

American Academy of Cosmetic Dentistry

Test Prep AACD

Version Demo

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QUESTION NO: 1

In a youthful maxillary anterior smile, the incisal edges of the central incisors are generally positioned:

- A. More incisally than the incisal edges of the lateral incisors
- B. At the same level as the incisal edges of the lateral incisors
- C. More gingivally than the incisal edges of the lateral incisors
- D. At the same level as the cusp tips of the canines

ANSWER: A

Explanation:

More incisally than the incisal edges of the lateral incisors is correct. A youthful incisal plane commonly demonstrates central dominance, with the maxillary central incisors slightly longer than the lateral incisors. This creates an incisal-edge progression that contributes to a natural smile arc and avoids a flat, overly uniform appearance.

The amount of length difference must be individualized according to tooth proportions, age, gingival architecture, lip dynamics, phonetics, and functional requirements. Restorative treatment should preserve a harmonious relationship among the central incisors, lateral incisors, canines, and lower lip rather than applying a fixed measurement to every patient. See the [PubMed literature on anterior incisal-edge position and smile design](#).

QUESTION NO: 2

What characteristic does etch and rinse adhesive systems exhibit?

- A. They produce high and substantive adhesion values for dentin only
- B. They are indicated for surfaces that have the preparation circumference primarily in dentin
- C. They work best when the preparation consists primarily of enamel
- D. They provide a macro-mechanical bond to the prepared tooth surface

ANSWER: C

Explanation:

Etch-and-rinse adhesive systems work best when the preparation consists primarily of enamel. These systems use a separate phosphoric-acid etching step before application of the primer/adhesive resin. On enamel, phosphoric acid predictably removes mineral from the surface and creates a highly retentive microscopic etching pattern. The low-viscosity adhesive infiltrates these enamel microporosities and polymerizes, producing resin tags and a durable micromechanical enamel bond. This predictable enamel conditioning is a central strength of the etch-and-rinse approach and is particularly useful when a restoration has substantial enamel margins or enamel-dominant bonding surfaces. Although the same systems can also bond to dentin when moisture control, collagen support, primer infiltration, and solvent evaporation are managed appropriately, their especially reliable and well-established performance on etched enamel supports the stated characteristic. Reviews of contemporary adhesive strategies describe phosphoric-acid etching as producing strong, stable bonding to enamel and distinguish this mechanism from dentin bonding considerations. See the [review of adhesive strategies in restorative dentistry](#) and the [review of dental adhesion mechanisms](#).

QUESTION NO: 3

The teeth that typically exhibit the greatest variation in symmetry with the contralateral teeth are the maxillary:

- A. Central incisors.

- B. Lateral incisors.
- C. Canines.
- D. First bicuspid.

ANSWER: B

Explanation:

Maxillary lateral incisors are correct because they are the most morphologically variable of the maxillary anterior teeth and therefore commonly show the greatest natural difference from their contralateral counterpart. Their crown form may differ subtly in mesiodistal width, incisal-edge contour, line angles, facial convexity, and the degree of incisal embrasure development. These differences can be completely normal and are important when evaluating or restoring anterior teeth in cosmetic dentistry.

Maxillary lateral incisors also have a relatively high frequency of developmental variation, including reduced tooth size, altered crown form, and occasional palatal anatomical features. Consequently, exact mirror-image replication is often less natural than carefully matching the patient's existing individual character. In esthetic treatment planning, the clinician should assess both lateral incisors in the context of the full smile, facial midline, gingival architecture, tooth proportions, and the patient's natural asymmetries rather than assuming that bilateral perfection is the goal. This biologic variability is a central reason lateral incisors require especially careful evaluation during smile design and restorative procedures. See the overview of tooth anatomy and variation in [StatPearls: Anatomy, Head and Neck, Teeth](#) and the American Academy of Cosmetic Dentistry's [clinical education resources](#).

QUESTION NO: 4

Centric relation is:

- A. only about the teeth
- B. only about the joint
- C. about the teeth and the joint
- D. about the teeth, the joint, and the slide into maximal intercuspation

ANSWER: B

Explanation:

Centric relation is correctly described as only about the joint. More precisely, it is a clinically determined, repeatable maxillomandibular relationship based on the position of the mandibular condyles within the temporomandibular joints. Its definition is independent of tooth contact and occlusal intercuspation. In centric relation, the condyles are in a stable musculoskeletally guided position, allowing the clinician to use the relationship as a reproducible reference for diagnosis, treatment planning, restorative procedures, and fabrication of occlusal appliances or prostheses.

This joint-based reference is especially valuable in complex restorative and cosmetic dentistry because tooth positions may be altered, worn, missing, or planned for change. A stable joint position enables records to be made consistently before establishing or modifying the tooth relationship. The Glossary of Prosthodontic Terms describes centric relation as a maxillomandibular relationship that is independent of tooth contact, reinforcing that its defining feature is the condylar-joint relationship rather than an existing bite position. See the [Glossary of Prosthodontic Terms, Ninth Edition](#) and the [American College of Prosthodontists](#) for prosthodontic terminology and clinical context.

QUESTION NO: 5



According to the AACD Accreditation Examination Criteria, the MOST appropriate fault listed below pertaining to this smile design case is which of the following?

- A. Improper margin placement/visible margins
- B. Improper labial anatomy (primary, secondary, tertiary)
- C. Excessive length of interproximal contacts
- D. Periodontal health is not optimal

ANSWER: D

Explanation:

Periodontal health is not optimal is the most appropriate fault because successful esthetic dentistry requires healthy, stable gingival tissues as the foundation for a pleasing smile design. In an anterior esthetic case, the gingiva frames the teeth and restorations; inflammation, redness, swelling, bleeding, inconsistent tissue contour, or compromised papillae can substantially diminish the esthetic result even when the restorative tooth form and shade are acceptable. Periodontal condition also affects the predictability of the gingival margin position and the long-term appearance of restorations. AACD accreditation assessment emphasizes that the submitted result must demonstrate an appropriate biologic and esthetic outcome, including healthy periodontal tissues surrounding the restored teeth. Before finalizing elective cosmetic treatment, the clinician should establish periodontal health, identify and manage etiologic factors, and allow tissues to stabilize so that restorative contours and margins can be evaluated in a healthy environment. This reflects the broader standard that periodontal health is integral—not secondary—to smile-design planning and outcome assessment. See the [American Academy of Cosmetic Dentistry Accreditation information](#) and the American Academy of Periodontology's [patient and clinical periodontal-health resources](#).

QUESTION NO: 6

The bond of the carbon fibers to the composite will be enhanced by:

- A. Using an unfilled resin to wet the fibers.
- B. Using a flowable or filled resin to wet the fibers.
- C. Using silane on the fibers prior to bonding with a microfill composite material.
- D. Incorporating fibers into the composite and bonding in small increments of 1.0 mm or less.

ANSWER: A

Explanation:

Using an unfilled resin to wet the fibers is correct because effective wetting is essential for developing a reliable fiber–composite interface. Carbon-fiber bundles contain closely packed individual filaments. A low-viscosity, unfilled bonding resin can flow readily around and between these filaments before the restorative composite is placed. This improves intimate adaptation, reduces voids at the interface, and permits the resin matrix to mechanically interlock with the fiber bundle. Once polymerized, the resin-wetted fibers are more effectively integrated into the overlying composite, which supports efficient transfer of functional stresses between the composite resin and the reinforcing fibers. This technique is especially important with chairside fiber reinforcement, where incomplete resin penetration can leave dry fiber areas and compromise reinforcement. Reviews of fiber-reinforced dental composites identify adequate impregnation and wetting of fibers by the resin matrix as key determinants of interfacial bonding and mechanical performance. See the review literature indexed by the [U.S. National Library of Medicine](#) and the discussion of fiber-reinforced composite principles in [PubMed Central](#).

QUESTION NO: 7

Most occlusal splints have one primary function; what is it?

- A. To alter an occlusion so it does not interfere with complete seating of the condyles in centric relation
- B. To increase the vertical dimension, taking all the loading forces off the TMJs and transferring the load to the teeth
- C. To relieve symptoms of orofacial pain since direct occlusal equilibrium does not have the same potential for the relief of symptoms
- D. To avoid having to remove any tooth structure by equilibrating the teeth to perfect the occlusion

ANSWER: A**Explanation:**

Most occlusal splints, particularly stabilization splints, are intended to provide an artificial occlusal surface that removes defective tooth contacts and permits the mandibular condyles to seat completely and repeatably in centric relation. Therefore, *To alter an occlusion so it does not interfere with complete seating of the condyles in centric relation* describes the primary function accurately. By creating stable, simultaneous contacts against a carefully adjusted appliance surface, the splint separates the effect of existing tooth interferences from the musculoskeletal position of the mandible. This lets the clinician assess the patient's occlusion and jaw relationship without a premature contact forcing the mandible away from its seated joint position. It also provides a reversible means of establishing a more stable occlusal condition while symptoms, parafunctional activity, and the need for definitive treatment are evaluated. This centric-relation/occlusal-disengagement role is the central design principle of a full-coverage stabilization appliance, rather than simply changing vertical dimension or serving as an irreversible substitute for occlusal treatment. Clinical literature on stabilization appliances and temporomandibular disorders discusses their role in providing controlled, stable occlusal contacts and managing occlusal influences; see [PubMed: Occlusal splints and temporomandibular disorders](#) and [NCBI Bookshelf: Temporomandibular Syndrome](#).

QUESTION NO: 8

When etching ceramic, proper results:

- A. Can be accomplished equally using either hydrofluoric acid or aciduated phosphorous fluoride.
- B. Require specific instructions for each brand of ceramic.
- C. Yield a more translucent porcelain that is more amenable to shade modification.
- D. Are accomplished with a 37% Phosphoric acid gel applied according to the manufacturer's instructions.

ANSWER: B**Explanation:**

“Require specific instructions for each brand of ceramic” is correct because successful ceramic surface conditioning depends on the restoration’s composition and the manufacturer’s validated bonding protocol. Dental ceramics are not a single material category: glass-containing ceramics, such as feldspathic porcelain and many lithium-disilicate products, are treated differently from high-strength polycrystalline ceramics. Even among materials within the same broad category, the recommended conditioning agent, concentration, exposure time, cleaning procedure, and primer or silane steps can differ by product. These variables determine the micromechanical surface texture and chemical conditions needed for predictable resin bonding while avoiding unnecessary surface damage or loss of strength.

Following the individual ceramic manufacturer’s instructions is therefore a clinical safety and quality requirement, rather than a generic etching preference. The instructions for use are based on testing of that specific material and indicate the appropriate preparation sequence before adhesive cementation. Ivoclar’s IPS e.max system resources provide material-specific information for lithium-disilicate restorations: [IPS e.max System](#). A peer-reviewed review of ceramic surface treatments also emphasizes that conditioning must be selected according to ceramic microstructure and composition: [Journal of Prosthetic Dentistry review](#).

QUESTION NO: 9

What minimum distance is needed between an implant and the root of a tooth in order to keep the tooth's bony attachment intact and prevent horizontal bone loss?

- A. mm
- B. 1.5 mm
- C. mm
- D. mm

ANSWER: B

Explanation:

The minimum recommended distance is **1.5 mm**, measured from the outer surface of the implant to the root surface of the adjacent natural tooth. This spacing preserves an adequate zone of interproximal bone and periodontal support around the tooth. When an implant is positioned too close to a neighboring root, the biologic remodeling that occurs after implant placement may compromise the crestal bone adjacent to that tooth. Maintaining at least 1.5 mm also provides practical clearance for atraumatic osteotomy preparation, correct three-dimensional implant positioning, and maintenance of a healthy peri-implant and periodontal environment.

This guideline is particularly important in esthetic and restorative treatment planning, where preservation of interdental bone contributes to stable soft-tissue architecture and predictable restorative contours. The distance should be verified during radiographic planning and surgical placement; cone-beam computed tomography can be useful when root proximity or ridge anatomy makes conventional imaging insufficient. Implant-site planning principles describe the need to respect adjacent roots and preserve supporting bone, while periodontal literature emphasizes the importance of interproximal osseous support for stable tissues. See the [NCBI Bookshelf overview of dental implants](#) and the classic periodontal study available through [Journal of Periodontology](#).

QUESTION NO: 10

When provisionalizing a preparation that will be definitively bonded with resin cement, the temporary cement of choice is generally:

- A. Zinc oxide-eugenol cement.
- B. Non-eugenol temporary cement.
- C. Conventional glass ionomer cement.
- D. Resin-modified glass ionomer cement.

ANSWER: B

Explanation:

A non-eugenol temporary cement. Eugenol-containing temporary cements may contaminate the prepared tooth surface and can inhibit polymerization of resin-based adhesives and cements. A non-eugenol provisional cement reduces this concern and is preferred when a subsequent adhesive restoration is planned.

Before definitive bonding, all provisional material and temporary-cement residue should be thoroughly removed using the cleaning method appropriate for the selected adhesive system and restorative material. The final bonding protocol should always follow the manufacturer's instructions. Evidence concerning eugenol and resin bonding is available through [PubMed](#).

QUESTION NO: 11

If a ceramic crown repeatedly fractures on the facial incisal of tooth #8. the MOST likely cause is tooth preparation with which of the following?

- A. Rounded incisal edge
- B. Minimal chamfer finish line
- C. Nearly uniform reduction of 1.5 mm
- D. Taper of 8 degrees

ANSWER: B

Explanation:

Minimal chamfer finish line is the most likely preparation-related cause. An all-ceramic anterior crown requires sufficient, continuous tooth reduction and a finish line that provides adequate ceramic thickness and support at the restoration margin. A minimal chamfer is generally too narrow for a ceramic crown because it limits the space available for strong ceramic at the cervical aspect and can create an unfavorable, thin restoration geometry. Under normal incisal loading, an inadequately supported ceramic restoration is more susceptible to flexure and stress concentration; cracks may then propagate and become clinically apparent at the facial-incisal area, where esthetic ceramic is exposed to tensile stresses. For an anterior all-ceramic crown, preparation design should provide the material thickness specified by the ceramic manufacturer, adequate incisal reduction, rounded internal line angles, and an appropriately broad shoulder or deep chamfer configuration when indicated by the restorative system. These features promote a more uniform ceramic bulk and reduce damaging stress concentrations. General evidence and literature on ceramic restoration preparation can be accessed through [PubMed's all-ceramic crown preparation literature search](#) and the [American Dental Association overview of dental materials](#).

QUESTION NO: 12



According to the AACD Accreditation Examination Criteria, the MOST important appropriate fault listed below pertaining to this smile design case is which of the following?

- A. Evidence of iatrogenic damage to opposing teeth
- B. Improper width to length ratio
- C. Improper axial inclination
- D. Periodontal health is not optimal

ANSWER: B

Explanation:

Improper width to length ratio is the most important fault because tooth proportions are a central, immediately visible determinant of successful smile design. The apparent width-to-length relationship of the maxillary anterior teeth affects whether the teeth look overly short, excessively narrow, or naturally proportioned within the smile. In AACD-style esthetic evaluation, the examiner considers proportion in conjunction with the facial and smile framework, including incisal display, gingival architecture, tooth position, and the relationship of the anterior teeth to one another. A proportion that is not harmonious can disrupt the overall esthetic composition even when shade, surface texture, and restorative craftsmanship are otherwise satisfactory. Clinical smile-design planning therefore uses diagnostic photographs, measurements, and a wax-up or digital design to establish anterior tooth dimensions that fit the individual patient rather than applying a single numerical ratio universally. Identifying an improper width-to-length ratio appropriately focuses attention on the visible proportional discrepancy that should be corrected in the proposed restorative design. AACD accreditation evaluates comprehensive esthetic and functional treatment planning and the quality of the final visual result. See the [AACD Accreditation program](#) and AACD's [education resources](#) for its esthetic dentistry standards and educational materials.

QUESTION NO: 13

What is the key factor in protecting the posterior teeth during chewing?

- A. Centric stops
- B. Anterior guidance
- C. Condylar path
- D. Muscles of mastication

ANSWER: B

Explanation:

Anterior guidance is the key protective factor because it directs mandibular movement so that the anterior teeth guide excursive movements and separate the posterior teeth when the jaw moves away from a stable intercuspal position. This posterior disclusion limits prolonged lateral and protrusive contacts on premolars and molars, helping reduce potentially damaging horizontal forces on teeth that are principally designed to tolerate axial loading. In restorative and cosmetic dentistry, an appropriate anterior guidance scheme is evaluated whenever anterior restorations, changes in vertical dimension, or comprehensive rehabilitations are planned, since changes to anterior tooth form or position can alter posterior contact patterns during function.

Effective guidance must be compatible with the patient's envelope of function and mandibular movements. It is therefore assessed clinically with the patient's actual excursive movements rather than created as an arbitrary steep angle. When properly designed, anterior guidance supports comfortable function while preserving posterior teeth and restorations from destructive excursive loading. This protective occlusal principle is central to functional esthetic treatment planning. See the American Academy of Cosmetic Dentistry's educational resources at [AACD](#) and the prosthodontic literature on anterior guidance and occlusal rehabilitation at [The Journal of Prosthetic Dentistry](#).

QUESTION NO: 14

When photographing the retracted (1:2) view, if the anterior teeth are in focus and the posterior teeth are not in focus, the likely cause is what?

- A. Flash is too low
- B. F-stop is too high
- C. Shutter speed is too slow
- D. F-stop is too low

ANSWER: D

Explanation:

F-stop is too low is correct because a low f-stop corresponds to a wider lens aperture, which produces a shallower depth of field. In a retracted intraoral view at approximately 1:2 magnification, the anterior and posterior teeth lie at substantially different distances from the camera. A shallow depth of field may therefore keep the anterior teeth sharp while allowing the posterior teeth to fall outside the zone of acceptable focus.

For clinical dental photography, adequate depth of field is essential when documenting multiple teeth and arch segments. Increasing the f-stop uses a smaller aperture and expands the depth of field, making it more likely that both anterior and posterior structures will be recorded sharply. Although a smaller aperture reduces the light reaching the sensor, a properly configured macro flash system can provide the illumination needed for an appropriate exposure. This relationship between aperture and depth of field is a fundamental photographic principle and is especially important in close-up and macro imaging, where depth of field becomes very limited. See [Nikon: What Is Depth of Field?](#) and [Adobe: Understanding Aperture](#).

QUESTION NO: 15

When marked with articulating paper, a perfected occlusion will result in which pattern on the maxillary teeth?

- A. Lines on anterior teeth, lines on posterior teeth
- B. Dots on anterior teeth, dots on posterior teeth
- C. Lines on anterior teeth, dots on posterior teeth
- D. Dots on anterior teeth, lines on posterior teeth

ANSWER: C

Explanation:

“Lines on anterior teeth, dots on posterior teeth” describes the expected marking pattern for a perfected, mutually protected occlusion. In maximum intercuspation, the posterior teeth provide stable, repeatable centric stops. Because these contacts occur primarily as teeth meet rather than during an extended sliding movement, articulating paper commonly records them as discrete dot-like marks on the maxillary posterior teeth. These stops help distribute closing forces through teeth designed to receive axial loading and establish a stable mandibular position.

The anterior teeth provide anterior guidance during functional excursions, especially protrusive movement and the anterior component of lateral movement. Articulating paper is dragged across the guiding surfaces as the mandibular incisors move against the maxillary anterior teeth. This dynamic contact produces linear streaks rather than isolated dots. The combination of posterior centric stops and anterior guidance is a practical visual indication that static closure and excursion guidance have been refined appropriately. Articulating-paper markings should be interpreted with the clinical occlusal examination, since mark size alone does not quantify contact force. See the overview of occlusal principles in [NCBI Books: Dental Occlusion](#) and the discussion of articulating-paper interpretation at [PubMed](#).

QUESTION NO: 16

In shade change using veneers, how much thickness is needed for one shade change?

- A. .05 mm - .1 mm
- B. .2 mm - .3 mm
- C. .4 mm - .5 mm
- D. .6 mm - .7 mm

ANSWER: B

Explanation:

For a one-shade color change with a ceramic veneer, approximately .2 mm to .3 mm of restorative thickness is generally needed. This amount provides enough ceramic bulk to modify the perceived shade while retaining a conservative preparation that is commonly compatible with enamel bonding. Veneer color is not determined by ceramic shade alone: the final result is influenced by ceramic thickness, translucency or opacity, the color of the underlying tooth, resin-cement shade, and the intended final value. As thickness increases, ceramic has a greater capacity to alter or mask the substrate color. Therefore, planning about .2 mm to .3 mm for a modest, one-shade change is a practical clinical guideline; more substantial discoloration or larger shade changes may require additional reduction, a more opaque ceramic strategy, or both. Preoperative shade analysis, diagnostic wax-up, and try-in procedures remain important because material systems differ in their optical behavior. Research evaluating ceramic veneers confirms that restoration thickness has a clinically meaningful influence on final color outcomes. See [this PubMed-indexed study on porcelain laminate veneer thickness and color](#) and the [American Academy of Cosmetic Dentistry](#) for cosmetic dentistry educational resources.