TOWN & COUNTRY

ESTABLISHED 1846
NOVEMBER 1985 / $3.00

SHIRES & SQUIRES

The Landed Gentry Of England

Why Everyone's in Love With San Diego

A Man's Best Look: The Classic Blue Chalk-Striped Suit

At Home in New York's Most Sumptuous Apartment

Discovering the Gourmet Pumpkin

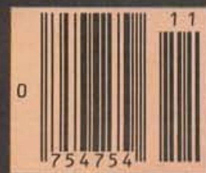
Jack Russell: The Status Terrier

Cosmetic Dentistry: The Smile You Always Wanted

The New Chic of Painted Furniture

The Elite World of Four-in-Hand Driving

Mrs. David S. Burton San Diego Beauty



New Techniques in Cosmetic Dentistry

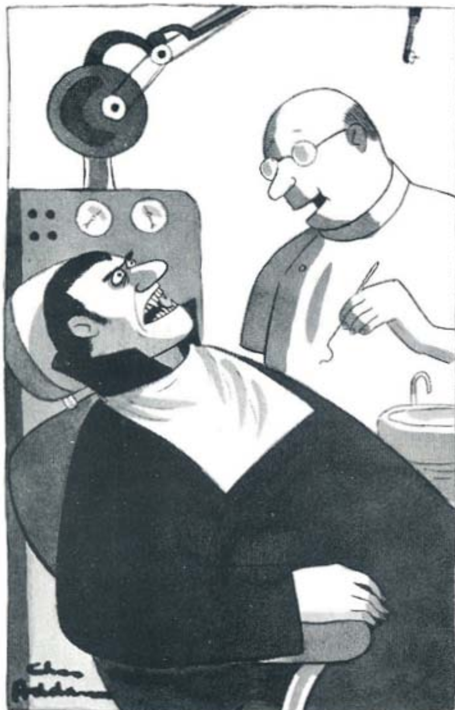
COMING UP SMILING

By Jeanie Wilson

Some of the most exciting progress in dentistry today is in the field of cosmetic improvements. A youthful, attractive smile can be extremely important to self-confidence. In an age when "make-over" experts are consulted for every problem from chin sag to dining-room décor, dentistry, that meticulous and traditionally conservative profession, has responded with a range of new techniques to beautify teeth.

Dentists can now bond or bleach teeth to make them brighter, or cover them with laminate veneers. They can cosmetically contour teeth to change their shape, or improve their alignment with almost invisible braces—even in adults. New crowning techniques make capped teeth look more natural than ever. These advances mean that teeth can be made not only healthier but also whiter, stronger, straighter, more natural, more youthful, even more "masculine" or "feminine" in appearance—and often these results can be accomplished in one painless appointment.

Of course, not every individual is an ideal candidate for every procedure. Some people's teeth just aren't strong enough to provide a sound base for bonding; a few patients may find bleaching too painful to endure without anesthesia. What's more, *any* of these procedures could prove unsuccessful in the wrong hands. Though cosmetic dentistry is not a separate specialty, the dentist you choose must be skilled in the techniques you're interested in and wise in judging if a given method is best in your case. Some of the latest technical advances are still so new (and some still so controversial) that not every dentist can or will do them.



"Some contouring and bonding could do wonders—without affecting your bite."

Bonding Breakthroughs

Not long ago, if you didn't like the color of your teeth, you had two choices: have them reduced in size and fitted with crowns (also known as caps) or learn to keep your mouth shut. The same was true if a large piece of tooth was broken off—you had to have a crown. And if there was a gap between your teeth, costly crowns or lengthy orthodontics were the only answer.

Now, though, recent advances in a technique called bonding allow dingy, misshapen or misaligned teeth to be transformed in many cases into dazzling near-perfection in just one sitting, usually without drilling or anesthesia. Bonding is also useful for reducing sensitivity in supersensitive teeth and those that show the effects of erosion. Although bonding has been around for nearly two decades, the materials and the methods for applying them have improved so much in the last few years alone that bonding is now a much more practical choice for greater numbers of people.

In this procedure, layers of tooth-colored plastic, called composite resin, are applied to the teeth after first etching the surfaces lightly with a mild acid to help the resin adhere. The resin is hardened, usually by brief exposure to a small blue light and *voilà*! Stains and discolorations are masked, chips and cracks filled in, and small gaps closed. In the process, the shape of the teeth can be subtly "resculpted" as well. The result: a bright, even, beautiful smile.

Beautiful, that is, if the job has been done well, explains Atlanta dentist Dr. Ronald E. Goldstein, lecturer on cosmetic dentistry at Emory University and author of *Change Your Smile* (Quintessence). "It requires meticulous care and a lot of artistic ability." Though most dentists do a little bonding now and then for small repairs, some experts estimate that only one in ten is skilled enough in the technique to bond an entire smile—all eight upper teeth, for instance—for aesthetic purposes.

What's more, not all dentists are yet convinced that bonding is a preferred alternative to capping. One main objection concerns longevity. Bonded teeth look good only for an average of three to eight years—sometimes less, sometimes more—before they begin to wear, discolor or chip, requiring occasional touch-up repairs. With good care and luck, however, the job may last for ten years or longer before the bonding must be completely removed and redone. Crowns, on the other hand, are known to last ten to fifteen years or more.

Dentists who do extensive bonding point out that no restoration lasts forever. Porcelain crowns can crack, and even silver fillings may eventually need repair or replacement. "What's beautiful about bonding is that

ILLUSTRATION BY CHARLES ADDAMS

repairs can be done in the mouth in fifteen minutes," says Manhattan dentist Dr. Norman Feigenbaum, editor of *The Forum of Esthetic Dentistry.* "Damaged crowns have to be remade." At $150 to $600 per tooth, bonding costs about one-third to one-half what crowns do.

Some dentists are reluctant to bond for fear of causing gum disease, a more serious threat. But dentists who are experienced in the technique agree that the key to success is how smoothly the resin is "feathered in" at the gum line. "Bonding will *not* cause gum disease if it's done properly," asserts Dr. Feigenbaum. "But if you leave an irritating, bulky ledge at the gum, yes, you are likely to have gum problems."

Another objection is that bonded teeth pick up stains too easily, particularly from red wine, coffee and cigarettes. While this was once a major drawback (in fact, early composite resins sometimes turned yellow no matter *what* you ate), new resins, called microfill, resist staining much better than the other composites. And like your own enamel or porcelain caps, bonded teeth can be cleaned and polished periodically. Sometimes the cause of color change is the mouth environment itself. About one in a hundred people have an unusual body chemistry that causes even the new resins to darken rapidly. "Before you choose bonding, consider whether your teeth stain more deeply and easily than others'," advises Dr. Goldstein. "If every tooth-colored filling you get discolors right away, bonding may not be right for your mouth."

Another kind of resin currently in use, called small particle, offers greater strength than microfill but isn't as natural looking and stains more easily. "In our office, we usually use both, in a 'sandwich technique,'" says Dr. Goldstein, "putting small particle on first for strength, then microfill on top for appearance. Microfill also *feels* very much like natural enamel to the tongue and lips, which is important for people who are bothered by any change in tooth texture." An even newer resin, called hybrid, falls somewhere between microfill and small particle in terms of strength and appearance. Dentists are experimenting to learn its best use.

Right now, new bonding techniques and materials are coming out so rapidly that not even the top specialists agree yet on exactly how to use them. One still-unresolved issue concerns whether some tooth enamel should be removed (not just etched with acid) before resin is applied. Some authorities say a half-millimeter or so should always be taken off, on the theory that unless you make room for the resin, the teeth might be overcontoured, or built out too far, which can look bad and lead to possible gum irritation. (On the other hand, some teeth might *need* to be built out somewhat for a better appearance.) Other dentists restrict tooth reduction to cases of staining so severe and penetrating that many layers of resin are needed.

"I'm always concerned about reversibility," says Dr. Goldstein, "so I rarely cut down a tooth for bonding." That way, the bonding could be removed later on, and the teeth would remineralize—a natural process that restores the enamel through the action of saliva. "Besides," says the doctor, "overcontouring is generally a problem only when you're doing just one or two teeth that might stand out. When you're doing eight or ten, the addition won't be visible and, if carefully applied, won't jeopardize gum health." The American Dental Association takes a similar stand on the issue by recommending conservation of tooth structure "wherever possible."

The position of the ADA on bonding in general is also a conservative one. Historically, the organization has put its stamp of approval only on treatments for therapeutic value, not for aesthetic purposes, so it's not surprising that the ADA officially recognizes bonding only for health reasons—fixing a fractured tooth, for instance, or sealing children's teeth to reduce cavities. Recently, however, the ADA Council on Dental Materials, Instruments and Equipment pronounced bonding "a practical intermediate approach to aesthetic modification of discolored or disfigured teeth." The ADA does advise that you make sure the dentist you choose has done enough of this work to be skilled in it.

For some people, bonding may be the ideal answer; for others, only a stopgap procedure until crowning becomes inevitable. Not everyone who wants bonding can have it, however. "If a tooth is weakened to the point where it needs added strength, I recommend crowning," says bonding expert Dr. Mark Friedman, assistant clinical professor of restorative dentistry at the University of Southern California.

Exactly what constitutes a tooth too weak for bonding is a matter of individual judgment, but teeth that are missing a great deal of structure due to accident, erosion or decay are probably better off capped. Otherwise they might fracture, and the bonding itself would be more prone to chipping. Even here, though, new dentin bonding materials have enabled dentists to bond directly to the dentin (the layer of tooth underneath the enamel) in eroded areas where little if any enamel remains.

Teeth that have been filled extensively and repeatedly also may not provide a sound base for bonding. But it can be done in some cases, reports Dr. Friedman. "We don't have scientific studies yet to tell us how long it will last, but we've seen things hold up we didn't expect to." Other contraindications include an end-to-end bite, where the edges of the front teeth come together during chewing (a situation that will quickly cause bonding to break down), and poor gum health. Inflamed gums must be completely healed before a reputable dentist will do the work. For teeth that have had root canals, the ADA does not recommend bonding, since dead teeth may be more brittle. "That doesn't mean it can't be done, though," says Goldstein. "We've bonded nonvital teeth as long as fifteen years ago that are still doing fine."

Existing crowns (as well as bridgework made of porcelain or acrylic) can be covered with composite resin, says the doctor, but results are short-lived—they look good only for about six to eighteen months. Research that is going on now may eventually improve the resin-to-porcelain (and resin-to-acrylic) bond.

Bonding is not recommended for the entire biting surfaces of back teeth, where heavy chewing and grinding take a toll. "But a good percentage of practices are beginning to use some of the new, stronger composites with confidence for fillings in the back teeth," reports noted cosmetic dentist Dr. Ronald Maitland of Manhattan. "Now you can start to get unsightly silver fillings replaced with tooth-colored material, understanding that they might not last as long as silver." In addition, research is going on to make the new materials stronger. "In twenty years or so," says Dr. Karl Leinfelder, director of the Biomaterials Clinical Research Program at the University of Alabama's Dental School, "we may not even need crowns anymore."

In the meantime, bonded teeth will stay looking good longer if you follow these tips from Dr. Goldstein: 1) Limit consumption of tea, coffee, red wine, soy sauce, grape juice, blueberries, cherries and tobacco, which stain. 2) Don't bite into hard or tough foods such as spareribs or bagels—cut them into pieces instead. 3) Don't chew ice. 4) Have your teeth cleaned three or four times a year, making sure the hygienist doesn't use electronic cleaning instruments, which can damage the bonded finish. 5) Don't bite your nails or pick at bonded teeth. 6) If you grind your teeth unconsciously, wear a bite guard when you sleep. 7) Be diligent with dental care, keeping a close watch on gum health.

Laminate Veneers

A variation on the bonding technique, laminate veneers are thin, tooth-shaped shells prefabricated in the laboratory and bonded to the etched teeth, somewhat like attaching false fingernails. Here, too, new materials mean that dentists can achieve more natural-looking and longer-lasting results than ever before.

The first laminates were made of acrylic, but though they cover stains nicely, they can pop off. Next came laminates made of composite resin, but these, too, can peel or pop off. Now dentists are excited about the newest version, made of porcelain, which is the strongest, most enamel-like substance available and masks stains better than any other.

(*Continued on page 292*)

"Porcelain veneers may be the wave of the future," predicts pioneering cosmetic dentist Dr. Irwin Smigel of Manhattan, founder of the American Society for Dental Aesthetics. "I think they may eventually replace bonding altogether. In the four years we've been using porcelain laminates, we have yet to see one chip. They still look as good as they did when we put them on."

Laminates are most useful for teeth that are stained too darkly for regular bonding to cover, and many dentists restrict their use to just these cases. Good candidates for the procedure include people with severe tetracycline stains, caused by taking the antibiotic during the formative years. People who are tooth grinders can especially benefit from porcelain laminates, says Dr. Smigel, since these don't chip or wear as much as regular bonding. "And they're a good choice for heavy smokers," adds the doctor, "because they stain less than bonded teeth."

Having strong, healthy teeth is a more important prerequisite for laminates than for bonding, since laminates provide even less additional strength to the tooth than bonding does. As in regular bonding, the procedure's reversibility depends on whether or not enamel is removed, and that, in turn, depends on the individual dentist's technique. Unless the teeth are reduced, however, the addition of the laminate may cause a bulging appearance. Dr. Smigel recommends removing up to a millimeter of enamel to accommodate the laminates. "I don't believe in cutting teeth, ever, except for aesthetic reasons, such as reshaping malformed teeth," he says, "and I rarely do when I bond. But with laminates you have to, in order to get them to tuck in at the gum properly." Laminates are *not* easy to put on or take off, he warns, and if your dentist isn't skilled in their use, the results could be less than beautiful.

The cost: Up to 40 percent more than regular bonding, due to lab expenses, but less than crowning.

Crown Options

Even though bonding has vastly improved in the last few years, most experts agree that the best bonding job still doesn't look as natural or last as long as the best-made crowns. "For people who want their teeth to look as much like enamel as possible, crowns may be the best choice," says Dr. Goldstein. And for those whose teeth aren't strong enough for bonding or laminate veneers, they may be the *only* choice.

The drawbacks are price—crowns cost from $350 to $1,250 per tooth—and lack of reversibility. Once you have them, you always have them. What's worse, crowns, if not skillfully made, can look false. "The most common error is making them too white compared to the other teeth," says Dr. Robert Winter, professor of prosthodontics at Marquette University and a crown specialist. "Another sign of a 'bad' crown is a dark or gray line showing at the gum, although in certain cases that can't be avoided. Or they might be overcontoured—too fat or bulky-looking—or too long, or too straight across at the edges."

Because most dentists have crowns made in a commercial lab, they rarely come back perfect, notes Dr. Winter, and a good dentist should be willing and able to alter them chairside, grinding, polishing, adding color, and should send them back to the lab if need be. "I make my own crowns, and I often try them in three or four times before I'm satisfied." If you don't like your new crowns, speak up before they're permanently cemented in, since after that they can only be *sawed* off in most cases.

Just how white should crowns (or bonded teeth, for that matter) be? Not as white as most of us believe, says Dr. Goldstein. "There's no such thing as a white tooth. They're all slightly off-white and contain many colors—blues and greens, especially at the edges, where teeth are more translucent; oranges and yellows, especially near the gum; and different shades of browns, creams, grays and whites. We have to build these colors into crowns for them to look natural." Crowns should blend in with surrounding teeth in terms of texture, too, adds Dr. Goldstein. If the other teeth have ridges or other irregularities, these should be included, in order to make light reflect the same way it would off the natural tooth.

The most natural results are obtained when crowns are made entirely of porcelain, which have more translucency than those made of porcelain fused to metal. But they're also more fragile, which is why dentists often use porcelain over metal where strength is needed on biting surfaces. Solid gold crowns are strongest, but also more obtrusive, and are little used today except on very back teeth. Sometimes only the chewing surface of the crown is gold and the sides porcelain, but this combination, if not carefully constructed, may not be as strong as all porcelain over metal. Unfortunately, the metal substructure is what often causes the telltale dark line to appear at the gum, particularly if the gum recedes over time.

One way to avoid the dark line, says Dr. Goldstein, is to use what dentists call a "porcelain butt joint"—a crown with metal on the inside, but not the outside, at the gum line of the tooth, where it might eventually show if the gum shrinks. "It's not easy, but in most cases the dentist can make this all-porcelain margin. Though it's not as strong, we feel it's a workable compromise, and it's important for the patient who worries about a dark line to ask for this."

If you already have gold margins showing at the gum line (or an all-gold crown that shows), the dentist can try dulling the metal with an abrasive air eraser, so that light no longer reflects off of it, advises Dr. Goldstein—"an effective procedure that takes only a few minutes and could save you the cost and trouble of replacing the crown."

As in other areas of cosmetic dentistry, recent developments mean more alternatives. Some dentists are now using new ceramic materials, including Cerestore, Dicor, and Renaissance, for crowning back teeth. These are stronger than all porcelain yet look more natural than porcelain over metal. Others still prefer porcelain over metal for back teeth, which don't show much anyway. Two other new crown materials, Dentacolor and Viso-gem, offer a unique advantage: when cracks or chips occur in the crown, these can often be repaired in the mouth with composite resin, without having to replace the entire crown.

The Bleaching Solution

Yet another way to get teeth whiter, without having to cap or bond them, is to have them bleached. In this process, up to twelve teeth at a time are isolated with rubber dams, treated with a strong bleach solution and exposed to heat, or heat plus light, for twenty to forty minutes. Properly done, bleaching doesn't harm the teeth and isn't usually painful, at least not for adults. If bleaching does hurt, the pain is likely to strike a few hours *after* the procedure, last several hours, then disappear after a day.

Three to ten separate treatments may be necessary to lighten the teeth, and even then results are not guaranteed. The stains might not come out or, if they do, they may gradually return, requiring repeat treatment. "Bleaching is successful in 75 percent of those cases where we think it may help," reports Dr. Goldstein. "We don't recommend it for very dark or ribboned tetracycline stains."

The technique is particularly effective when used on teeth that have had root canal treatment. Here, the bleach is sealed inside the tooth and allowed to stay in place for a week, a procedure called a "walking bleach." Since the final color doesn't always exactly match the surrounding teeth, the dentist may opt to bleach all of them.

Finding someone to bleach your teeth might not be easy, however. Not all dentists know how to do it, and many who do prefer not to because the results aren't predictable. But if your teeth *do* lighten, you might be able to avoid bonding or crowning. "It's unfortunate when you take a person with mild staining and bond the teeth or cut them down for crowns when they might have responded to bleaching," says Dr. Goldstein, "yet that happens every day." And at an average cost of $75 to $250 for treating ten teeth, or just $7 to $25 per tooth per treat-

ment, adds the doctor, it's worth a try.

Cosmetic Contouring

Sometimes all the dentist has to do to improve a smile dramatically is to take a rotary instrument and carefully reshape certain teeth. Called cosmetic contouring, this technique is actually one of the oldest known dental procedures, and is almost always painless (except for children, who may have sensitive pulps).

In a matter of minutes, and for comparatively little money ($50 to $450, depending on the complexity of the problem), "fangs" can be filed down, snaggleteeth unsnaggled, small fractures and chips repaired and irregular edges smoothed. Crowded teeth can often be contoured to give the impression of straightness, and teeth worn straight across at the edges can be reshaped to make the smile appear more youthful. Often cosmetic contouring is done in conjunction with bonding or laminate veneers in order to achieve more pleasing tooth shape as well as color.

"You can create astounding results in disfigured smiles just by carefully and selectively reshaping tooth structure," says Dr. Maitland. "But the dentist has to have great facility in sculpting, because once you take away part of the tooth, it's gone forever. That's why we do so much planning first." The parts of the teeth to be removed may be painted with blackout material beforehand, to see what the final outcome will be. Occasionally a cast of the teeth is made and carved on first. The dentist must also make sure that a correct bite is maintained and that the enamel of the teeth is thick enough to be reduced without exposing the dentin.

Mrs. Hyland Erickson and Mrs. L. Patrick Bales, cochairman of the Evanston and Glenbrook Hospitals' Ball, which raised more than $275,000 for the hospitals.

Selective tooth shaping can even create a more masculine or feminine look. "There is no biological correlation between tooth shape and gender," says Dr. Goldstein, "but studies show we perceive teeth with rounded edges and softer shapes as belonging to females, and we associate square shapes and harsher angles with males. This doesn't mean a woman shouldn't have angular teeth; in fact, that can be very effective on a woman with an outdoors look and a great all-American smile. But if you want to soften the smile, you can do that with contouring. Similarly, you can masculinize the teeth by making them a little less rounded."

Face shape should be considered, too, when contouring, says Dr. Goldstein. "If a person has a perfectly square face, the teeth should be rounded a little. If the face is overly long, we would emphasize the width of the teeth."

But remember, cautions the doctor, your teeth shouldn't be *too* perfect. "A smile is much more attractive when it has some asymmetry built in, and slight irregularities make teeth look more natural. A perfect tooth is a rare thing. Each one is really a little bit different."

Orthodontics for Adults

Bonding and cosmetic contouring are fast, easy ways to correct slightly crowded or gapped teeth. But often the best way is with braces, not only for appearance's sake but also for dental health. Crowded teeth can be impossible for even a hygienist to clean, and a bad bite just gets worse over the years. The good news is that it's never too late to do something about it. Orthodontics for adults has become so popular in the last ten years that now more than one in five patients is an adult. Barbara Walters, Linda Gray, Nancy Kissinger, Jill St. John, Diana Ross, Carol Burnett and Cher have all been adult braces patients.

In some cases, the braces don't even have to *show*. Although metal bands or brackets bonded to the teeth are still the most common type, new "invisible" braces now offer a more discreet alternative. Technically termed lingual appliances, these are brackets attached to the backs of teeth that work by pulling, rather than pushing, the teeth into position. They're so new that fewer than one in fifteen orthodontists is skilled in their use, estimates Dr. R. G. Alexander, associate professor of orthodontics at Baylor University in Dallas.

Even if you can find a dentist to put them on, though, you may not be able to wear them. According to the American Association of Orthodontists, some mouths don't have enough space for linguals, or it may be necessary to wear traditional braces during at least part of the treatment. They also require more adaptation time, since they can irritate the tongue and make speaking difficult during the early stages of treatment. And because they take longer to put on and adjust, they're also more expensive—anywhere from a third to half again as much as conventional braces. "Even so," says Dr. Alexander, "about half of our patients who are eligible for linguals choose them."

Other attempts to make the orthodontic process less visible include braces made of clear plastic. These must be carefully brushed and cleaned on a regular basis to prevent staining, so they may not be a good choice for those who smoke or drink a lot of coffee or tea. And they don't control tooth movement as well as metal braces, says Dr. Alexander, which makes them useful "only in a few cases." Still being researched are tooth-colored ceramic brackets, but because they're large and bulky, they don't look good at close range.

How long braces must stay on depends on the nature of the problem. Adults have the same problems as adolescents, says Dr. Alexander, but treatment can take longer. Since adults are more cooperative and motivated, however, actual treatment time is often the same or even less. "Closing a space between the front teeth might take six months and cost $600," says the doctor. "A major problem could take over two years and cost up to four thousand." Adults also have more dental difficulties to work around, such as fillings, bridgework, caps or gum disease. Unhealthy gums must be treated *before* braces go on, and teeth and gums kept scrupulously clean thereafter.

The Smiling Future

We'll soon have more to smile about than ever before, say the experts. Still in the research stage, for example, is a vaccine against the bacteria that cause cavitites. And here are the most promising leads in cosmetic dentistry research:

Better bonding: "I expect a totally new bonding material made of actual enamel crystals by the year 2000," predicts Dr. Goldstein. "It's already been formulated in the lab and will prove a stronger, more lasting way to bond." There may also be better ways to harden bonding materials, adds Dr. Friedman. "We might be using microwave, ultrasound or some other rapid activating technique."

Tooth cloning: "Instead of painting on composite resin, dentists might be painting on little cells that will grow new enamel," says Dr. Friedman. "That sounds fantastic, but cloning enamel is exactly what they're doing in the laboratory at the University of Southern California right now."

Moving teeth faster: Braces that work by means of magnets, battery-operated electrical pulses or pneumatic pressure are on the drawing board now and might enable patients to get in and out of orthodontics in record time. "I don't foresee these becoming

available for public use within the next ten years," says Dr. Alexander, "but who knows?"

Computers that design teeth: "Sometime in the next five to ten years we should have computers that can diagnose the ideal size, color, shape and proportion for any given tooth," says Dr. Goldstein, "thus taking these judgments out of the realm of the artistic and making it possible for every dentist to get a good aesthetic result."

Other advances on the horizon include crown materials that will look as good as porcelain but won't break, lasers that will seal fillings and remove decay without loss of tooth structure, and mouth rinses that will kill plaque and control gum disease.

In the meantime, the options we have already can prove bewildering to anyone who isn't a dentist. How do we decide what's best for our own mouths? Ask your dentist which particular procedures would work in your case, advises Dr. Goldstein, and which wouldn't, and why. It also helps to show the dentist pictures of teeth you'd like yours to resemble and ask if they could. Ask, too, to see before and after photos of the dentist's previous work (or meet another patient who has had the procedure you're considering), and if you don't like the way they look, see another dentist. Try to find one who not only has extensive experience in the techniques but also has a good aesthetic sense. And feel free to get several consultations. ☐

LEADING DENTISTS SKILLED IN COSMETIC TECHNIQUES

Here's a sampling of dentists who have top reputations in the field of cosmetic dentistry.

Leonard Abrams, D.D.S., *Medical Tower Building, 255 South 17th Street, Philadelphia, Pa. 19103. (215) 546-0300.*

Paul Belevedere, D.D.S., *585 Southdale Medical Building, Edina, Minn. 55435. (612) 922-9119.*

Gordon Christensen, D.D.S., *3707 North Canyon Road, Provo, Utah 84604. (801) 226-6565.*

Dudley L. Davis, D.D.S., *2603 University Boulevard, Tuscaloosa, Ala. 35401. (205) 345-3400.*

Peter E. Dawson, D.D.S., *One Plaza Place, St. Petersburg, Fla. 33701. (813) 821-4433.*

Norman Feigenbaum, D.D.S., *Parksouth Dental Group, 18 East 53rd Street, New York, N.Y. 10022. (212) 486-1606.*

Robert B. Friedman, D.D.S., *3001 South Cobb Drive, Smyrna, Ga. 30080. (404) 432-1713.*

Robert M. Gibson, D.D.S., *1441 Kapiolani Boulevard, Honolulu, Hawaii 96814. (808) 949-5571.*

Ronald Goldstein, D.D.S., *1218 West Paces Ferry Road N.W., Atlanta, Ga. 30327. (404) 261-4941.*

Joseph R. Greenburg, D.M.D., *2 East Montgomery Avenue, Ardmore, Pa. 19003. (215) 649-1510.*

Ronald E. Jordan, D.D.S., *University of Western Ontario, London, Ontario N6A5C1 Canada (519) 679-2749.*

Jerry Lucas, D.D.S., *9520 North May Avenue, Oklahoma City, Okla. 73120. (405) 755-9012.*

Ronald I. Maitland, D.D.S. and **David Shelby, D.D.S.,** *155 East 55th Street, New York, N.Y. 10022. (212) 753-6740.*

Lloyd Miller, D.M.D., *56 Colpitts Road, Weston, Mass. 02193. (617) 894-0347.*

Robert L. Nixon, D.M.D., *2500 Grubb Road, Wilmington, Del. 19810. (302) 475-2150.*

Jack Preston, D.D.S., *University of Southern California School of Dentistry, University Park, MC 0641, Los Angeles, Calif. 90007. (213) 743-8715.*

Harold M. Shavell, D.D.S., *2726 West Peterson Avenue, Chicago, Ill. 60659. (312) 743-7932.*

Cherilyn Sheets, D.D.S., *400 Newport Center Drive, Newport Beach, Calif. 92660. (714) 644-2455.*

David E. Simmons, D.D.S., *1534 Aline Street, New Orleans, La. 70115. (504) 899-2333.*

Irwin Smigel, D.D.S., *635 Madison Avenue, New York, N.Y. 10022. (212) 371-4575.*

R. Sheldon Stein, D.M.D., *50 Staniford Street, Boston, Mass. 02114. (617) 523-5451.*

Stanley W. Vogel, D.D.S., *9201 Sunset Boulevard, Los Angeles, Calif. 90069. (213) 278-0440.*

Henry Yamada, D.D.S., *11645 Wilshire Boulevard, Los Angeles, Calif. 90025. (213) 820-6696.*

For more information about cosmetic dentistry or for referral to dentists in your area, write the American Academy of Esthetic Dentistry, Suite 948, 211 East Chicago Avenue, Chicago, Ill. 60611, or the American Society for Dental Aesthetics, 635 Madison Avenue, New York, N.Y. 10022, or inquire at your local dental society.

For more information about orthodontics, write the American Association of Orthodontists, 460 North Lindbergh Boulevard, Saint Louis, Mo. 63141. ☐

Edwin C. Whitehead presenting the first annual Edwin C. Whitehead Award to Mrs. Albert Lasker at the benefit for the National Center for Health Education.