MARK YOUR CALENDAR!

We have many events coming up from affiliate meetings to networking mixers...

look inside
Program includes (complete details found at www.sfdda.org)
- The latest trends in Patient Care With Dr. Jean Wu
- Social Media Marketing - Do’s, Don’ts and Liability
- Experts in Strategies for Start-up or Practice Acquisition
- Vendor Area
It is probably not too shocking to our members to find out that our organization represents one of the most culturally and generationally diverse districts in the nation. Very often, other components around the state look to us for the coming trends that may stand to affect their own members in the not-too-distant future.

For such reasons, our new format of centralizing and streamlining our three affiliate societies is being closely examined by all of our colleagues within the other districts.

The results are in, and the future thus far looks bright! Our initiatives have lead to the greatest increase in membership among all of our six component organizations in Florida.

Considering the fact that the number of dentists establishing themselves in South Florida is constantly in flux, we have still managed to increase our market share in the region. This is very good news for all of us, considering our level of representation is testimony to the degree of impact that we can have - not only from a legislative standpoint, but also relative to leveraging our relationships with the corporate world.

At the state level, your representatives attended the Florida Dental Association (FDA) House of Delegates this past January in order to discuss the issues that affect us all. In addition, the FDA decided to provide your leaders with valuable training on various topics aimed at better preparing them to serve you.

Your local affiliate societies continue to provide you with high quality CE at no additional cost. If you have not had the opportunity to attend your five meetings, you still have a chance to participate in the last lectures of the season. Feel free to consult our calendar at [http://www.sfdda.org/events.html](http://www.sfdda.org/events.html) for more details.

Should you be looking for more opportunities to network and spend time with your fellow colleagues, we have created a series of social events aimed at encouraging members to link up in a friendly and collegial environment. Our first event will be held at Midtown Athletic Club on Wednesday, March 22. For more details about this venue, feel free to visit their website at [https://www.midtown.com/weston#mtpbcs-108](https://www.midtown.com/weston#mtpbcs-108).

Finally, we will be hosting our annual SFDDA Business Meeting on Wednesday, April 26 at Tropical Acres Restaurant in Fort Lauderdale. This is a great opportunity for anyone wanting to take their mandatory courses early - as we will be offering both Medical Errors and Domestic Violence (DV)* in conjunction with the business meeting this year.

*DV is required every third, biennium, which for the majority of members, falls within our current 2016-17 biennium.

Cheers!
Mark A Limosani
A Table of Information On Drug Induced Osteonecrosis of the Jaws (DIONJ)
- A Summary of Almost Everything You May Want To Know, But Were Afraid To Ask

by Richard A. Mufson, DDS

This is most likely a throwback to my childhood “arts and crafts,” filling some inner need to occasionally just “create stuff,” and especially stuff with lots of fancy lines and colors.

In truth, this mini-project also had very much to do simply with the important reason of “need.”

I have received quite a number of phone calls and emails in recent years from dental colleagues asking questions such as, “Can I place an implant when my patient is taking Fosamax?” Or, “How long should I ask his/her MD to discontinue the medication?” “How about Aredia and Zometa?” “Will a CTX test help?” “How do I write the prescription, and how do I interpret the results?” “Can I do regular dental treatment?” “How about orthodontic treatment?” “What about these newer drugs, Reclast, Prolia, and XGEVA?” “How are they different?” “How long does it take before the risk of necrosis begins?” And on and on.

Often with the phone still in my ear, I have provided answers to such questions, and especially on the newer medications and time frames for “drug holidays,” by opening an adjacent desk drawer, grabbing, and then riffing through, several pages of hand-written notes from two or more lectures I had attended covering the most recent updates on “Drug Induced Osteonecrosis of the Jaws (DIONJ).” The lectures were given by Dr. Robert Marx, Professor and Chairman of the Division of Oral and Maxillofacial Surgery (OMS) at University of Miami, whom many or most OMS regard as the go-to “guru” and leading source of knowledge on this and other clinical issues affecting bone.

An interesting idea then came to me at some point. Rather than randomly thumbing through pages of hand-written notes with questionable legibility and organization at best – “What if the information could be organized, collated and logically placed into the format of a colorful and easy-to-reference table?”

And so, with the help of my same hand-written notes, previous notes and lecture slides of my own, and additional vetting and editing provided by Dr. Marx, I created what I felt would be a user friendly “DIONJ-at-a-Glance Table,” with the hope that others may find it helpful and useful.

In all honesty, much of the motivation for this also began with my basic need to keep the information straight and available for my own eyes and mind.

I feel the need to share several other important points: (1) By the very nature of periodic changes which may inherently occur within any such area of science, this document should be considered “fluid” and subject to future modifications as new information may emerge. (2) I plan to likely rerun this article and the associated table in a future “printed” version of our SFDDA newsletter (i.e., Summer or Fall issue, which are published in print, in addition to email/on-line, format) – as the table would be more amenable to self-printing, or sharing with others, if one may choose to do so.

In truth, this mini-project also had very much to do simply with the important reason of…my basic need to keep the information straight and available in my own eyes and mind.

Other Background Information:
I would not, in my wildest imagination, attempt to cover the full scope of information pertaining to DIONJ in an article such as this. My limited purpose was to organize and format the table of information. However, I felt that a few supplemental points of important information would provide additional helpful perspective.

DIONJ is a condition that impacts all dentists and dental patients, and the clinical concerns of which are far from being limited to one specialty group or another. As we know by now, ever-increasing numbers of patients come into our offices with seemingly longer lists of medications, many which have challenged our treatment planning strategies over the years. Another very notable example would be the varied groups of “blood thinners”
currently on the market and in use today.

However, it would appear that this one unique group of medications which induce bone necrosis in our patients has undoubtedly resulted in a greater level of consternation, befuddlement, and questions for those of us who practice dentistry on a daily basis.

Although all the medications share a common thread of providing significant help in the prevention of health and life-endangering skeletal fractures in at-risk osteoporotic patients, and in the prevention of bone metastasis in cancer patients, they also share another common thread – interference in some form with alveolar bone turnover, remodeling and healing.

Due to the varied numbers and categories of such medications which have surfaced in recent years, with differing dosages, timing, routes of administration, and variable time frames relative to (a) when the risk of necrosis begins and (b) half-lives of the medications within bone, which may then in turn affect the time frame of a recommended “drug holiday” – our ability to maintain a clear and concise vision or “handle” on how to clinically manage patients taking these medications has seemed somewhat elusive at best, and quite challenging in terms of having the most relevant information organized and available to us literally at our fingertips.

A number of changes have also occurred, as information, data and general knowledge have progressively evolved. The very name of the condition, since it first became apparent, has undergone important changes. As newer medications have emerged, such as Prolia, XGEVA, and antiangiogenic drugs, which have resulted in the same/similar problem of bone necrosis, but are not members of the bisphosphonate group, the name, “Bisphosphonate Related…” has since been changed to, “Drug Related ONJ.”

The case has also been made by Dr. Marx and others that the term “Drug -Related…” is a misnomer, given the fact that the drugs in question are not merely “related” (as would be a brother, sister, or cousin) to the condition, but rather represent the direct “cause-and-effect” agents of bone necrosis via their toxic and killing effects on osteoclasts. Therefore, a change in the name reflecting this has also been made (by Dr. Marx and others), to “Drug Induced ONJ.”

Finally, I wish to personally thank the one individual who has provided virtually all of the information I am currently sharing with you - Dr. Robert Marx. Many or most of us have long considered Dr. Marx a mentor, leading clinician, researcher, and a uniquely gifted educator and communicator of information, and we are very thankful for the many pearls he has given our profession over the years.

These have included, but are certainly not limited to, his groundbreaking research and journal articles in the mid-1980’s on “radiation” induced bone necrosis (ORN) and the role of hyperbaric oxygen (HBO), followed by other major contributions in our understanding of pathology, bone grafting and reconstruction of the face and jaws, and in the development and use of adjuncts such as platelet rich plasma [PRP], bone marrow aspirate, bone-morphogenetic protein [BMP] and others.

I sincerely hope you find this information useful, and would invite you to offer any feedback or questions on any aspect of what appears in this article or DIONJ Table (see next pg 6-7)

Dr. Mufson is the editor of the SFDDA Newsletter, and may be contacted at (305) 935-7501 or MufsonOral-Surg@aol.com
### Drug Induced Osteonecrosis of the Jaws (DIONJ)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Drug Class</th>
<th>Used to Treat</th>
<th>Dosage</th>
<th>Risk Begins at:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fosamax(^1) (alendronate)</td>
<td>Oral bisphosphonate*</td>
<td>Osteoporosis</td>
<td>10 mg/day po, or 70 mg po/wk</td>
<td>2.5 – 3 years</td>
</tr>
<tr>
<td>Actonel(^2) (risedronate)</td>
<td>Oral bisphosphonate</td>
<td>Osteoporosis</td>
<td>5 mg/day po, or 35 mg/wk; or 150 mg/wk</td>
<td>3 yrs (lower dose, risk, case #’s/occurrence)</td>
</tr>
<tr>
<td>Boniva(^3) (ibandronate)</td>
<td>Oral bisphosphonate</td>
<td>Osteoporosis</td>
<td>150 mg/mo</td>
<td>3 yrs (lower dose, risk, case #’s/occurrence)</td>
</tr>
<tr>
<td>Reclast(^4) (Zometa)</td>
<td>IV bisphosphonate</td>
<td>Osteoporosis</td>
<td>5 mg IV/yr</td>
<td>sharp increase after 4(^{th}) dose</td>
</tr>
<tr>
<td>Prolia(^5) (denosumab)</td>
<td>RANKL inhibitor**</td>
<td>Osteoporosis</td>
<td>60 mg sub-cu/6 mo</td>
<td>5(^{th}) dose (2(^{nd}) dose if after Reclast)</td>
</tr>
<tr>
<td>XGEVA(^6) (denosumab)</td>
<td>RANKL inhibitor</td>
<td>Ca - mets</td>
<td>20 mg sub-cu/mo</td>
<td>2(^{nd}) dose (1(^{st}) dose if after Reclast)</td>
</tr>
<tr>
<td>Avastin(^7) (bevacizumab)</td>
<td>Antiangiogenic</td>
<td>Lung, prostate Ca</td>
<td>500 mg/2 wks</td>
<td>insufficient cases/data (?)</td>
</tr>
<tr>
<td>Sutent(^8) (sunitinib)</td>
<td>Antiangiogenic</td>
<td>Kidney Ca</td>
<td>25 mg/day</td>
<td>insufficient cases/data (?)</td>
</tr>
<tr>
<td>Zometa(^9) (Zolendronic acid)</td>
<td>IV bisphosphonate</td>
<td>Breast, prostate, lung Ca, multiple myeloma (also Paget’s)</td>
<td>4 mg/mo IV</td>
<td>after 4(^{th}) dose</td>
</tr>
<tr>
<td>Aredia(^10) (Pamidronate)</td>
<td>IV bisphosphonate</td>
<td>Breast Ca multiple myeloma (also Paget’s)</td>
<td>90 mg/mo IV</td>
<td>after 8(^{th}) dose</td>
</tr>
</tbody>
</table>

**DIONJ defined:** Exposed non-healing bone in mandible or maxilla persisting > 8 wks, in absence of any other systemic drug known to cause ONJ and/or Hx of local RAD Tx to jaws.

*\(^{*}Bisphosphonates\) - half life in bone = 11+ years
**\(^{**}RANKL Inhibitors\) - half life = 26 days (easier to treat/debride sooner)
1 – Oral bisphosphonates – drug holiday of 9 months prior to an invasive oral surgery + 3 months after surgery
2 – RANKL inhibitors: drug holiday of 3 months prior to an invasive oral surgery + 3 months after surgery
3 – IV Bisphosphonates: drug holidays - not practical
4 – CTX – helpful with osteoporosis, but not useful in Ca pts (readings too high), or Hx of steroids, or methotrexate (readings too low)

**Comorbidities:** steroids, chemotherapy, diabetes, smoking, obesity (do not cause ONJ, but result in earlier, more severe, more extensive occurrence)

**Other bisphosphonates** (not known to cause ONJ) – Clodronate (osteoporosis), Etidronate/Tildronate (Paget’s)

Information courtesy of Robert Marx, DDS / Table, Graphics by Richard Muison, DDS
### Drug Induced Osteonecrosis of the Jaws (DIONJ)

<table>
<thead>
<tr>
<th>CTX Test Helpful?</th>
<th>Prevention or Drug Holiday (+ add 3 mo's after Tx)</th>
<th>Mechanism of Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9 month (empiric) drug holiday** or sooner (3 mo? 6 mo?) per CTX &gt; 150 pg/ml</td>
<td>Osteoclast death at bone sites mostly, lesser effect on precursor inhibition; and death in marrow</td>
</tr>
<tr>
<td>Yes</td>
<td>same as above**</td>
<td>same as above</td>
</tr>
<tr>
<td>Yes</td>
<td>same as above**</td>
<td>same as above</td>
</tr>
<tr>
<td>Yes</td>
<td>9 month drug holiday after last dose**</td>
<td>same as for Zometa below (or request until clinical healing occurs)</td>
</tr>
<tr>
<td></td>
<td>3 months** after last injection^</td>
<td>Osteoclast inhibition, death in bone, marrow blood, tissue spaces, and at resorption site</td>
</tr>
<tr>
<td>No</td>
<td>3 months** after last injection^</td>
<td>same as above</td>
</tr>
<tr>
<td></td>
<td>Prevention: see below</td>
<td>Blocks action of vascular growth factor (VEGF)</td>
</tr>
<tr>
<td>No</td>
<td>3 months (?)</td>
<td>Blocks action of multiple GF's (VEGF, PDGF, TGF-b, etc.)</td>
</tr>
<tr>
<td>No</td>
<td>Prevention: (prior to therapy) remove unsalvageable teeth, prophy, treat caries, periodontitis + defer start of therapy x 2 months</td>
<td>Osteoclast death (both Zomeda, Aredia)</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>During therapy: Avoid invasive dental Tx (ext's, peri surg, implants); RCTx if needed, amputate crown, supragingival scaling, splint mobile teeth. If ext's are unavoidable – provide consent/inc risks</td>
</tr>
</tbody>
</table>

"Non-Invasive Dental Tx (not involving bone/bone healing) – is safe at all times" (restorations, crowns, bridges, dentures, endodontic therapy, non-osseous periodontal surgery).

<table>
<thead>
<tr>
<th>CTX:</th>
<th>Writing the Rx:</th>
<th>Tx of Exposed Bone in IV Bisphos:</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 100 pg/ml - high risk</td>
<td>&quot;Morning fasting C-Terminal Telopeptide (CTX) bone turnover marker&quot; + Osteonecrosis (M87.10)</td>
<td>- Avoid debridement, smooth sharp edges, PCN (or Levaquin, Zithromax, Doxycycline); add Flagyl 500 x 10 days in refractory cases, - if surgery unavoidable - perform alveoleectomy or continuity resection</td>
</tr>
<tr>
<td>101-150 pg/ml – moderate risk</td>
<td>Please FAX result to: [fax number] + Please report results in pg/ml</td>
<td>- Adult Orthodontics in Bisphosphonate and Denosumab pts – &quot;teeth will not move.&quot;</td>
</tr>
<tr>
<td>&gt; 151 pg/ml – little or no risk</td>
<td></td>
<td>- Ineffective therapies in DIONJ: clindamycin, HBO, Laser, Ozone</td>
</tr>
</tbody>
</table>

^ Reclast – may also consider CTX 6-9 months after dose/injection

** Avoid debridement, other surg Tx without drug holiday, smooth sharp edges, Tx w/ Pen VK or Doxycycline and Peridex

- Adult Orthodontics in Bisphosphonate and Denosumab pts – "teeth will not move."
- Ineffective therapies in DIONJ: clindamycin, HBO, Laser, Ozone
- Antibiotic of choice in DIONJ – PCN/Amox or (if PCN allergic), Doxycycline x months needed; if Zithromax or Levaquin - no longer than 1-2 weeks.

Information courtesy of Robert Marx, DDS / Table, Graphics by Richard Mufson, DDS
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SFDDA NEWSLETTER
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Published by the South Florida District Dental Association
420 S. Dixie Highway, Suite 2E
Coral Gables, FL 33146

Send announcements and correspondence to the Editor:
420 S. Dixie Hwy, 2E
Coral Gables, FL 33146-2271
Phone: (305) 667-3647
FAX: (305) 665-7059
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New Dentist Networking Mixer

March 22, 2017
Midtown Athletic Club
6:30-9:00PM
2300 Royal Palm Blvd
Weston, FL 33326

Attendance is limited, please RSVP at (305) 667-3647

SFDDA Members,

join us for this networking event to meet the new dentists in our district. Light snacks and beverages will be served.
Pemphigus and Pemphigoid: The Unique Role of Dentists

(Pemphigus and pemphigoid (P/P) are rare, autoimmune blistering diseases that affect a very small percentage of the population. The average patient with P/P sees five doctors over ten months in search of a diagnosis for their condition. Delays in diagnosis and appropriate treatment can lead to a number of complications, including significant functional impairment, resistance to treatment, psychological stress, and a lower likelihood of achieving remission.

The majority of P/P patients present with oral symptoms before the onset of skin lesions. Because of this, dentists have a unique opportunity to help shorten diagnosis times by identifying signs and symptoms when they are first encountered.

Pemphigus vulgaris (PV) and mucous membrane pemphigoid (MMP) are two forms of P/P with increased presentation in the mouth. Oral lesions of PV/MMP are often initially misdiagnosed as “allergies” to dental products, foods or environmental agents or “non-specific gingivitis”, further delaying diagnosis (a biopsy) and appropriate treatment.

A catch-all clinical descriptor often used in dental practice is “desquamative gingivitis.” This describes a chronic type of gingival inflammation in which the epithelium detaches, leaving exposed ulcers. Desquamative gingivitis can be caused by several diseases that affect the oral cavity, so the practitioner needs to obtain a definitive diagnosis.

Consider a diagnosis of P/P when a patient presents with a combination of: Multiple ulcerated or erythematous oral lesions that don’t resolve in 7-10 days Lesions outside the mouth, including those on other mucosal surfaces and the skin

Lesions that develop following minor trauma (Nikolsky sign), such as gentle lateral pressure, which weakens the adhesion between epithelial cells and the underlying connective tissues

Care and Maintenance

PV/MMP patients require special care during dental appointments to manage sensitive areas of the mouth and prevent further lesions from forming. Oral lesions can be very painful for patients, making it difficult to brush teeth and maintain proper hygiene. Consequently, patients may experience increased incidence of dental caries and periodontal disease. Dental prophylaxis should be performed on a regular basis, even when lesions are present. Good oral hygiene is very important to positive treatment outcomes.

Care and maintenance tips for dental professionals:

- Do a complete oral mucosal examination. Evaluate for any abnormalities, including secondary complications of PV/MMP treatment, such as candidiasis.
- Be gentle during maintenance appointments.
- Schedule more frequent appointments to control plaque build-up.
- Consider scheduling extra time and using local anesthesia, as patients may experience pain and bleeding during dental treatment.
- Use simple hand scaling instruments to increase control and minimize trauma to the oral tissues.
- Polish teeth with a non-abrasive toothpaste, avoiding harsh abrasives and air polishers, as particles may become embedded in the ulcerated tissue and set off a foreign body reaction.
- Avoid alcohol-based mouth rinses.

Oral hygiene instructions for home care should be tailored to the level of mucosal involvement. When significant oral disease is present, gentle home care — including extra-soft toothbrushes, mildly flavored toothpastes, and mild mouth rinses — may be all the patient can tolerate. Some patients may not be able to floss due to bleeding and pain, so soft interdental brushes may be recommended instead.

If patients are on a soft diet due to presence of oral ulceration and pain, suggest intake of nutritious, non-cariogenic options such as vegetable soups, fruit smoothies, etc.

More information can be obtained by visiting the IPPF Awareness Campaign website at www.pemphigus.org/awareness or by contacting awareness@pemphigus.org)
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D4346 – New Scaling Procedure Code
Effective Jan. 1

It’s here – Dentists may use “D4346 Scaling in the generalized presence of moderate or severe gingival inflammation — full mouth, after oral evaluation” as of Jan. 1. This code reflects the procedure for patients with gingival disease and no attachment loss. Dentists who have delivered the procedure have not been able to document and report it with an appropriate CDT code until now.

This CDT 2017 addition has been the subject of two ADA News articles, a guidelines document posted on ADA.org, and a webinar that has been accessed by thousands of dentists and practice staff.

To learn more about this procedure and its new code, either for the first time or to refresh your memory, visit the CDT Code education page on ADA.org. Search for “Guidance on the D4346 Scaling Procedure” to watch the webinar and download the free publication “Guide to Reporting D4346.” The guide, first published in May, has been updated and incorporates content and feedback from the webinar.

Do you have any questions? If so, please contact us.

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(305) 667-3647

new members 2016-17

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Dr. Dolcie Chin
Dr. Andres De Cardenas
Dr. Luis de la Puente
Dr. Joel Figueredo
Dr. Michael Franco
Dr. Luisa Garcia
Dr. Shane Hodson
Dr. Santiago Lopez
Dr. Katia Mattos
Dr. Zaily Montesinos
Dr. Dominic Morel-Maynard
Dr. Annette Perez
Dr. Greg Ross
Dr. Sydney Sher
Dr. Safiya Smith
Dr. Paola Suglio Villalon
Dr. Gabriela Vegas

sfdda affiliate meetings in march

March 8, 2017
6:30pm
Tropical Acres
2500 Griffin Road
Fort Lauderdale, FL 33312

“Mental Well-Being and Dealing with Stress in Dentistry”

Speaker: Daniel J. Reidenberg, PsyD, BCPC, CRS, CMT, CPAI, FAPA

March 14, 2017
6:30pm
Graziano’s
394 Giralda Ave,
Coral Gables, FL 33134

“Treatment of Severe Malocclusions with the new MEAW Technique”

Speaker: Dr. Jorge Coro

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– Melvyn Nathanson, DDS –
Boca Raton, FL
South Florida District Dental Association
Annual Business Meeting &
State Mandated Courses for Re-licensure

April 26, 2017
6:30pm
Tropical Acres
2500 Griffin Road
Fort Lauderdale, FL

Guest Speaker:
Dr. Richard Mufson
Medical Errors and Domestic Violence

The Agenda Includes:
- State of the Association Address by Dr. Mark Limosani, President
- Voting of any resolutions
- Voting of leadership positions - SFDDA Secretary and FDA Trustee
- State Mandated Courses (Satisfies state required courses)

CC Payment please fax to (305) 665-7059 or checks payable to SFDDA mail: 420 S.Dixie Highway, 2E, Coral Gables, FL 33146

Yes I will attend: ___ Please charge my Visa __ MC__Disc __ Amex  Credit Card $65.00

I will have the ____NY Strip Steak or ___ Norwegian Salmon

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Credit Card No. Exp. Sec Code

Signature
Six out of Six Board Members Agree.
Renewing Your ADA Membership is a Good Thing!

of Hello SFDDA Members,

You will soon receive your ADA tripartite dues renewal in the mail. Once you do, do not hesitate to renew it right away and here is why.

Throughout this newsletter, we have shown you how rewarding it is to be a member of the tripartite through the South Florida District Dental Association.

Your board of officers has worked together at all three levels of the associations to provide relevant benefits that not only help you with your practice and careers, but also help you save money and time.

These include benefits such as credit card processing that substantially saves you in fees, in addition to the FDA Supplies website (fdasupplies.com) that practically pays for your dues in just a couple of dental supply orders. Among our most recent and successful benefits, affiliate dues are now included with your tripartite (ADA/FDA/SFDDA) membership, that entitles you to enjoy the benefits of up to five dinner meetings of your choosing at any affiliate. This is a great savings to you, as well as an amazing opportunity to increase networking and camaraderie between all the affiliates of the SFDDA. FDA Services is also available, and due to a unique understanding of the dental community, and of the needs of our member dentists, they are specialized in helping you with all of your insurance needs.

You also have the benefit of a staff that works on your behalf to keep you up to date on the latest dental profession news, legislative actions, technology and so much more. Yolanda Marrero, our Executive Director, along with Jackie Quintero, your local membership concierge, are available to answer your questions, hear your concerns and work with all levels of the tripartite, whether local, state, or national, to provide you with the best services possible.

There are many other benefits that you can take advantage of. They can be found on our websites at www.sfdda.org or www.floridadental.org or www.ada.org. Take a moment to review them. We are confident you will find your membership to be very worthwhile.
Dental Practice Financing

Together, we’ll find the right financing solutions to help you reach your business goals.

As your practice financing experts, we’ll work with you to identify your unique business needs and find the right financing solutions to help you reach your goals — like purchasing new equipment, expanding your operation and more efficiently managing your cash flow.

- New Office Start-Ups
- Practice Sales and Purchases
- Business Debt Consolidation
- Office Improvement and Expansion
- Owner-Occupied Commercial Real Estate
- Equipment Financing

Bank of America can also help you with Cash Management, Employer Solutions and Individual needs.

For more information or to get started today, please contact us. We look forward to speaking with you soon.

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Your local dental financing experts

Jonathan Burns
614.309.7611
jonathan.burns@bankofamerica.com

Jason Nunez
614.804.0627
jason.nunez@bankofamerica.com

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WHAT YOU NEED TO KNOW ABOUT FDASUPPLIES.COM
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OPPORTUNITIES AVAILABLE

IF YOU ARE A GENERAL DENTIST OR A SPECIALIST: and are looking for a quality large private practice full of integrity that feels like your own, then you should join Regency Dental of Port Saint Lucie. We have been serving the local community since 1993, with a great reputation. Please send your CV to jenn@regencydental.org, or call 772-785-9515 ext. 113.

RECEIVE CONTINUING EDUCATION CREDITS: on a personalized level at my office. David Vine, D.D.S. over 44 years of experience and author of the book “Understanding First Class Dental Care”. Call 305.538.1115. dvine@davidvinedentist.com

SHARE OVERHEAD OR EXPERIENCED ASSOCIATE: and or Start own practice in shared office. Hollywood dentist looking to bring in another experienced dentist(s), to share overhead expenses in a well-established Hollywood Dental Practice. Call Kim (954) 981-4500

JACKSONVILLE CLINIC SEEKING DENTIST: Must be licensed in state of FL. Must have malpractice insurance & no convictions within last 2 years. Hours are Tues-Fri 8am until completion (usually 4pm) You choose your days! Email staffing@1daydenturejax.com or call 904-683-0415

FLORIDA (SOUTHEAST AND ORLANDO – Over 45 practices): Seeking experienced General Dentists and Specialists to come grow with us! We offer excellent earning potential and the opportunity to focus on patient care in our state-of-the-art facilities. We take care of the administration (insurance claims, payroll/staffing, marketing, etc.) for you so that you can enjoy a work-life balance again! Take the next step in your career and apply online at https://www.mysagedental.com/career-opportunities/ or email your CV to bcabibi@mysagedental.com today!

PART TIME: High quality prosthodontist and periodontist needed for selective cases at my office. Please call or e-mail. David Vine, D.D.S. 305.538.1115 (dvine@davidvinedentist.com ).

SEEKING: an “on call” substitute General Dentist in Dade Co. Salary Negotiable. Ideal opportunity for retired or persons needing extra income. Please call for details. Judy Jones 615-202-8864

GENERAL / SPECIALIST: Ft/Pt Great opportunity for General Dentist / Specialist. Excellent compensation, bonus and partnership positions. Multiple locations in South Florida. Please fax resume to (305) 770-1232 or call Kathy (954) 430-2188 or email to haroldhui@aol.com

BUSY DENTAL PRACTICE: Looking for PT associate dentist in Fort Lauderdale and Delray Beach. Competitive % compensation based upon experience. Ask Dr. Martin 786-525-9946


OFFICE SPACE-SALE OR RENT

OPPORTUNITY FOR YOUNG DENTIST: Current owner wants to retire. Dental office with 800 sq ft of space and 2 dental chairs and space for another 2 chairs. Includes Dentrix G5 and Dexis Platinum EHR with 3000 patient charts. Rent is $1500/month. Located at 8220 SW 24 St (Coral Way), Miami, FL 33155. Two blocks from the Palmetto Expressway. Large parking area. Interest person, please contact Dr. Abel De Anna at 305-505-4768 or Claudia at 305-222-1150.

GABLES PROFESSIONAL BUILDING: Space available for rent with interior bathroom. Great location. Rent ranges $1,250-$1,400/month. Call (305) 763-6106

To run a classified or display advertisement in the SFDDA Newsletter, please contact: Jackie Quintero at (305) 667-3647 ext 13 or email jackie.sfdda@gmail.com
LET’S TAKE A CLOSER LOOK AT YOUR INSURANCE COVERAGE

Contact us for a full review of your professional insurance portfolio. We’ll make sure you have the coverage you need to practice with peace of mind.

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Director of Sales
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