjoyed running their own businesses – the entrepreneurial spirit. They liked the science part of it and treating patients. Not all sections of medicine treat people in pain, like we do, and I think that instantaneous ability to relieve pain for our patients, and how grateful they are, is a huge positive factor.

You've held some demanding positions, serving as an Air Force IMA (Individual Mobilization Augmentee) three times and then as the Commander of an Air Force Medical Squadron. Could you please tell us about some of your experiences leading these units?

Initially you're commissioned as a captain. After a couple of years, I made Lieutenant Colonel. I was able to take all these leadership courses in person and by correspondence. Most of the courses I took were taught by the Harvard Business School and the Universities of Texas and Tennessee in their MBA programs, and they had some wonderful speakers. We learned a lot about leadership and how to help a team achieve a goal. Most of that is really helpful, and you can apply it to your practice or organized dentistry. I was president of the Maine Dental Association when I was 36 years old, and some of the leadership experiences that I had in the military prepared me really well for that job and beyond.

Another position was working at the Pentagon for two years on the medical side of the Reserves. We were responsible for the health care of all the reservists in the Air Force. The only way I can describe the Pentagon as far as working there is, you go to work with 28,000 people going into the same building, and you're working in a museum at the same time. The walls are filled with leaders staring down at you, all the way from George Washington to Eisenhower. It was really a neat experience.

I worked a lot with military programs for our wounded veterans. Most of the work there was on the medical side, including helping veterans with their disabilities, and I first saw suicide prevention. It was a very rewarding job. My direct supervisor. was a nurse, a colonel like myself, and the Chief of the Air Force Reserve was a three-star general, a wonderful guy, and a great mentor.

One thing you learn is that people mistake the military sometimes; they think that generals bark orders. They think of Patton, but that's not really the model. You don't lead people by brute force. You lead people by example, by work ethic, and how you interrelate with them. Leadership is all about relationships, and there's a lot you can learn from that I readily applied in my practice and everything that I did with the AGD.

Being a medical commander of a 240-person squadron deployed to six continents and several war zones was the highlight and privilege of my career. Going to Germany again to see our folks work and help the wounded was sobering and rewarding at the same time. I had some very highly trained medical people: respiratory therapists, critical care, ICU - you name it, we had it. During the Iraq and Afghanistan wars, we hadn't had that many wounded since Vietnam. You had to process a lot of people and get them through the system. I still get goosebumps when I think about meeting a plane, and that back ramp coming down and offloading the patients. It was a tremendous honor to serve our country in that respect

How have you applied some of this leadership expertise in your work with the AGD and the ADA?

When you're exposed to leadership at such an early phase in your career, you're exposed to an incredible range of people at the state level and at the national level. And we have one common thing: we're dentists and we practice. The diverse skill sets that our people have is one of the things that we were taught in the military. Find qualified people, and to ensure the diversity, make sure the room looks like your membership. What are the needs of your organization? Do you need a different perspective? For instance, I'm actually an ESL kid; I spoke French before I spoke English. So, when I was at the AGD meeting in Montreal in July, I felt really comfortable. Because of my education and experiences, I understand what it is to try to practice when you have two languages on board. It's a different feeling, and I can certainly relate to any accents or backgrounds that people come from and respect that. I think part of leadership is being able to recognize that this person will bring in a totally different perspective, and that's what you need.

What have been some of your favorite experiences in the ADA and the AGD?

Serving on three ADA councils (ADPAC, Government Affairs, Members Insurance and Retirement Programs) and as ADA Vice President for two years prepared me well to serve on the AGD Legislative and Government Affairs Council, as the relationships in Congress and among dentists were similar in both camps.

What do you enjoy most about being a consultant and an educator?

They say when you teach, you are the one that learns the most, and I loved doing onsite consulting, because I learned from all the dentists, as many had concepts I adapted for my clients while helping them. The same goes for lecturing, as people ask great questions and it gives me ideas and content for future lectures. I feel when I speak that I am the recipient of the knowledge. The practice management and AI lectures I have given the past four years have been great experiences.

What aspects of the AGD would you like to strengthen?

The CE portion of the AGD has always been the gold standard in organized dentistry, but regardless of practice settings, advocacy will increasingly take on a bigger role, either at the state or national level. I want to grow the Advocacy Fund, because we don't have a political action committee per se. I find the local issues need help. Every state has varied issues, like in Florida we just defeated dental therapy again for the ninth consecutive time. I think every AGD dentist needs to look at that donation to the Advocacy Fund as a political malpractice investment in their practice future.

We do a really good job of representing the general dentist. That is our primary mission. Not to say that the other organizations don't, but we are the spokesperson for the specialty of general dentistry. It is not recognized as a specialty. But when 80% of the dentists do it, you have to understand how we deliver care. I would like to expand the leadership, practice management, and financial planning role in state AGD societies, by incorporating that into the Mastership program.

Obviously, growing the organization is a constant goal. I think we're in a unique position right now to grow the AGD membership. I've been a member of both the ADA and the AGD. I joined the AGD the month before I graduated from dental school, and I had joined the ADA as a student member two years before that. A lot of our leaders are dual leaders and have done work for both. But I think that the AGD structure, because of its size, is in a better position in the future to attract people who would like to find a niche in the organization that they could excel at.

I'd like to ensure that we have an adequate pipeline of younger leaders, and I think that mentoring is something that can be done very easily. I looked at the House of Delegates at the AGD, and it has a very diverse body of people. I think that's where you get your future leadership.

Finally, I would like to build stronger relationships with all the other specialty groups and re-establish a stronger bond with the ADA, while maintaining the unique mission of the AGD.

How can we encourage more general dentists to recognize the value of the AGD?

Membership is all about adding value. What do you get for that membership? There's no question that we get the value for the CE. Value-adding benefits through CE and business opportunities are a good start, and we have to convince dentists who don't own their own practices to encourage their employers to pay their dues, until they can get their student loans under better control. Member benefits have to be coordinated at the national and state level to be the most effective.

A Mastership program is a very noble way for people to continue to improve their clinical processes, especially today with young dentists who may not have been able to get all the skills they need in dental school because it's such a compressed curriculum. I think the AGD is well positioned by having both Fellowship and Master tracks.

I think we should survey our young dentists to find out where they want to go for an annual meeting. Where would they like to bring their families? I spoke at the AGD in Toronto and Nashville, and we brought our son to Nashville, and he had a really great time. We have the advantage of size to survey our young dentists and find out what cities they would want to have a national meeting, past the 2028 meeting in Orlando. Maybe a western Canadian city?

Thank you, Dr. Huot, and we wish you success in your campaign for AGD Vice President!

Repair or Replace? Making Smart Decisions for Peak Performance

By Rick Ball, Summit Handpiece Express

> *"Every handpiece has a story—you just have to know when it needs a tune-up and when it's time to turn the page."*

Every dentist has faced that moment: you're in the middle of a procedure, and your highspeed handpiece starts to sputter. Power drops. Noise increases. Or worse—it just stops. The question then becomes: Do I repair it, rebuild it, or replace it entirely?

This second installment of our "Handpiece Lifeline" series helps dentists make informed, cost-effective choices when it comes to the fate of their handpieces. With the right approach, what seems like a disruption can actually become an opportunity to improve performance, reduce downtime, and protect your investment.

About the Author

Rick Ball is the owner and CEO of Summit Handpiece Express, a family-owned dental handpiece repair company trusted by practices nationwide.

Since 2009, Rick has helped dentists extend the life of their equipment through expert repairs, fast turnaround, and straightforward advice.

Summit Handpiece Express is known for its personal service, affordability, and commitment to helping dentists keep their schedules running smoothly.

Need a hand with your handpieces? Let's talk.

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Understanding the Core Issue

Most handpiece problems originate in the turbine—the tiny, high-precision engine that drives your bur. The turbine contains miniature bearings, a spindle, impeller, chuck, and O-rings. It's designed to function at extreme speeds, but those same speeds make it vulnerable to wear, especially under repeated sterilization.

What many dentists don't realize is that turbine issues often stem from a single failing component—typically the bearings or chuck—not the entire unit. This opens the door to more cost-effective repair options.

The Case for Rebuilding

Rebuilding a turbine involves replacing worn-out bearings, O-rings, and other serviceable components while preserving the core structure of the turbine

assembly. A skilled technician can extend the life of a handpiece by performing this process quickly and affordably.

For many practices, rebuilding is the most economical and sustainable choice. A quality rebuild can cost 30% to 50% less than ordering a brand-new turbine—and still deliver like-new performance.

But the key word here is quality. Not all rebuilds are created equal. Look for repair partners who use OEM-grade parts, follow torque calibration standards, and offer warranties on their work. Poor-quality rebuilds may result in frequent breakdowns, higher long-term costs, and increased frustration.

Make sure you have the proper amount of handpieces per operatory. A shortage of handpieces will result in "overuse," which can lead to premature failures of critical components such as turbines and bearings. Ensuring you have enough handpieces in circulation will help prevent these issues and reduce the risk of unexpected repairs.

When to Consider Full Replacement

There are situations where a rebuild simply isn't the right call:

- Cracks or damage to the handpiece shell or head
- Multiple failed rebuilds within a short time
- Extensive internal corrosion affecting performance
- Obsolete models with no parts availability
- Manufacturer design limitations that prevent rebuild

In these cases, replacing the turbine—or the entire handpiece—is often the best solution. While the initial investment is higher, newer models often feature improved ergonomics, better spray patterns, upgraded optics, and longer warranties that may lower future repair costs.

OEM vs. Independent Repairs

Dentists today have more choices than ever for handpiece servicing. While sending your handpiece back to the manufacturer guarantees a new OEM turbine and factory settings, it also tends to come with higher costs and longer turnaround times.

On the other hand, a reputable independent repair shop can often rebuild or replace your turbine within 24–72 hours, with performance that matches or exceeds factory standards—at a fraction of the cost.

The key is to build a relationship with a repair expert you trust—one who will explain what failed, show you your options, and offer honest guidance based on your handpiece's condition and value.

Quick Decision Guide

Situation	Best Option
Minor drop in power or noise	Rebuild
Bearing failure with no body damage	Rebuild
Chuck issues or bur slippage	Rebuild or Replace Turbine
Cracked or deformed shell	Replace Handpiece
Repeated failures in short time	Replace or Evaluate Maintenance
Outdated model with poor performance	Replace with newer model

A Final Thought

Repairs don't have to feel like a setback. With the right knowledge and a trusted repair partner, you can stretch the life of your equipment, keep procedures running smoothly, and make every dollar count.

In Part 3, we'll shift focus to preventive maintenance—how small, consistent steps can dramatically extend the life of your handpieces and minimize the need for repairs altogether.

FLORIDA ACADEMY of GENERAL DENTISTRY

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2-DAY HANDS-ON DENTAL LASER SEMINAR

Snoring/Airway • Minimally Invasive Surgery • Facial Aesthetics

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A Basic Overview & In-Depth Understanding of:
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✓ Choosing & Using the Right Laser Wavelengths
DISCOVER CLINICAL APPLICATIONS FOR:

- Non-invasive Laser Snoring Treatment
- Virtually Bloodless Soft Tissue Procedures
- An Essential Tool for Implant Surgery
- Successful Periimplantitis Management
- Laser Assisted Periodontal Therapy
- Non-invasive Laser Hygiene
- Facial Aesthetic Treatments with Fractional CO_2

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COURSE OBJECTIVES:

- Understand how fractional CO_2 lasers enhance sleep quality
- Learn how to incorporate laser therapy into daily dentistry
- Expand your services beyond restorative dentistry
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- Fractional CO_2 Facial Aesthetic Procedures

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