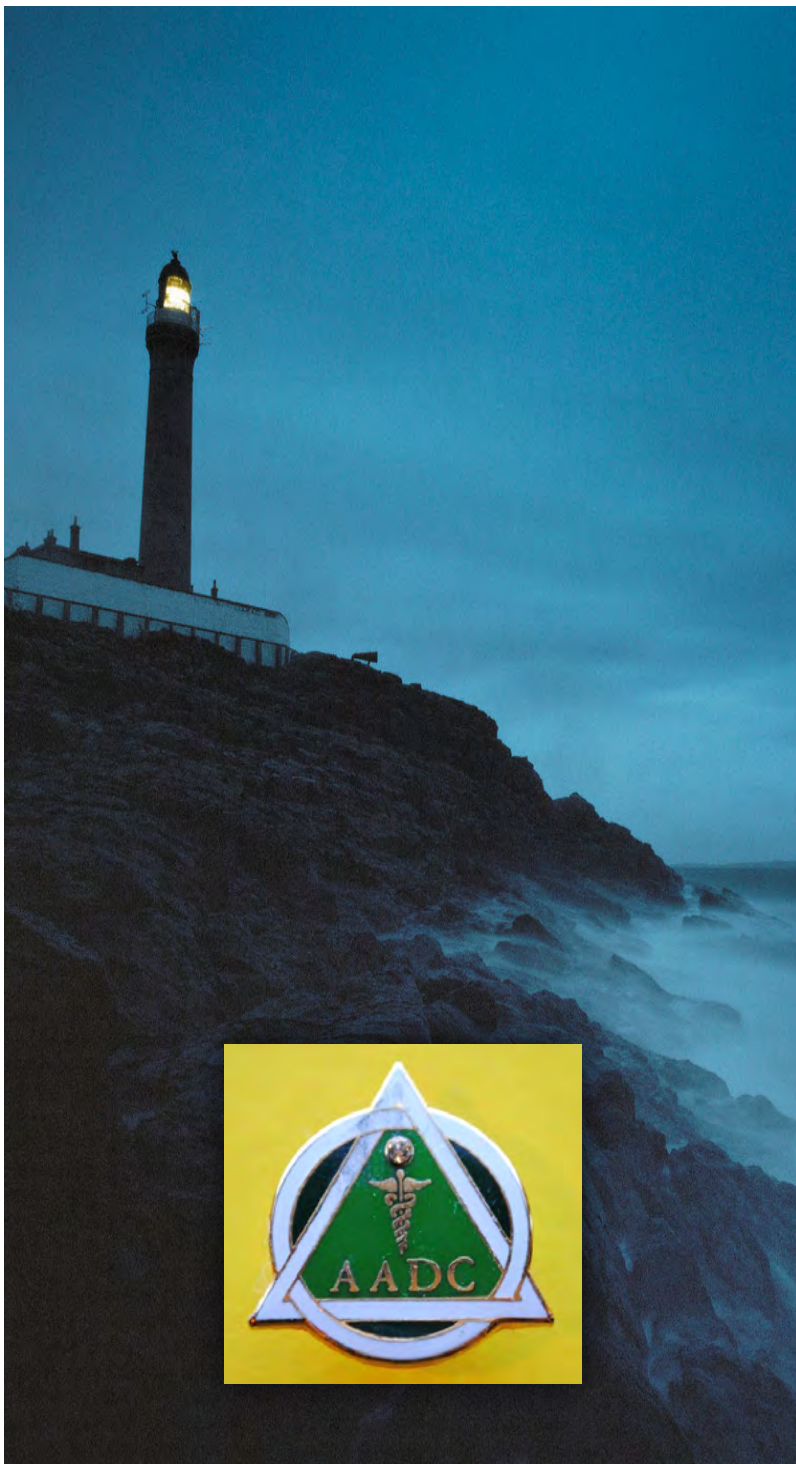


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YEARS

FALL 2026

THE BEACON

Official Publication of the American Association of Dental Consultants



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AMERICAN ASSOCIATION OF DENTAL CONSULTANTS

Updated May 2026
Terms expire annually in May

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Published articles in *The Beacon* are for educational purposes only and are not intended to direct or influence dental claims payments or to be considered legal advice.



President's Message

Wayne Silverman, DDS, FAGD

President, American Association of Dental Consultants

I hope you had an enjoyable summer as we head towards the holiday season.

As mentioned in my remarks at this past annual workshop, I attended my first AADC workshop in 1997, also in Scottsdale. I revamped my scripted thoughts after I met Dr. Oqba Memar from Temple University, at breakfast. I was enraptured by his story, how he and his family (his wife also a dentist) fled their homeland, leaving their home and dental practice behind. Eventually enrolling and graduating from dental school and becoming a faculty member of the Kornberg School of Dentistry at Temple University.

I am recapturing this for you because meeting Dr. Memar defines one of the purposes of the AADC workshop. When I think of the number of people I have met in 29 workshops, and how so many of them have enhanced my professional career I realize how fortunate I am.

The profession of dentistry has changed. But the mission of the AADC has not. Promoting education relevant to the dental



benefits industry, the benefit policies, interpretation of coding/billing and understanding utilization management remain our mission.

The annual workshop brings us together, providing the opportunity to refresh old friendships and make new ones. In my remarks at the annual workshop, I made a plea to all members: be active and participate in our organization, join a committee!

To all our members, young and not so young, a reminder, this is your organization, it has thrived and will continue to succeed with your input and ideas. As a participant in committee meetings, I am always fascinated and encouraged by the ideas proposed to make the AADC a better organization.

I thank the board members and every chairperson and members of the committees for their energy and creativity. Special thanks to Ellen Kessler, our executive director, steering AADC and keeping it on course. My thanks to Madeline Thomas, immediate past president, for her leadership and development of the Vanguard group, linking our members with other dental organizations.

To all my AADC colleagues, I wish you a happy and healthy holiday season and look forward to seeing all of you in Scottsdale in May 2027.



AADC Members are dedicated to serving patients, the public, purchasers of dental benefits, and the profession of dentistry. An experienced dental benefits consultant can provide valuable insight and input on:

Network issues

Dental claim policy and standards of care

Dental plan coverage and utilization management

Our goal is to connect dentists and others involved in dental benefits consulting and administration, to identify and promote best practices, and to advance education and promote a common base of knowledge for consistent, evidence-based plan and claims evaluations.



AADC Spring Workshop 2026



Randi Tillman, DMD
Executive Dental Director, DNoA
Chair, Program Committee

By all accounts this year's Annual AADC Spring Workshop was a great success. The beautiful Westin-Kierland Resort did not disappoint. The setting was lovely and welcoming, the accommodations were first rate, and the meeting space suited our needs perfectly. Can you imagine how beautiful the resort will be next year when all the renovations are complete? The venue, construction and all, received excellent reviews, as did our speakers and our educational program.

Westin Kierland Resort & Spa



The event started with the traditional Dr. Larry N Browning Memorial Golf Outing sponsored in part by Dynamic Dental Safety. Sixteen golfers making up 4 teams played in friendly competition at the Westin-Kirkland golf club located at the resort. A luncheon at the club was included.





With 193 attendees along with exhibitors and speakers, the meeting brought together an impressive cross-section of our profession. Our educational sessions covered a broad range of topics from artificial intelligence and claims review to sleep apnea and other emerging issues in dental care and benefits. The diversity of the program reflected the wide-ranging interests and responsibilities of our members.



General Session

The Lunch and Learn sessions were very popular, and I know that they stimulated some interesting and provocative discussion.

Perhaps most important was the opportunity to connect, network and learn from one another. Luncheons, cocktail receptions and daily breaks gave us the time to talk with colleagues whose interests and challenges parallel our own.



Lunch & Learn



Collaborative: "Let's Talk About..."



Collaborative: "Let's Talk About..."

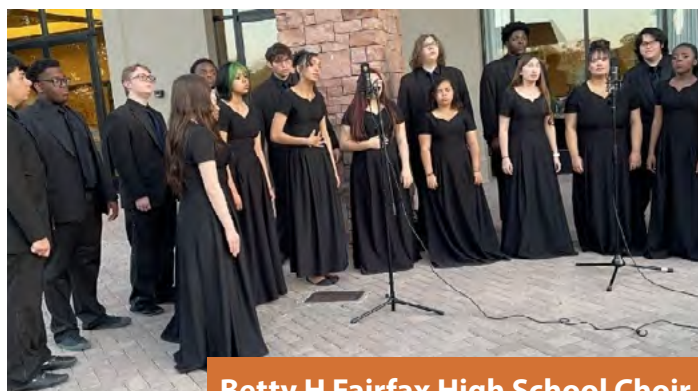


New Member Reception

The opportunity to mingle with others who share our concerns and our challenges on a daily basis is one factor which makes this meeting so unique. There are few places in our industry where professionals can come together to share ideas and experiences about dental benefits, health insurance, advances in clinical dentistry and the ongoing challenges of access, quality and patient care.



New Member Reception



Betty H Fairfax High School Choir



President's Welcome Reception



2026-2027 Board of Directors

We hope that everyone left the meeting with new knowledge, new connections and renewed enthusiasm for the work we do. We look forward to seeing you next year back at the Westin-Kirkland Resort from May 5-8, 2027.



Past Presidents

Save the Date!



May 5-8, 2027
Westin Kierland Resort & Spa
Scottsdale, Arizona

You Don't Want to Miss This Meeting!

Enjoy Two and a Half Days of:
Dynamic Networking
Professional Development
Valuable Continuing Education
Business Opportunities
President's Welcome Reception

Plus:

Dr. Larry Browning Memorial Golf Outing

New for 2027:

Pickleball • Mah Jongg & Lessons • Game Night



Certification Examination Committee Update

Linda Vidone, DMD, CDC



The Certified Dental Consultant (CDC) Committee is pleased to announce another successful year for the certification program. We extend our sincere congratulations to the five candidates who completed and passed the CDC examination during the Annual Workshop held at the Westin Kierland Resort & Spa, in Scottsdale, AZ. Achieving CDC status reflects a significant commitment to professional development and excellence within the dental benefits industry, and we proudly welcome our newest certified consultants.

The Annual Workshop also featured the CDC Committee's gathering recognizing current Certified Dental Consultants and AADC Past Presidents. This networking event has become a valued tradition, providing an opportunity for members to reconnect, share insights, and celebrate the accomplishments of our consulting community. The committee continues to explore new ways to enhance the experience and provide additional educational value for attendees in future years.





Drs. Jennifer Hinshaw, Angela Marie Davis, Wayne Silverman (President), Tushara Johnson, Paul V. Rickard (Not pictured: Marysia Lynn Taylor)

For dentists interested in pursuing CDC certification, the program remains an excellent opportunity to demonstrate expertise in dental consulting and the dental benefits industry. Eligibility requirements include being a licensed dentist, having a minimum of five years of experience working in the dental insurance field, attending two AADC Annual Workshops within the previous three years (excluding the year the examination is taken), and contributing an article to *The Beacon*.

Additional eligibility details, application information, and certification resources can be found on the American Association of Dental Consultants website at www.aadc.org. The CDC Committee encourages qualified members to consider pursuing certification and joining the growing community of Certified Dental Consultants.

Questions regarding the certification process may be directed to CDC Committee Chairperson, **Linda Vidone, DMD**, at lvidone@yahoo.com.

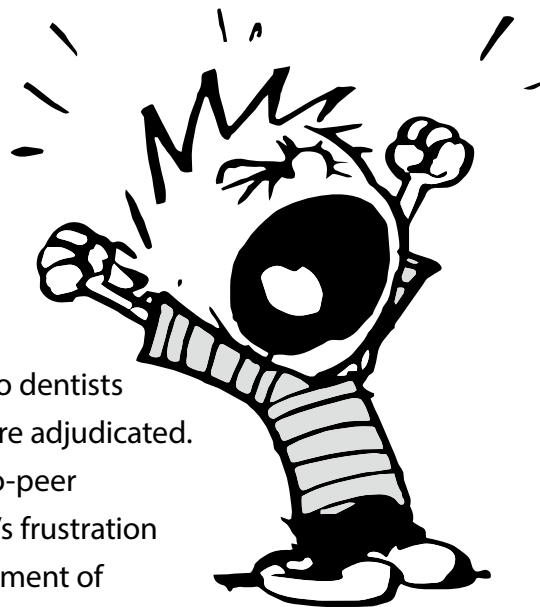




Peer-To-Peer Frustrations

Navigating the Gap between D4346 and D4341

Paul V. Rickard, DDS



As dental consultants, we are often requested to make peer-to-peer calls to dentists who disagree with how their claims were adjudicated. If you are like me, many of your peer-to-peer conversations are related to the doctor's frustration regarding the use of codes for the treatment of periodontal disease. Often, at least for the dentists requesting peer reviews, they are doing the best they can to provide quality treatment while also trying to earn a living. Their problems arise when attempting to submit the appropriate codes to insurance companies for reimbursement.

Dental consultants are charged with evaluating information so that insurance companies can make appropriate payments based on the terms of the insured's policy. AADC members have ethical responsibilities of non-maleficence, in that they should work in a way that does not unnecessarily jeopardize the important relationships between dentists and their patients. We have an ethical responsibility to provide truthful information. More importantly, the decisions we make must be without bias; without any regard to whom we believe may benefit from the decisions we make.¹

It is important for us to understand that prior to 2017, difficulties occurred because there was no specific code for the treatment of moderate to severe gingival inflammation in the absence of attachment loss. Code D4345 (scaling in the presence of

inflammation) had been available between 1990 and 1995, but it had serious issues—most notably, it lacked a distinctive descriptor to distinguish itself from ADA code D1110. Consequently, insurance claims for D4345 were often treated as routine prophylaxes.²

D4345: Periodontal scaling performed in the presence of gingival inflammation.

*Gingivitis can be characterized clinically by marked changes in color, gingival form, position, surface appearance, presence of bleeding, and/or exudate. With no loss of attachment or bone loss gingivitis requires scaling of coronal surfaces, including below the gingival margin. Such scaling in the presence of gingival inflammation is a more precise descriptor describing therapy for generalized gingivitis and is not meant to be performed on a routine basis. Upon completion of treatment, the gingival tissues should be normal and can be maintained by adult prophylaxis on a regular basis. This is a scaling-only procedure; it may require single or multiple visits. This code should not be reported in conjunction with an adult prophylaxis, nor should it be reported in conjunction with root planing.*³ (CDT 1990)

Obviously, the dentists of that time were still responsible for ensuring teeth were appropriately cleaned, home care instructions were provided, and patients were placed on appropriate recalls. There were additional pressures on dentists as it became increasingly apparent that untreated periodontal conditions contributed to a myriad of medical conditions, ranging from diabetes complications to

pancreatic cancer and an increased incidence of low birthweight babies (among others).⁴

A dental prophylaxis was not the appropriate treatment of generalized gingival inflammation. Documenting and billing a diagnosed case of moderate to severe gingival inflammation as a simple prophylaxis could leave the dentist—who may have removed every bit of calculus—not only undercompensated but in jeopardy of being accused of undertreatment.

It is inappropriate to complete an exam and D4355 during the same visit; this is clear in the CDT descriptor of D4355. Billing for D1110 and “hoping for the best” was not the best treatment either, and advising non-treatment was not an option. The defunct ADA code D4345 had its own set of issues.⁵ Often, codes D4341 and D4342 provided a better description for the treatment of teeth with bleeding gums and probing depths over 3mm, especially when treatment was completed over multiple visits, monitoring healing was required, as was the use of local anesthesia.

At the same time, dentists realized that some patients with gingival inflammation and pocketing, especially young patients, did well if their teeth were methodically cleaned and placed on recall. Aside from obvious cases, there was no clear way to predict which patients would improve with “just a cleaning”. Radiographs were considered helpful but were not universally considered diagnostic for these specific cases.⁶ Dentists relied heavily on periodontal probes, and treatment was often

driven by hygienists who did not routinely read radiographs. The strategy was simple: hygienists removed the calculus, and the dentist ensured the gingival tissues returned to health while preventing recurrence.

In 1961, Gargiulo et al. described what he called the “biological width”, noting that it was an average distance of 2.04 mm from the alveolar crest to the CEJ.⁷ As biological width became better understood, it became accepted that a healthy periodontal attachment would appear on a bitewing as a 1 to 3 mm space between the crest of the alveolar bone and the CEJ. By the mid-2010’s, the 2mm criteria was widely accepted by periodontists, and the term “biologic width” began to be replaced by “supracrestal tissue attachment”.⁸

Despite this, many dentists continued to rely solely on probing depths. Disputes arose regarding proper coding: patients with gingival inflammation needed more than a prophylaxis, but those without bone loss needed less than scaling and root planing. There were even fears that dentists were harming patients without bone loss by performing actual root planing on healthy cementum.⁸

Finally, on January 1, 2017, the ADA introduced code D4346 to fill the gap. This was a welcome addition because it established a category for patients with increased pocket depths and inflammation who showed no signs of bone loss.

D4346: Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation.

The removal of plaque, calculus and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures.⁹ (CDT 2017)

D4346 was also useful in flagging patients who did not receive scaling and root planing yet still required special attention during follow-up care. The ADA guidelines suggest the minimal standard for “moderate to severe” gingivitis is when at least 30 percent of the teeth exhibit redness, edema, and glazing with bleeding on probing. If less than 30 percent of the dentition is involved, it is not considered “generalized”, and the inflammation may be treated with a standard D1110.¹⁰

A “difficult prophylaxis” does not qualify for D4346, even if it requires local anesthesia or multiple appointments. D4346 requires the documented presence of moderate to severe generalized gingival inflammation. Furthermore, D4346 does not apply to the cleaning of implants.

Codes for scaling and root planing (D4341 and D4342) have higher standards. The descriptor specifies that root planing “involves instrumentation of the crown and root surfaces”. If the roots are not exposed, they cannot be planed. When radiographs display a bone level within 2 mm of the CEJ, that space is presumably occupied by the supracrestal tissue attachment. In these cases, a consultant looks closely for other signs of attachment loss, such as radiographic root calculus or furcation involvement. Claims should be reviewed with the expectation that the dentist collected information to determine that the root surfaces were exposed before prescribing root planing.

D4341: Periodontal scaling and root planing – four or more teeth per quadrant.

This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus... It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms.¹¹ (CDT 2026)

The need for multiple appointments or the presence of gingival bleeding does not meet the requirements for SRP. There must be an indication that the cementum was exposed. While subgingival calculus alone doesn't trigger SRP, the presence of calculus on root surfaces with inflammation and abnormal pocketing does.

Old habits die hard. Even after nearly ten years, code D4346 needs to be better understood and implemented. Some offices may still be unaware of the code or ignore it, fearing it would be as ineffective as the defunct D4345. In 2026, arguments persist between dentists insisting they performed “more than a prophy” and insurance companies noting the procedure was “less than SRP.” Often, both are correct. Dental consultants who possess a clear understanding of D1110, D4346, and D4341 can lead the way toward more positive experiences for dentists, patients, and insurers alike.

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The Impact of Artificial Intelligence

on Dental Benefit Management and Utilization

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Introduction

Artificial intelligence (AI) is increasingly influencing healthcare systems by enabling data-driven decision-making through machine learning, predictive analytics, and pattern recognition.¹⁻³ In dental benefit management, traditional workflows have long relied on manual claims review, retrospective audits, and rule-based adjudication systems that can be time intensive and inconsistently applied. These limitations become more pronounced as utilization volume increases and payer systems face pressure to improve efficiency and cost containment. Recent advances in AI offer an alternative approach in which large scale claims data, electronic health records (EHR), and clinical documentation can be analyzed in near real time. Rather than replacing existing structures, AI technologies function as augmentative systems that support decision-making, improve operational efficiency, and enhance clinical oversight.^{2,3} Across healthcare, evidence suggests that machine learning applications can improve diagnostic performance, strengthen predictive modeling, and support early intervention strategies, all of which are relevant to dental benefit systems.⁴

This paper examines how AI is reshaping dental benefit management, with emphasis on claims processing, utilization management, fraud detection, and workflow integration. It also explores the evolving role of dental consultants and highlights ethical, regulatory, and operational challenges associated with AI adoption.

Modern AI Applications in Dentistry: Diagnostic and Clinical Support

AI applications in dental imaging have expanded significantly, particularly through deep learning-based image analysis. These systems can identify radiographic patterns associated with caries, periodontal disease, periapical pathology, and restorative discrepancies with increasing accuracy.^{5,6} Unlike traditional interpretation methods that rely heavily on subjective clinical judgment, AI-based systems can quantify radiographic features such as bone levels, lesion size, and restoration integrity. For example, in periodontal assessment, AI tools can assist in distinguishing bone loss and calculus deposits on root surfaces, supporting more standardized clinical evaluations.⁷ Although these technologies demonstrate promising diagnostic performance, their effectiveness remains dependent on data quality, training datasets, and appropriate clinical validation.

In dental electronic health records (EHRs), structured data includes standardized information such as patient demographics (age, gender, insurance ID), CDT procedure codes, periodontal charting measurements, tooth numbers and surfaces, appointment dates, and billing records. Because

this information is organized in a predefined format, it can be easily searched, filtered, and used for reporting or clinical decision-making. In contrast, unstructured data consists of materials like clinical notes, narrative, radiographs and their interpretations, intraoral images, and patient communications. These elements are rich in clinical detail but are harder to organize or analyze in their raw form.⁸

In modern dental informatics, AI is increasingly helping to connect these two types of data. Through tools such as natural language processing (NLP), large language models (LLM), and image analysis, AI can extract meaningful clinical information from unstructured sources and convert it into structured formats. This improves the quality and consistency of documentation, supports better clinical decisions, and makes dental data more useful across healthcare systems.⁸

Figure 1 shows how dental radiographs are collected, processed, and analyzed by AI algorithm. It demonstrates how these models can accurately detect a range of periodontal and restorative conditions, such as bone loss, caries, the integrity of restoration margins, and periapical lesions.⁹

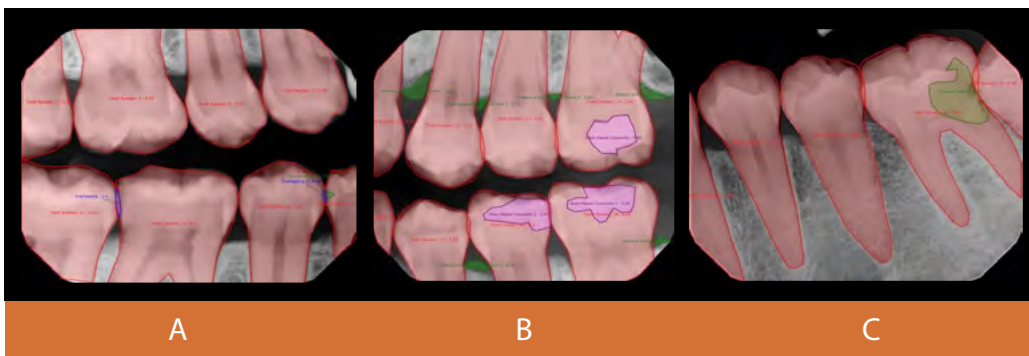


Figure 1.

AI Analyzed Dental Radiographs: A and B: Bitewing radiographs. C: Periapical radiograph. Interproximal caries is detected and annotated in light green in A and C. Alveolar bone loss is annotated in dark green in B. Existing restorations are annotated in purple in B. Overlapping structures are annotated in blue in A. Anatomical tooth boundaries are annotated in red in A, B, and C. (Source: Temple University).⁹

Transformation of Dental Benefit Management Through AI

The integration of AI into dental benefit systems represents a shift from retrospective, rule-based adjudication toward dynamic, data-driven decision support. Machine learning algorithms can process large datasets to identify utilization patterns, predict outcomes, and flag anomalies that may require further review.^{1,7}

Operationally, AI can reduce administrative workload by automating routine tasks such as eligibility verification, documentation checks, and policy compliance screening. This allows human reviewers and dental consultants to focus on complex or ambiguous cases requiring clinical interpretation. Additionally, integration of AI into EHR systems and claims platforms enhances interoperability, data exchange and facilitates continuous monitoring of provider behavior in relation to evidence-based guidelines.^{2,3}

AI in Claims Processing and Adjudication

Claims adjudication is one of the most immediate areas impacted by AI adoption. Traditional workflows typically involve manual validation of documentation, coding accuracy checks, and policy review, which can be time-consuming and subject to variability.¹

AI-based systems streamline this process by automatically evaluating claims against predefined coverage criteria, identifying missing or inconsistent documentation, and flagging potentially non-compliant submissions. Over time, machine learning

models refine their accuracy through exposure to historical claims data, improving consistency in decision-making.^{1,7}

Importantly, these systems are not intended to replace human oversight but to enhance it by reducing administrative burden and minimizing preventable errors. This contributes to more consistent adjudication outcomes and improves operational efficiency.^{4,7}

Utilization Management and Predictive Analytics

A significant advantage of AI lies in its ability to support predictive utilization management. Rather than relying solely on retrospective reviews, AI systems can forecast future service needs based on patient risk profiles, historical utilization trends, and clinical indicators. Predictive models may assist in identifying individuals at elevated risk for conditions such as dental caries or periodontal disease, enabling earlier preventive interventions. Similarly, analysis of provider-level treatment patterns can help identify deviations from standard practice guidelines.^{5,6} These capabilities support a shift toward proactive care management, where interventions are guided by anticipated risk rather than historical utilization alone. Over time, this approach may contribute to improved patient outcomes and more efficient allocation of resources.

Fraud Detection and Anomaly Identification

Fraud detection remains a critical function within dental benefit systems. Traditional approaches

rely heavily on manual audits and static rule-based flags, which may fail to detect complex or evolving patterns of inappropriate billing. AI enhances fraud detection by identifying anomalies across large datasets, including unusual billing frequencies, duplicate claims, and atypical provider behavior. Machine learning models can continuously adapt to emerging patterns, improving sensitivity and scalability compared to conventional methods.^{1,4}

While AI improves detection capabilities, it also introduces the need for careful validation to avoid false positives that may unfairly target legitimate providers.

Impact on Dental Utilization Patterns

The integration of AI into benefit systems is gradually influencing patterns of care delivery. One of the most notable shifts is the increased emphasis on preventive care and early intervention. By identifying risk earlier in the disease process, AI-supported systems can reduce reliance on

emergency or reactive treatments. Additionally, diagnostic consistency is improved through standardized algorithmic assessments, which may reduce variability in clinical decision-making.³

AI Integration into Dental Benefit Workflows

AI functions most effectively when embedded within existing clinical and administrative workflows rather than operating as a standalone system. In practice, AI tools are integrated across claims platforms, EHR systems, and utilization management dashboards, enabling continuous data exchange between stakeholders.^{2,3,8} This integration supports a hybrid decision-making model in which AI-generated insights inform but do not replace human judgment. Dental consultants, administrators, and clinicians collectively interpret outputs to ensure clinical appropriateness and policy compliance. Figure 2 illustrates the conceptual AI workflow in dental benefit management.

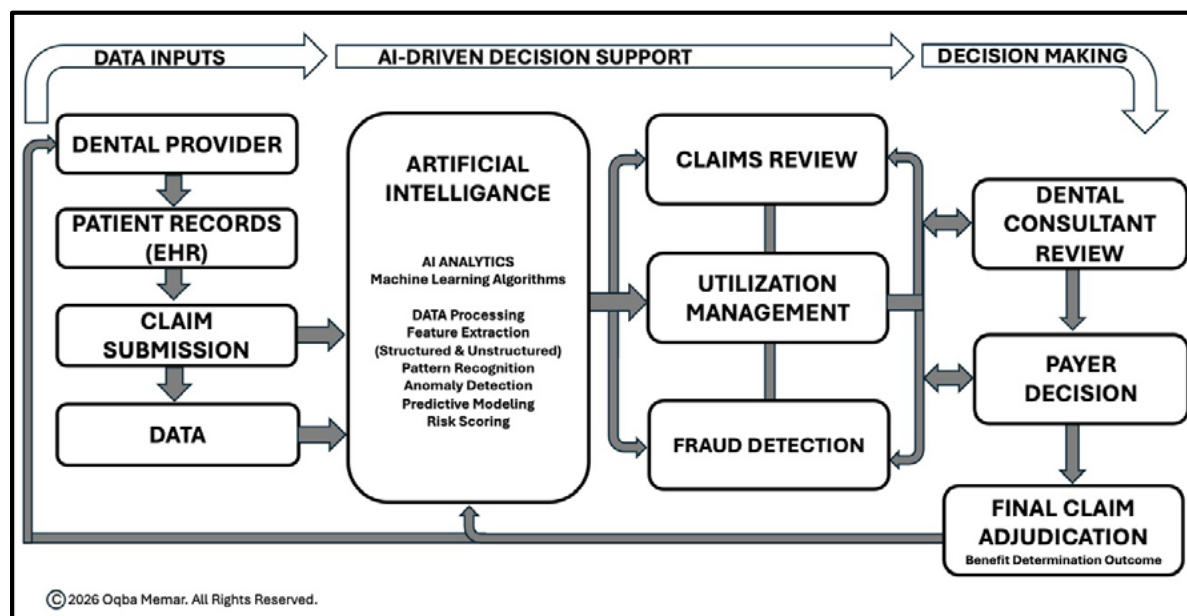


Figure 2.
Conceptual AI Workflow
in Dental Benefit
Management and
Utilization

Role of Dental Consultants in the AI Era

As AI systems become more prevalent, the role of dental consultants is evolving rather than diminishing. Consultants increasingly serve as intermediaries between algorithmic outputs and clinical decision-making. Their responsibilities include evaluating AI recommendations, interpreting flagged cases, ensuring alignment with clinical guidelines, and identifying potential sources of algorithmic bias.³ In this capacity, consultants provide essential oversight to ensure that AI-supported decisions remain clinically valid, ethically appropriate, and patient-centered.

Ethical, Regulatory, and Operational Considerations

Despite its benefits, the adoption of AI in dental benefit systems introduces several challenges that require careful management. AI models trained on historical data may unintentionally perpetuate existing biases in care delivery and utilization patterns⁵, raising concerns about equity. Additionally, many advanced machines learning systems function as “black boxes,” limiting transparency and making it difficult to interpret or justify decision-making processes, which in turn affects accountability.³ The reliance on large-scale clinical and claims data also heightens the importance of stringent data privacy protections to ensure patient confidentiality and compliance with regulatory standards.⁴ Furthermore, the rapid advancement of AI technologies has outpaced current regulatory frameworks, underscoring the need for updated and specialized governance models tailored to healthcare applications.

Traditional and AI-Driven Approaches in Dental Benefit Management and Utilization

Table 1 below summarizes the comparison between traditional and AI-driven approaches to dental benefit management and utilization.

Table 1: Summary Comparison of Traditional and AI-Driven Approaches

Category	Traditional Approach	AI-Driven Approach
Claims Processing	Manual review, slower turnaround, higher variability	Automated processing, faster decisions, consistent outputs
Decision Making	Rule-based system with significant dependence on human judgment	Utilizes real-time data analytics and predictive modeling to support adaptive decision-making
Utilization Management	Predominantly retrospective	Shifts toward proactive management through predictive analytics and personalized insights
Fraud Detection	Limited to periodic manual audits with constrained detection capacity	Continuous monitoring of provider behavior and pattern recognition across large datasets
Clinical Support	limited decision-support tools and depends largely on clinician interpretation	Integrates AI-assisted diagnostics, including imaging analysis and risk stratification tools
Efficiency	Labor-intensive workflows with higher administrative burden	Streamlined operations through automation and process optimization
Accuracy & Consistency	Subject to inter-reviewer variability and subjective interpretation	Enhances standardization through data-driven and algorithmic consistency
Cost Impact	Higher administrative and long-term operational costs	Reduced costs through automation, efficiency gain, and preventive interventions
Patient Experience	Longer wait times and reactive care delivery	Improves timeliness and supports more proactive, personalized care
Risk Management	Reactive identification of issues (after they occur)	Predictive risk identification and early intervention

Limitations

This paper is based on a conceptual synthesis of existing literature rather than an empirical evaluation of a specific artificial intelligence system or dataset. Therefore, the findings should be interpreted as theory informed insights derived from previously published evidence, rather than as results validated through direct real-world implementation or experimental analysis.

Future Directions

Future developments in AI-driven dental benefit management are likely to focus on deeper integration with real-time clinical systems, expansion of predictive and prescriptive analytics, and improved interoperability across platforms. Additionally, AI applications are expected to play an increasingly central role in value-based care models, where reimbursement is tied to outcomes rather than volume of services. As these systems mature, the role of AI will likely transition from supportive analytics to embedded decision infrastructure within dental benefit ecosystems.

Conclusion

Artificial intelligence is reshaping dental benefit management by improving operational efficiency, enhancing predictive capabilities, and supporting more consistent decision-making across claims processing, utilization management, and fraud detection. While these advancements offer substantial benefits, they also introduce ethical and operational challenges that require careful oversight.

Dental consultants will remain essential in this evolving landscape, ensuring that AI-driven systems are applied appropriately and that clinical judgment remains central to care decisions. As integration deepens, AI is expected to become a foundational component of modern dental benefit systems, supporting a shift toward more proactive, efficient, and evidence-based care delivery.

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SPOTLIGHT

The Moments We Don't Recognize: Reflection on a Career in Dentistry

Stewart Balikov, DDS CDC AHFI

I was genuinely honored to be asked to contribute to the Spotlight section and share a few reflections on the professional journey that has shaped my career.

Growing up, my parents always told me I could be anything I wanted to be in life — as long as I became either a doctor (physician), a dentist, or a lawyer . . . and attended the University of Southern California (USC). Fast forward to May 13, 1983 — yes, it was a Friday the 13th! — when I graduated from the USC School of Dentistry and officially began a professional journey that has now spanned more than four decades.

As I reflect on that journey today, I'm reminded of the words spoken by Dr. Archibald "Moonlight" Graham to John Kinsella in Field of



Dreams: *"We just don't recognize life's most significant moments while they're happening."* Looking back, I realize how true that has been throughout my career. Many of the experiences and opportunities that ultimately shaped my professional path seemed ordinary at the time yet became defining moments in both my personal and professional growth.

After graduating from USC, I began practicing general dentistry in Southern California. Early in my career, I worked in private practices focused on general, cosmetic, and sports dentistry. Eventually, I became a partner in a general practice with a senior dentist named Dr. 'Bernie' —one of those 'most significant moments' in hindsight. Bernie was an exceptional clinician whose gold inlays and onlays were truly textbook quality. His box forms looked as if he used hand instruments, yet all were done with diamond burs. Working alongside him was a genuine professional apprenticeship. I can still picture him chairside: no gloves and, quite literally, smoking his pipe while treating patients. Those years taught me invaluable lessons about both the clinical and business sides of dentistry . . . although, regrettably, I never quite succeeded in getting Bernie to routinely wear gloves.

Sadly, Bernie's health began to decline, the practice

struggled, and we eventually parted ways. I became an associate in a larger practice, where I met Dr. 'Harris'. We quickly became close friends and remain so to this day, although at the time I didn't recognize that meeting Harris would become another one of those "most significant moments" of my journey. Stay tuned.

One of the highlights of my clinical career was my involvement in sports dentistry, which began at the local level volunteering as the "team dentist" for a nearby high school and later serving as Team Dentist for a nearby junior college. Those early experiences eventually led to opportunities to serve as one of the dental consultants for the Los Angeles Raiders and to participate as part of the medical staff for the 1994 FIFA World Cup in Los Angeles. Along the way, I also contributed to research and publications focused on oral injury prevention and sports dentistry.

During my time at the larger practice, I was introduced to Dr. 'Dan', who was looking for an associate for his smaller, highly cosmetic-focused practice. Dan and I immediately connected professionally, and I eventually joined him as a partner. Dan also happened to be the lead dental consultant for the Los Angeles Raiders, which allowed me to spend nine memorable seasons



working with the players, their families, coaches, and staff. It truly was a once-in-a-lifetime experience.

When the Raiders returned to Oakland following the 1995 season, Dan and I made the decision not to relocate, as both of our families were rooted in the Los Angeles area. Shortly thereafter, Harris re-entered my professional journey. Having transitioned into the dental benefits industry with a small dental plan owned by General Electric, he reached out to me regarding an opportunity in administration and compliance.

Dan and I eventually sold the practice — although we remain in contact to this day — and in 1999, I transitioned into the dental benefits industry. My work focused on regulatory compliance, quality assurance, provider credentialing, and HIPAA implementation. Helping lead the organization into HIPAA compliance ahead of the federal deadline was both a major challenge and a rewarding accomplishment, ultimately leading to my Green Belt Certification in Six Sigma.

I later joined Aetna, where I had the privilege of reporting to Dr. Richard Celko — another one of those ‘most significant moments in my professional journey, and perhaps one of the most

influential. Dr. Celko became an outstanding mentor and introduced me to the American Association of Dental Consultants (AADC), where he was serving as President at the time. He invited me to my first AADC meeting in Scottsdale, Arizona, and like so many others attending for the first time, I immediately recognized it as an organization I wanted to become deeply involved with.

Over the next 13 years at Aetna, I advanced through several leadership positions, ultimately serving as National Dental Director for Utilization Management and Dental Director for Aetna Dental of California. Dr. Celko also introduced me to the field of healthcare fraud, waste, and abuse, as well as the National Health Care Anti-Fraud Association (NHCAA), both of which became important aspects of my career.

During my time at Aetna, I was also fortunate to work closely with Dr. George Koumaras, another influential mentor who succeeded Dr. Rick Celko as President of AADC several years later. Both Dr. Celko and Dr. Koumaras strongly encouraged me to become more involved within the organization and helped foster my growing commitment to AADC. Within three years of attending that first AADC meeting, I was elected to the Board of Directors and was later honored to serve as President in 2011.



“Over the course of my career, I’ve learned the importance of adaptability, continuous learning, and valuing the journey itself.”

Dr. Koumaras would once again influence my professional path when he invited me to join Anthem — now Elevance Health — in 2017.

Since joining Elevance Health, I have continued to expand my leadership responsibilities in utilization management, dental policy oversight, and dental special investigations. Currently, I serve as National Director of Dental Utilization Management and Director of Dental Special Investigations. In these roles, I work closely with clinical, legal, analytics, and operational teams to support quality care, regulatory compliance, payment integrity, and positive provider and member experiences.

An important focus throughout my career has been healthcare fraud identification and prevention. Through my involvement with the National Health Care Anti-Fraud Association, I became an Accredited Healthcare Fraud

Investigator in 2013 and currently serve as co-chair of their Dental Fraud Interest Group, supporting education and collaboration around fraud prevention initiatives.

Looking back, I fully appreciate Dr. “Moonlight” Graham’s reminder about “recognizing life’s most significant moments while they’re happening”. Over the course of my career, I’ve learned the importance of adaptability, continuous learning, and valuing the journey itself. Many moments that once seemed routine or incremental ultimately became the experiences that shaped my professional path and defined who I am today.

I’m grateful for the opportunities, experiences, and relationships that have shaped my career, and I look forward to continuing to contribute to the dental profession while supporting its ongoing growth, integrity, and future successes.





GLP-1 Medications & Oral Health: What Dental Professionals and Health Plans Need to Know

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Introduction

Glucagon-like peptide1 (GLP1) medications—including semaglutide (brand names Ozempic, Rybelsus, Wegovy) and tirzepatide (brand names Mounjaro, Zepbound)—have rapidly reshaped the management of type 2 diabetes and obesity. Their demonstrated benefits for glycemic control, weight reduction, and cardiovascular risk have driven unprecedented utilization across the United States.

As these medications become increasingly common among dental patients, oral health professionals and health plans need to understand their potential oral health implications, both positive and negative. While research specifically examining oral outcomes remains limited, existing evidence from pharmacology, diabetes care, nutrition science, and dental medicine offers important actionable insights. This article summarizes what is currently known, highlights emerging concerns, and outlines practical considerations for dental teams.

Overview of GLP1 Medications

GLP-1 medications work by mimicking natural hormones in your body that help regulate blood sugar and appetite. They encourage insulin release when blood sugar is high, reduce sugar production by the liver, slow digestion, and help you feel full longer. Together, these effects can improve blood sugar control and support meaningful weight loss, while also causing whole-body changes that may influence oral health.^{1,2}

Potential Oral Health Implications

1. Xerostomia (Dry Mouth) and Salivary Changes

Xerostomia (Dry mouth) has been reported by patients taking GLP1 medications, in fact emerging clinical reports—including a published case series describing semaglutide-associated hyposalivation—support that clinically significant oral dryness can occur.^{3,4} Xerostomia may also result indirectly from reduced fluid intake, nausea, or altered appetite, rather than a direct pharmacologic effect on salivary glands.⁵

Reduced salivary flow is clinically significant, as saliva plays a protective role in buffering acids, remineralizing enamel, and controlling oral microbial populations. Persistent xerostomia increases the risk of:

- Dental caries/Tooth decay
- Erosive tooth wear (when the hard outer layer of the tooth, enamel, is gradually worn away by acids.
- Oral candidiasis (a yeast infection in the mouth)
- Mucosal discomfort (soreness of cheeks, lips,

tongue or gums) and dysphagia (difficulty swallowing)

Dental Professionals practice tip: Proactively screen patients receiving GLP-1 therapies for dry mouth symptoms, hydration status, caries risk, and consider intensified preventive strategies (e.g., topical fluoride, salivary substitutes, and individualized recall).⁶

2. Gastrointestinal Effects: Acid Reflux, Gastric Changes, and Risk of Enamel Erosion

Nausea, vomiting, and gastroesophageal reflux disease (GERD) are among the most common adverse effects of GLP1 receptor agonists, particularly during dose escalation.^{1,7} Repeated exposure of teeth to gastric acid can contribute to dental erosion, especially on the palatal surfaces of maxillary teeth.

Dental Professionals practice tip: Ask patients specifically about reflux/vomiting. Patients may not volunteer this information unless specifically asked, making chairside screening critical. Preventive counseling should include:

- Rinsing with water or baking soda after meals to neutralize acids in the mouth.
- Avoiding immediate toothbrushing postacid exposure since the toothbrush can scrub away the softened enamel, causing more erosion over time.
- Prescribing special products that help strengthen and rebuild tooth enamel such as fluoride varnish applied in the office or a high-fluoride toothpaste.⁸

3. Changes in Taste, Appetite, and Diet Quality

Dysgeusia (taste alterations) have been reported

anecdotally and in post-marketing surveillance of GLP1 agents.⁹ Changes in taste perception may affect food choices and appetite changes, sometimes increasing reliance on acidic or carbohydrate-rich foods that are easier to tolerate, potentially elevating caries risk.

Changes in taste and food preference have been documented with GLP-1 therapy and may impact on oral health risk. In a randomized controlled trial sub study, liraglutide was shown to suppress appetite and reduce cravings to eat something sweet, salty, savory, or fatty.¹⁰

In a real-world cohort of oral semaglutide users, craving measures for “something sweet,” chocolate-flavored foods, and starchy foods declined after treatment initiation.¹¹

Oral-health relevance: If patients reduce intake of sugar-sweetened snacks/beverages, caries risk may decrease, because sugar consumption is consistently associated with dental caries development. Additionally, reduced appetite and caloric intake may lead to nutritional deficiencies, including inadequate intake of calcium, vitamin D, or B vitamins, all of which play roles in oral and bone health.⁸ Some patients may shift toward “easier-to-tolerate” foods (e.g., frequent small snacks, acidic beverages, or refined carbohydrates) when nausea is present, which could increase caries/erosion risk despite lower total intake.¹¹

Dental Professional practice tip: Dentists should individualize counseling to emphasize low-sugar,

non-acidic options and avoid frequent sipping/snacking patterns.

4. How Periodontal Health May Improve: Indirect (and Possibly Direct) Benefits

Improved glycemic control is associated with reduced periodontal inflammation and better periodontal outcomes, consistent with the well-established two-way relationship between diabetes and periodontitis.¹³ In addition, weight loss and reductions in overall body inflammation may help support healthier, more stable gums.

Early research suggests that GLP-1 medications may have anti-inflammatory effects beyond their role in blood sugar control, though their direct impact on periodontal disease is still being studied.¹⁴ For people with diabetes, these medications—when combined with regular dental care—may help support better overall oral health.”

Clinical implication: For patients with diabetes or obesity receiving GLP-1 therapy, periodontal treatment planning should continue to prioritize glycemic optimization, risk-factor management, and maintenance care—while recognizing that systemic inflammation reduction and dietary improvements may support periodontal stability.

5. “Ozempic Mouth”: Evaluating Social Media Claims and the Evidence

You may have seen terms like ‘Ozempic mouth’ in the media, used to describe changes such as facial aging, dry mouth, or dental concerns in people taking GLP-1 medications. However, there is currently no strong scientific peer-reviewed evidence showing

that these medications cause a unique or specific oral disease.¹⁵ Most experts believe these reported changes are more likely related to common side effects of rapid weight loss—such as dehydration—or medication-related dry mouth, rather than a new or distinct dental condition. Ongoing research continues to explore these topics, but currently, routine dental care and good hydration remain key to maintaining oral health.

Dental professionals play a critical role in helping patients distinguish evidence-based risks from anecdotal or social media-driven concerns, emphasizing preventive strategies and reassurance rather than alarm.

6. Blood Pressure Lowering: Potential Dental Considerations

GLP-1–based therapies, including tirzepatide, have been associated with sustained reductions in blood pressure in patients with obesity. In clinical trials (e.g., SURMOUNT-1), blood pressure–related adverse events such as dizziness were uncommon but occurred slightly more frequently with treatment than with placebo. Rare events, including hypotension and syncope, have also been reported.¹⁶

Why this matters in dentistry: Even modest blood pressure lowering (especially when patients are concurrently taking antihypertensive medications) may increase the risk of lightheadedness or presyncope in susceptible patients. The risk may be amplified by dehydration related to gastrointestinal side effects or reduced oral intake. Dental teams should be mindful of orthostatic symptoms when

repositioning patients from supine to upright positions, and consider measuring vital signs in patients reporting dizziness, recent dose escalation, poor intake, or significant weight loss.

Dental Professional practice tips: document GLP-1 use on the medical history; ask about dizziness, fainting, vomiting/reflux, and hydration; use slow chair-position changes; ensure appropriate breaks and postural transitions; and coordinate with the medical prescriber when patients report recurrent presyncope or symptomatic hypotension.

Recommendations for Dental Teams and Health Plans

As GLP1 utilization increases, dental providers and health plans should consider the following clinically supported actions:

- Update medical history forms to explicitly capture GLP1 receptor agonists use.
- Screen patients for xerostomia, reflux, dietary changes, nausea, and dizziness/orthostatic symptoms.
- Educate patients on acid erosion prevention and hydration and reinforce caries prevention strategies such as limiting sugar intake, avoiding frequent snacking or sipping, and selecting non-acidic, low-sugar foods- particularly during periods of nausea.
- Coordinate care with medical providers for patients experiencing significant or persistent side effects.
- Support preventive services for high-risk patients, including topical fluoride treatments and more frequent recall.

From a population health perspective, dental plans are well-positioned to integrate oral health messaging into broader chronic disease management efforts.

Conclusion

GLP1 receptor agonists represent a major advance in metabolic disease management, with far-reaching implications for overall health. While current evidence does not suggest severe or unique oral pathology directly attributable to these drugs, secondary effects—particularly xerostomia, reflux, and dietary changes—can alter caries and erosion risk, and the tendency toward reduced cravings for sweet foods may offer an oral-health benefit when it translates into lower sugar exposure. Modest blood pressure lowering is usually beneficial but can contribute to chairside dizziness or presyncope in susceptible patients, especially during dehydration or medication changes.

Ongoing research is needed to better define longterm oral outcomes. In the meantime, proactive screening and prevention-focused counseling, patient education, and interdisciplinary collaboration will help ensure that patients receiving GLP1 therapies maintain optimal oral health alongside systemic benefits.

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Please join us in welcoming
these new members who joined AADC
after the 2026 Spring Workshop

New Active Members:

Dr. Santiya Bell – Dental Care Alliance
Greensboro, NC

Dr. Matthew McDonough – Acentra
Jonesboro, AR

New Associate Members:

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Henrietta, NY

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