Planning a practice transition?
Practice ownership is the major focus for most dentists. ➤ page 8

Thinking outside the box
Dental makeovers without resorting to extensive surgical solutions. ➤ page 10

We braved chilly Boston ...
So you didn’t have to! Read all about the Yankee Dental Congress. ➤ page 14

FDI, FOLA and DTI launch campaign for Haitian dentists

By Javier M. de Pison, Editor in Chief
Dental Tribune Latin America

The president of the Haitian Dental Association, Dr. Samuel Prophet, told Dental Tribune Latin America that he and several colleagues he was able to contact in Port-au-Prince were fine after the devastating earthquake in his country. “So far, we only have reports of two missing dentists,” Prophet wrote in an e-mail.

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FOLA president Adolfo Rodriguez, center, asks for help for Haiti at a meeting in Panama. Rodriguez is flanked by the president, right, and vice president of the Panama Dental Association.

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➤ See page 5 for the test
➤ See page 6 for the answer (no skipping to this page first)

Signs point to uptick for dental products industry

By Fred Michmershuizen, Online Editor

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The gross domestic product, which is considered the broadest measure of economic activity, expanded at an annual rate of 5.7 percent in the fourth quarter of 2009, its biggest jump in more than six years.

The growth followed a 2.2 percent increase the previous quarter.

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Added raisins to cereal doesn’t inrease acidity of dental plaque

Elevated dental plaque acid is a risk factor that contributes to cavities in children. However, eating bran flakes with raisins containing no added sugar does not promote more acid in dental plaque than bran flakes alone, according to new research.

In the study, published in the journal Pediatric Dentistry, children ages 7 to 11 compared four food groups – raisins, bran flakes, commercially marketed bran cereal and a mix of bran flakes with raisins lacking any added sugar.

Sucrose, or table sugar, and sorbitol, a sugar substitute often used in diet foods, were also tested as controls.

Children chewed and swallowed the test foods within two minutes. The acid produced by the plaque bacteria on the surface of their teeth was measured at intervals.

All test foods except the sorbitol solution promoted acid production in dental plaque over 30 minutes, with the largest production between 10 to 15 minutes.

Wu said there is a well-documented danger zone of dental plaque acidity that puts a tooth’s enamel at risk for mineral loss that may lead to cavities.

Dr. Reinit Utreja, a research scientist and dentist formerly on Wu’s team, said plaque acidity did not reach that point after children consumed 10 grams of raisins.

Adding unsweetened raisins to bran flakes did not increase plaque acid compared to bran flakes alone.

However, eating commercially marketed raisin bran led to significantly more acid in the plaque, he said, reaching into what Wu identiﬁed as the danger zone.

Plaque bacteria on tooth surfaces can ferment various sugars such as glucose, fructose or sucrose and produce acids that may promote decay.

Sucrose is also used by bacteria to produce sticky sugar polymers that help the bacteria remain on tooth surfaces. Wu said, Raising themselves do not contain sucrose.

In a previous study at UIC, researchers identiﬁed several natural compounds from raisins that can inhibit the growth of some oral bacteria linked to cavities or gum disease.

The study was funded by the California Raisin Marketing Board and the UIC College of Dentistry. (Source: UIC College of Dentistry)
Medical-dental health links continue to build

By Fred Michmershuizen, Online Editor

New evidence shows improvements in oral health can have a positive impact on reducing atherosclerosis, or plaque, in arteries. The science behind why a diseased mouth puts one at a higher risk for numerous systemic diseases, such as heart attack, stroke, Alzheimer’s disease and some forms of cancer, continues to build.

As more dentists and physicians become aware of how this affects their patient’s general health and medical conditions, patients’ and the public’s expectations of the role their dentist plays in health will likely shift.

“Almost a hundred years ago there were a few dentists and physicians who were very forward thinking who postulated that dental disease could actually impact general health,” said Dr. James McAnally, CEO of Big Case Marketing, a marketing and case acceptance consulting firm for dentists with advanced clinical training.

“Unfortunately, at that time, quackery in medicine and dentistry was being fought, and valid lines of questioning were rejected instead of being fought, and valid lines of questioning were rejected instead of explored, delaying the study of what relationships were present between the mouth and entire body.”

McAnally offered his remarks during an interview about the role of the dentist and heart health with Dr. Dean Vafiadis, a New York-based prosthodontist, on New York City Cosmos radio FM 91.5 WNYE.

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“In our current environment, thanks to professional rigidity and failure to change the existing standards of care rapidly, regardless of the science, most dental schools and state dental licensing boards are artificially slowing the progress of advances in understanding of disease relationships from benefiting the general population’s health,” McAnally said.

Vafiadis, McAnally and many other dentists are on the forefront of putting the information needed in front of the lay public so they can be informed as to what they should be hearing from their local dentist.

“The recent report out of Case Western University where a study found the exact same strain of bacteria from a 55-year-old California woman’s infected gums in her still-born baby serves as a vivid example of a direct systemic infection resulting from an oral infection,” McAnally said.

“While that makes for good headlines, the line that isn’t being put out there is the literal millions in the population who will suffer more whole body disease, worse whole body disease and a potentially shortened lifespan simply as a consequence of what their dentists aren’t talking to them about.”

As part of the interview, the Medical-Perio Referral Program, designed for general dentists, periodontists, oral surgeons and prosthodontists, which allows an easy facilitation of the physician-dentist relationship to improve patient health in both environments, was also discussed.

“This is really a two-way street that benefits every patient,” McAnally said. “If patients go to a dentist that is part of the referral program, they know they are under the care of someone who understands the links in health and how to do everything the current science shows is effective to help the patient become healthier and stay healthier.

“Furthermore,” he said, “by improving the referral relationship between the family practice physicians and cardiologists and the dentist, more medical patients with serious medical conditions are likely to receive appropriate dental treatment to reduce dental disease’s effects on their systemic health. Everyone wins. For some dentists, this referral model literally recreates the entire focus of a practice.”

Dentists or medical doctors interested in the Medical-Perio Referral Program can contact Big Case Marketing at info@BigCaseMarketing.com, call (206) 601-6754 or visit www.MedicalPerio.com.

Meanwhile, the jobs situation may also be starting to improve. The Labor Department reported Feb. 5 that the American unemployment rate dipped from 10 percent to 9.7 percent in January, causing some economists to speculate that the worst job market in at least 25 years may at last be getting better.

According to a recent report from Robert W. Baird & Co., a dental equipment rebound at the end of 2009 was continuing into January and the demand for dental consumables was picking up slightly.

“We continue to believe slow/steady recovery in 2010 will lead to more normalized industrywide performance in 2011,” stated the report, titled “Dental Market Rebound Continues in January, 2010 Optimism Growing.”

The report offered several specific signs of optimism for the dental products sector, including the following:

Dental consumables demand is not just stable, but slightly improving, the report said, as volumes are flat to up slightly and 1 to 2 percent price increases are sticking.

For distributors, a modest rotation away from telesales and Internet distributors back to value-added sales seems to be occurring, while manufacturers seem to be benefiting from modest restocking at distributors and dental offices.

At the recent Yankee Dental Congress in Boston, exhibit hall booth activity was “generally upbeat,” the report said.

“All in, we continue to believe 1 to 3 percent domestic dental consumables market growth in 2010 remains a reasonable assumption, with the upper end of that range possible if December/January trends persist throughout the year,” the report said. [1]

Fight oral cancer!

Did you know that dentists are one of the most trusted professional groups? Thus, no other medical professionals are in a better position to show patients that they are committed to detecting and treating oral cancer.

Prove to your patients just how committed you are to fighting this disease by signing up to be listed at www.oralcancerself.com.

This new Web site was developed for consumers in order to show them how to do self-examinations for oral cancer.

Self-examination can help your patients to detect abnormalities or incipient oral cancer lesions early.

Early detection in the fight against oral cancer is crucial and a primary benefit in encouraging your patients to engage in self-examinations.

Secondly, as dental patients become more familiar with their oral cavity, it will vitally stimulate them to receive treatment much faster.

Conducting your own inspection of patients’ oral cavities provides the perfect opportunity to mention that this is something they can easily do themselves as well.

You can explain the procedure in brief and then let them know about the Web site, www.oralcancerself.com, that can provide them with all the details they need.

If dental professionals do not take the lead in the fight against oral cancer, who will?

And in the eyes of our patients, they likely would not expect anyone else to do so — would you?

[2]
Are new patients tripping over your phone line?

By Sally McKenzie, CMG

It’s the usual busy day in the dental practice. The phone is ringing. Patients are flowing in and things are moving along smoothly. Sure there’s a cancellation or two and maybe an emergency. As the dentist passes the front desk, he hears Linda, the business assistant, wrapping up a conversation.

“No, I’m sorry, we don’t.” We don’t what? What don’t we do that someone wants to know about? The dentist makes a mental note to follow-up with Linda. He’s overheard her give similar replies in the past and meant to ask her about it before.

Here’s what the dentist didn’t hear ...

Linda: Good morning, Dr. Stanton’s office, Linda speaking.

Carolyn: Hello Linda, my name is Carolyn Samson. I recently moved to town and I was just calling to find out if the doctor is accepting new patients.

Linda: Yes, he is, although the schedule is pretty full right now.

(Without even realizing it, Linda is sending a message to this prospective patient that she might not be welcome in the practice. It’s already a busy place and Linda doesn’t know how the office is keeping up with the patients it has, let alone encouraging any new patients to join. That comes through loud and clear to the caller.)

Carolyn: Do you offer any Friday afternoon appointments?

Linda: No, I’m sorry, we don’t.

(Silence ensues for a few moments while Carolyn waits for another option from Linda, but none is offered.)

Carolyn: OK, thank you. Goodbye.

To Linda, this is just a routine inquiry — nothing special, and she doesn’t think much about it. After all, there’s no established protocol. She’s just answering questions as they come in.

No, the practice doesn’t offer Friday afternoon appointments because the office is closed, but perhaps the practice offers Wednesday evening appointments or Saturday morning appointments. Alternatively, perhaps the practice sees new patients at a specific time of day so that the dentist can spend quality time with the patient and is less likely to be interrupted with emergencies or oral hygiene exams.

Yet, Linda makes no effort to offer possible alternatives or to educate the patient on the options and why they would be worth considering. She simply answers the questions the prospective patient asks and feels she’s done her job. It’s a common scenario because few practices find that it tends to be a major incentive for dental teams to identify exactly where protocols can be established so that the practice can make improvements right away.

Meanwhile, dentists go about performing dentistry and seldom give those perfunctory phone duties a second thought. In fact, only 12 percent of dentists believe the telephone has a major impact on their practice even though it is typically the only point of entry for new patients.

In addition, only 5 percent of practice staff is trained to properly handle phone communication.

The irony is that while dentists typically place little importance on the telephone, this is the make it or break it point of contact in the opinion of most patients. It is through the telephone conversations with your office that prospective patients begin to assess the competency of the dentist and team and whether this practice deserves their business and that of their families.

In today’s consumer-driven dental marketplace, the old cliché that you only get one chance to make a first impression couldn’t be truer. If your practice doesn’t measure up, chances are very good that prospective new patients will be moving on to the next office on their list, and this loss is yours.

In fact, if poor telephone protocol causes your practice to lose just 20 new patients a month and each would spend an average of $1,000 on dental care a year, that’s 240 patients and nearly a quarter of a million dollars.

But it’s usually not until dentists start feeling the effects of poor phone communication in the form of scheduling problems, fewer new patients, no shows, financial strain, etc., do they begin to question just how those perfunctory phone duties are handled.

Have you been disconnected?

How well does your team manage phone calls from current and prospective patients? The truth is you don’t know until you hear both sides of the conversation.

In the medical community, “mystery shoppers” have been used for several years. Dentistry is embracing the concept as more practices have come to realize the business potential of it. Dentistry “mystery shoppers” have been used for several years. McKenzie Management has developed a telephone assessment protocol in which a professionally trained and certified “mystery shopper” makes multiple calls to a dental practice and assesses the effectiveness of the team’s telephone skills.

The calls are recorded and the dentist has the opportunity to hear firsthand what is transpiring between his/her staff members and prospective patients. What we are finding is that dentists are often very surprised by what they hear and, unfortunately, not in a pleasant way.

Dentists really cannot judge how well their staffs handle telephone communication until they hear it firsthand. Does the business team use proper phone etiquette and correct grammar? Do patients have to wait too long on hold or for a return call? How does the staff handle questions and requests for information? What are the staff’s tone, attitude and demeanor? Do staff members come across as welcoming and helpful or annoyed and rushed? Most importantly, how many new patients might be lost month after month because of inadequate telephone protocols?

While the reality of how phone calls are commonly handled can be an unpleasant shock, we also find that it tends to be a major incentive for dental teams to identify exactly where protocols can be established so that the practice can make improvements right away.

Oftentimes, very capable dental employees unwittingly drive new patients away because they simply haven’t been trained, and educating staff on effective telephone communication can significantly improve their approach. Most significantly, it can prevent the loss of hundreds of patients and tens of thousands of dollars every year. However, it doesn’t stop there.

Callers expect follow-through

Another element of effective telephone commun...
Welcome to a new topic area among the pages of Dental Tribune! The thanks for this new topic area go to a number of oral pathologists who seek to expand their role in the dental community by writing for Dental Tribune. These authors will provide us with selected case studies to help educate our readers about the various oral pathology situations they might encounter in daily practice. We hope you enjoy this new topic area and welcome your feedback at feedback@dental-tribune.com.

Identify the ulcer

The patient presents with an ulcer on the left lateral border of the tongue. The patient noticed the ulcer — which causes pain and a burning sensation when eating — about three months ago. The patient has smoked five cigarettes a day for the past seven years.

Clinical examination of the lesion shows that the ulcer is reddish-grey in color with slight sloughing, inflamed margins, a firm and indurated base and about 2 x 2 cm in size.

Which type of ulcer is this?

a) Tuberculosis associated ulcer
b) Traumatic ulcer
c) Squamous cell carcinoma
d) Aphthous ulcer
e) Herpetic ulcer

(See page 6 for the answer)

Diagnose this ...

About the author

Sally Mckenzie is CEO of McKenzie Management, which provides success-proven management solutions to dental practitioners nationwide. She is also editor of The Dentist's Network newsletter at www.theden-
tist network.net; the e-Management Newsletter from www.mcken-ze mgmt.com; and The New Dentist™ magazine, www.thedentist.net. She can be reached at (877) 777-6151 or sallymck @mckenziegmt.com.
Identify the ulcer (the answer)

Which type of ulcer is this?
- a) Tuberculosis associated ulcer
- b) Traumatic ulcer
- c) Squamous cell carcinoma
- d) Apthous ulcer
- e) Herpetic ulcer

Answer:
- c) Squamous cell carcinoma

Factors that point to OSCC
- Persistent for more than two weeks
- Associated habits (tobacco use)
- Indurated base
- Absence of general signs and symptoms (i.e., fever, pulmonary signs)
- No evidence of any injury

How to rule out other aetiologies

Tuberculosis associated ulcer
Oral tuberculosis is very rare and when present it is usually secondary to pulmonary tuberculosis and may pose a diagnostic problem.
- Coexisting pulmonary disease
- Other signs and symptoms of tuberculosis
- Ulcer
  1. Irregular edges and minimal induration
  2. Granular or covered with pseudomembrane
  3. Most often painful

Traumatic ulcer
Diagnosis based upon history (biting, denture irritation, drugs, e.g., aspirin).
- Ulcer
  1. Generally diagnosed at acute stage
  2. Shallow base and non-raised margins
  3. Mildly painful

Recurrent apthous ulcer
One of the most common ulcers seen in the oral cavity, commonly misdiagnosed and poorly understood.
- Recurrent, one or more at a time
- Types: Minor (1 cm), major (>1 cm) and herpetiform (pin-head size)
- No prodromal symptoms, takes days to months to heal
- Begins at adolescent age and frequency decreases with age

Herpetic ulcer
It’s a viral infection, afflicts most of the population; sub-clinical or clinical infection.
- Numerous, pin-head sized vesicles in the beginning that collapse and coalesce later to form large shallow and irregular ulcer
- Very painful
- Associated prodromal symptoms
- Types: acute (commonly seen at an early age); recurrent (often seen in the immunocompromised and may solely present as herpes labialis)

Please circle all the aetiology/aetiologies of an oral ulcer (answer is at the end):
- a) Physical and chemical trauma
- b) Infection
- c) Malignancy
- d) Malnutrition
- e) All of the above

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- a) Physical and chemical trauma
- b) Infection
- c) Malignancy
- d) Malnutrition
- e) All of the above

Let’s explore your knowledge about oral squamous cell carcinoma (OSCC).

Mark true (T) or false (F) next to the following questions:

1. Five-year survival rate is 50 percent
2. Commonly seen above the age of 40 years
3. Most commonly associated with chronic trauma
4. Can present both as endophytic and exophytic growth
5. Ulcers (endophytic pattern) commonly present with rolled borders
6. Precancerous lesions may or may not be seen
7. OSC of the soft palate and oro-pharynx are easiest to diagnose
8. Most common site is tongue
9. Clinical evaluation should include TNM classification (T = tumor size and how far it has spread; N= spread to the lymph nodes; M = metastasis)
10. Final diagnosis is a histological (biopsy) diagnosis based upon history (biting, denture irritation, drugs, e.g., aspirin).

Please choose the correct answer:

11. If treatment of intraoral SCC is guided by the clinical stage (TNM), which consists of:
   - a) Wide (radical) surgical excision
   - b) Radiation therapy and chemotherapy
   - c) Surgical excision and chemotherapy
   - d) Combination of the above

Discussion
Squamous cell carcinoma of the mouth constitutes the sixth most common cancer worldwide, and the third most common in developing countries, with evidence of an increase in incidence and mortality, particularly in young adults.

It accounts for more than 90 percent of all oral malignancies.

Patients with oral cancer generally do poorly, with the five-year survival rate for carcinomas of the tongue and floor of the mouth being less than 40 percent.

The most important risk factors for oral carcinogenesis remain tobacco and alcohol.

Apart from the risk factors, the possibility of a genetic predisposition has also been suggested.

Many oral carcinomas are preceded by clinically evident premalignant lesions.

About the author
Dr. Monica Malhotra is an assistant professor at the Sudha Rustagi Dental College in India and also maintains a private practice.

Malhotra completed her master’s in oral pathology at the Manipal Institute, India, in 2009.

In 2008 she was presented with a national award for the best scientific study presentation by the Indian Association of Oral and Maxillofacial Pathology.

You may contact her at drmonicamalhotra@yahoo.com.
Recommend a system that virtually eliminates plaque...

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*vs. a standard manual toothbrush and anti-cavity toothpaste.
Practice transition planning

This is part 1 of a two-part series on this topic

By Eugene Heller, DDS

For most dentists, ownership of their dental practice is the major focus of their energy expenditures, financial situation and professional lives.

Years of blood, sweat and tears, coupled with the relationships formed with both staff and patients, have caused dentists to form a deep-seated emotional attachment with their practice.

For many, the dollar value of that practice represents a significant portion of their financial assets.

For the new dentist, there is a definite value in acquiring the patient base that has taken the transitioning dentist years to develop and will provide an immediate and substantial cash flow.

All experience transition

Whether it is due to a change in career direction, a desire to cut back on the responsibilities of ownership while still enjoying the benefits of clinical dental practice or the desire to retire from dentistry, every practice owner faces an ownership transition.

Ownership transition can be a total sale or a partial sale, that is, the formation of a partnership. The level of success achieved as a result of this practice transition will be directly linked to the amount of detail given to, and the successful execution of, the “Transition Plan.”

A buyer’s market

Decreased dental school enrollments and other demographic factors have created an imbalance in the numbers of graduating versus retiring dentists.

This trend, which will continue for at least the next 10 years, has contributed to falling dental practice sale prices, and has created a buyer’s market.

This dental work force shortage has made finding dentists to serve in more rural dental practices, which are difficult to market, almost impossible. These changes in the marketplace relative to practice transitioning have made advance, detailed transition planning mandatory.

Goals of a successful transition

Before discussing the development of a transition plan, a brief discussion of the goals of transition is required. In addition to identifying the actual goals, each dentist will need to assign an order of priority to these goals.

This prioritization will have a significant impact on certain aspects of the transition plan. The most common goals discussed by dentists include:

1. In accordance with their preferred timetable, a desire to transfer patient care responsibility.
2. Securing future employment for their staff and giving back to the profession by passing the baton to a new dentist.
3. Maximizing their practice equity (financial gain from the sale).

There is no right or wrong order to the priority emphasis. The economic health of the transitioning dentist will usually determine the order of the priorities.

If the practice sale proceeds are a significant portion of the dentist’s retirement assets, then maximizing the financial return will be at the top of the list.

If the clinician has a well-funded pension plan or other financial resources, and the sale proceeds will enhance the quality of retirement rather than providing the primary support for retirement, the order of importance will typically be the desire to provide continuity of patient care, ongoing employment and passing the baton, where maximizing the financial gain appears at the end of the list.

Factors affecting successful transitions

Prior to discussing the components of a transition plan, it will be useful to understand what is presently occurring in the transition marketplace. For a successful transfer of ownership, we must first have an interested new dentist.

Subsequently, location is at the top of the list relative to a new dentist’s interest in a specific practice opportunity.

As previously discussed, rural practices, although typically more profitable than big city practices, are having serious recruitment problems.

For many dentists, owning a dental practice will provide the opportunity to live in communities with populations of 50,000 or more, and 80 percent of these sales are in cities where the metro population exceeds 500,000.

The second factor is the practice’s ability to meet the financial needs of the new dentist. As a result of current levels of dental school-related debt, the new dentist must meet specific levels of production to pay for the practice acquisition, school loans and basic living expenses.

Therefore, a practice needs to provide, on the average, $500,000 worth of production for an employed dentist, and $400,000 worth of production if the dentist is purchasing a practice.

It is for this reason that 85 percent of total practice sales involve practices with gross receipts of $550,000 to $500,000.

While the highly productive and profitable practices of today frequently exceed $500,000 in annual receipts, the average new dentist (five years or less since graduation) does not possess the clinical skills required to produce this level of dentistry, and subsequently, sales trend toward the lower grossing practices.

After finding a suitable location and determining that the practice will provide for the financial needs of the new dentist, the new dentist will consider a multitude of other factors in selecting one opportunity over another.

The major factors considered include:

1. The practice’s overhead to revenue percent,
2. Number of active patients,
3. New patient flow,
4. Recall system effectiveness.

In addition:

5. Quality and length of the staff’s prior employment,
6. Practice history,
7. Types of procedures previously offered and/or produced,
8. Involvement in any discounted dental plans,
9. Appearance of the physical space occupied by the practice, and
10. The age, type and appearance of the equipment and furnishings will play a major role in the selection process.

The 10 items listed above represent the major concerns and factors reviewed by the new dentist.

However, the owner dentist is concerned with:

1. The ability of the new doctor to pay for the practice — obtain financing with all the school debt, the tax implications and subsequent net proceeds derived from the sale,
2. The personality and ability of the new dentist to relate to patients and staff,
3. The amount of post-sale relationship required between the seller and buyer, and of course,
4. The new dentists’ clinical competence.

With the exception of the final concern, the other factors can be readily determined and resolved.

Today, 100 percent owner financing is readily available, the tax implications can be calculated and, typically, several meetings with the new dentist will address the communication skills and personality of the new dentist.

About the author

Dr. Eugene W. Heller is a 1976 graduate of the Marquette University School of Dentistry. He has been involved in transition consulting since 1985 and left private practice in 1990 to pursue practice management and practice transition consulting on a full-time basis. He has lectured extensively to both state dental associations and numerous dental schools. Heller is the national director of transition services for Henry Schein Professional Practice Transitions. For additional information, please call (800) 750-8885 or send an e-mail to ppm@henryschein.com.
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ARIZONA
Aurora-Dentist seeking to purchase general dental practice #12110
Shaw Lane-2 Ops, 2 Hygiene Rooms, GR in 2007 $546K
Phoenix-General Dentist seeking practice purchase opportunity #12108
Phoenix-3 Ops, 3 Equipped, GR $515K+, 3 Working Days #12113
N Scottsdale-General Dentist seeking practice purchase opportunity #12109
Urban Tucson-6 Ops, 6 Equipped, 1 Hygiene, GR $900K 12/112
Tucson-1,600 active patients, GR $800K, Asking $500K #12116
CONTACT: Tom Kimbel @ 602-516-3219

CALIFORNIA
Altura-3 Ops, GR $611K, 3/2 day work week #14279
Acworth-2 Ops, 1,800 sq. ft., GR #177K #14407
El Sobrante-3 Ops, 3 Equipped, 1,300 sq. ft, GR $550K #14502
Fresno-3 Ops, 1,500 sq. ft., GR $81M #14250
Greater Auburn Area-5 Ops, 1,800 sq. ft., GR $763K #14301
Madera-7 Ops, GR $61M #14263
Modesto-12 Ops, GR $1M Same location for 10 years #14289
Modesto-5 Ops, GR $888K, adjusted net income of $340K #14289
N California Wine Country-4 Ops, 1,500 sq. ft., GR $958K #14296
Pine Grove-Nice 3 Ops fully equipped office/practice $11K #14299
Ponderosa-5 Ops, 2,000 sq. ft., GR $2.2M #14291
Red Bluff-8 Ops, 2008 GR $51M Hygiene 10 days/wk #14252
CONTACT: Dr. Dennis Hooper @ 503-519-1508
Dayton-4 Ops, 1,100 sq. ft., GR $122K #14265
Greene Valley-5 Ops, 1,500 sq. ft., GR $714K #14272
Redding-5 Ops, 2,200 sq. ft., GR #1M #14285
Yuba City-5 Ops, 4 days toss, 1,300 sq. ft., #14273
CONTACT: Dr. Thomas Wagner @ 916-812-3255
Rancho Margarita-4 Ops, 1,200 sq. ft., Take over lease #14301
CONTACT: Thelma Trim @ 714-530-8808

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Stratford-3 Ops, GR $254K #16111
Newington-2 Ops, GR $500K #16115
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FLORIDA
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CONTACT: Jim Beck @ 954-287-8300
Jacksonville-GR $1.3M, 3000 sq. ft, 7 ops, 8 days hygiene #18118
CONTACT: Donna Wright @ 800-730-8883

GEORGIA
Atlanta Suburb-3 Ops, 2 Hygiene Rooms, GR $863K #19123
Atlanta Suburb-2 Ops, 2 Hygiene Rooms, GR $615K #19128
Atlanta Suburb-3 Ops, 1,270 sq. ft., GR $499K #19131
Atlanta Suburb-Pediatric Office, 1 Op, GR $410K #19134
Duluth-GR $1 Million+, Asking $825K #19117
Macon-3 Ops, 1,625 sq. ft., Suit of the art equipment #19103
North Atlanta-3 Ops, 3 Hygiene, GR $768K #19122
Northeast Atlanta-4 Ops, GR $590K #19120
Northern Georgia-4 Ops, 1 Hygiene, Est. for 45 years #19119
South Georgia-3 Ops, 2 Hygiene Rooms, GR $722K #19133
CONTACT: Dr. Jim Cole @ 404-516-1573

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1 HR SW of Chicago-3 Ops, 2007 GR $140K, 28 years old #21215
Chicago-3 Ops, GR $600K, 3 day work week #22119
Western Suburbs-3 Ops, 2,200 sq. ft., GR Apprx $1.5M #22120
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Boston SouthShore-5 Ops, GR $380K #10125
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NEW YORK
Brooklyn-3 Ops (Fully equimped), GR $175K #41113
Woodstock-2 Ops, Building also available for sale, GR $500K #41112
CONTACT: Dr. Don Cohen @ 845-460-3034
Syracuse-1 Ops, 1,800 sq. ft., GR over $700K #11007
CONTACT: Mary Hart @ 315-203-3411
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PENNSYLVANIA
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CONTACT: Dan Slain @ 412-855-4537
Lockhaven County-4 Ops, 1 Hygiene, GR $515K #47138
Cheser County-High End Office, 4 Ops, Digital, Fetal + a few PPO #47714
Philadelphia County (NE)-4 Ops, GR $500K, Est 25 years #17142
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CONTACT: Dr. Peter Goldberg @ 617-680-2930

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Hilton-Dentist seeking to purchase a practice producing $500K/ year #91903
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CONTACT: Jane Cole @ 803-513-1573

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Elizabethton-GR $350K #15107
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Thinking outside the box

By Drs. Jay Padayachy and David Bloom, United Kingdom

When it comes to extreme dental makeovers, amazing transformations can be achieved without resorting to some of the extensive surgical solutions that might otherwise be required.

As dentists, we naturally lean toward our historical training, which might involve treatment plans that don’t embrace some of the newer concepts available to us as restorative dentists.

Many years ago, the concept of leaving an anterior restoration high in the bite to create space would have been regarded with scepticism.

However, now this “Dahl Principle” is readily accepted and used to create anterior occlusal space in certain clinical situations by allowing a combination of anterior intrusion and posterior “over eruption.”

Likewise, this thinking can extend to more complicated situations. Yet, as long as there is sound treatment planning via adherence to sound aesthetic and occlusal principles together with fully informed consent, amazing transformations can be achieved without resorting to some of the extensive surgical solutions that may otherwise have been required.

Communicate with your patient
The starting point for all of this is: ask the patient what he or she wants to achieve and fully discuss all available treatments; this may include extended orthodontic therapy with or without surgery.

From here, a sound understanding of the principles of smile design is essential (see Table 1, below) and an understanding of occlusal schemes.

Table 1: Criteria of smile design
- Incisal edge position at rest
- Midline and cant
- Width: height ratio and Golden Proportion
- Buccal corridor
- Smile line
- Axial inclination
- Embrasures and contact points
- Gingival zeniths and heights
- Arch form

We will now demonstrate many of the principles we have discussed in previous articles, but applied to some more complex cases.

Case study No. 1, Figures 1–11
This 34-year-old woman presented having seen us on the television show “Extreme Makeover U.K.”

She had not visited a dentist for 10 years and disliked the fact that her front teeth did not show. She was also aware that her gums bled when cleaning.

A full examination revealed early periodontal breakdown with BPE scores of three in all sextants. She had a plaque score of 42 percent and bleeding scores of 58 percent.

Her initial treatment focused on achieving health and involved periodontal care, direct posterior composite restorations to treat early decay in previously unrestored molar teeth and indirect restorations (one crown and one tooth coloured inlay) to replace heavily decayed crowned posterior teeth. She received from her re-attendance to her AOB was discussed and she was fully informed that this could mean that the AOB would open somewhat post treatment.

As for her cosmetic concerns, all options for her severe anterior open bite were discussed, including orthodontics with or without orthognathic surgery.

A diagnostic wax up allowed a visual diagnostic try-in to show the patient what could be achieved with four anterior restorations to lengthen the teeth.

The possible tongue thrust element to her AOB was discussed and she was fully informed that this could mean that the AOB would open somewhat post treatment.

The patient approved the aesthetic and decided upon this line of treatment. She was advised that there would be a greater amount of unsupported porcelain than ideal and, therefore, care would be required when incising into anything hard.

For this reason also, it was decided to place 560 degree veneers for increased structural integrity. As the procedure was agitative, it was possible to ensure all preparations were entirely within enamel.

Whilst the final result does not follow all the principles of smile design, these should be considered as a guide in such extreme cases.

The final restorations on the central incisors may be 18 mm long, but fit in with her smile beautifully.

The life-changing effects of this cosmetic transformation by only treating four units and whitening are self-evident.

Case study No. 2, Figures 12–18
This 42-year-old woman presented as part of the “Extreme Makeover U.K.” television show.

She hated the appearance of the teeth, including their length and the
large spacing between them.

She had a naturally outgoing personality, but over time, she felt embarrassed to smile and now would hold her hand over her mouth even when talking to people.

Previously she had undergone periodontal treatment and surgery at a teaching hospital; this had been stable for more than 10 years.

When one first looks at her teeth, one would assume that they would be all mobile. However, they were all stable with no mobility evident at all despite having half and two-thirds horizontal bone loss.

This made discussion of her treatment options more straightforward as a mixture of crowns and veneers could achieve what she wished for without the need for multiple extractions and dentures or implants.

But she was informed that two teeth would need to be electively root filled to achieve these desired aims as they were either a long way out of the arch or too long.

Given the constraints imposed by the show’s timings (work to be completed within six weeks) orthodontic treatment would have proved difficult, but she was still informed of this option.

She was advised that orthodontics would minimise the risk of root treating any teeth, but she declined this treatment.

Five upper veneers, three veneer onlays and two Procera crowns were placed along with four lower veneers to correct the lower spacing.

She was advised of the importance of ongoing hygiene maintenance to ensure adequate plaque control around the anterior restorations that now had a much fuller contour gingivally as they were in effect porcelain cantilevers.

Case study No. 3, Figures 19-25

This long-standing patient of more than 15 years had always been unhappy with her smile and existing crowns.

The UR1 crown had been under review for some time and when the tooth developed caries under the margin, it was time to replace it.

All options were discussed with the patient, including just replacing the one crown, orthodontic treatment (with or without surgery) to...
correct the Class III malocclusion or instant orthodontics by opening her vertical dimension and so jumping the anterior crossbite.

Before deciding on a definitive plan, a wax-up was made so a visual diagnostic try-in could be carried out to give the patient an idea of how she would look if the crossbite were corrected by restorative means. She was happy as to what could be achieved and decided she wanted the restorative pathway as so many of her teeth were already crowned or heavily restored.

This also gave us the opportunity to bridge the space mesial of the UR6 and so build out the buccal corridor in this area.

By crowning the very heavily restored lower right-hand side molars, the tilting of these molars could also be improved at the same time.

It is important to plan all these changes at the same time because opening the vertical means less occlusal reduction is required. The only unprepared tooth that required preparation was the UR3.

This received a minimal veneer preparation; palatal coverage was not required on this tooth due to the Class III nature of the occlusion.

However, the pre-operative planning with a diagnostic wax up is essential for this.

Whilst the final result appears somewhat flared in the retracted view, the smile and full face demonstrate that the result works well.

Again she was advised of the importance of ongoing hygiene maintenance to ensure adequate plaque control around those restorations that now had a much fuller contour gingivally as they were also, in effect, porcelain cantilevers.

**Conclusion**

To quote two eminent colleagues: “Learning smile design is the process of training your eye to spot details you can fix” (Dr. Chip Steele).

“The hand can only perform what the eye has been trained to observe and the mind has striven to understand” (Dr. Newton Fahl).

The out-of-the-box thinking required for some of these extreme dental makeovers can only truly occur with a thorough understand-

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**About the authors**

A graduate of the Newcastle-upon-Tyne Dental School, Dr. David Bloom has been a principal at Senova Dental Studios since 1990 focusing on comprehensive restorative and cosmetic dentistry. A past president of the British Academy of Cosmetic Dentistry (2007–2008), Bloom is also an accredited member of the BACD. He is a member of The British Society of Occlusal Studies, The British Society of Restorative Dentistry, The British Dental Association and is a sustaining member of The American Academy of Cosmetic Dentistry (AACD).

He is also a fellow of the International Academy of Dental Facial Aesthetics. Bloom is on the editorial board of the Journal of Cosmetic Dentistry, the official journal of the American Academy of Cosmetic Dentistry.

Bloom is a clinical director of CO-OP.R8 seminars and lectures on all aspects of cosmetic dentistry in the United States (www.coopr8.com).

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A graduate of the Newcastle-upon-Tyne Dental School, Dr. Jay Padayachy has been a principal at Senova Dental Studios since 1998, focusing on comprehensive restorative and cosmetic dentistry. Full member of the British Academy of Cosmetic Dentistry, he is a member of The British Society for Occusal Studies, The British Society of Restorative Dentistry, The Pankey Association, The British Society of Periodontology and the American Academy of Cosmetic Dentistry of which he is a sustaining member.

In addition, he is a director of CO-OP.R8 Seminars and lectures in all aspects of cosmetic dentistry in the U.K.

Find out more about CO-OP.R8’s cosmetic dentistry treatments, including tooth whitening, porcelain veneers, dental implants or general dental surgery.

Contact CO-OP.R8 for more details or to request a brochure. Also, check out the new “Extreme Makeover” feature.
The application and modification of the principles involved in smile design and their application and modification to fit each individual scenario together with correct occlusal planning. Thus, aesthetics with longevity (functional aesthetics) can be achieved. When correctly applied, the results can be life changing and can be achieved in ways that may previously have been deemed not possible.

Acknowledgements

[Editorial Note: This article first appeared in Dental Tribune U.K. Edition, Vol. 2 No. 5.]
Yankee Dental Congress: education from every angle

Yankee Dental Congress 55, held Jan. 28–30 in Boston, offered plenty of opportunities for dental professionals to learn and grow, both in lecture halls and on the exhibit hall floor.

For someone looking for a little education and/or C.E. credits during the meeting, all he or she had to do was wander around the exhibit hall floor like a pinball and wouldn’t be long before he or she would stumble across one of the six classrooms, the Live Dentistry Theatre or the many opportunities available at individual booths.

The six classrooms featured speakers such as Marilyn Ward, DDS, who spoke about “Predictable In-office Whitening,” which was a Discus Dental hands-on course.

Other classroom topics included Dr. Robert Lowe’s lecture, “Composite Restorative Dentistry: A Blend of Artistry and Technique,” which was sponsored by VOCO.

Live dentistry included Bart Blaeser, DMD, MD, who spoke about “Cone-beam Tomography Implant Imaging and Treatment Planning with Live Surgical Procedure” in the morning (Keystone Dental).

Carl Boscketti, DMD, took to the stage to offer “Live Patient Demonstration Utilizing CEREC Restoration” (Patterson and Sirona).

The Live Dentistry stage also featured Frank Milnar, DDS, speaking about “Creating A Composite Veneer” (VOCO).

Dr. Ben Miraglia lectured at the Align Technology booth about “Invisalign: From Evolution to Innovation.” Many other speakers offered presentations at several other booths.

Gregory Sawyer, DDS, presented “Immediate Denture Stabilization with IMTEC’s MDI Small Diameter Implant System” (IMTEC Corp.).

More than 400 exhibitors

Meanwhile, more than 400 companies offered the latest in dental products and technology. The exhibit hall was bustling with activity.

Those looking to stock up on fluid dentin, cements and adhesives for example, found they were in the right place. There were plenty of endodontic files and obturation equipment, latex gloves, orthodontic appliances — and much, much more.

Many companies offered educational presentations right in their booths for small groups, so attendees could learn something.

Some companies offered special giveaways — including tickets to see the Red Sox or Celtics, making attendance not only worthwhile for one’s practice but also a lot of fun.

Other highlights on the exhibit hall floor included the following:

- At the P&G Professional Oral Health booth, attendees learned about an oral care regimen that includes use of the Oral-B Professional Care SmartSeries 5000 with SmartGuide, Crest PRO-HEALTH Toothpaste and Crest PRO-HEALTH Rinse.
- Attendees learned about gingivitis reduction at the Colgate booth.
- At the Triodent booth, attendees checked out the V3 Ring for posterior composite restorations and the Triotray for posterior impressions.
- The new Under Armour Performance Mouthwear was on display at the Patterson Dental Supply booth. A launch kit was available to help dentists become an exclusive provider for this new technology.
- At the DMG America booth, there was a lot of interest in the new Icon caries infiltrant, which offers treatment without the use of a drill.
- At the InfoStar booth, company reps were on hand to show...
Dr. Robert Lowe’s lecture, ‘Composite Restorative Dentistry: A Blend of Artistry and Technique,’ is well-attended at the Yankee Dental Congress. Standing in the background in a white lab coat is VOCO Clinical Manager Nicole Russell, representing the lecture’s sponsor. (Photo/Robin Goodman, Group Editor)

At the Shofu Dental booth, interest was high in the BeautiBond adhesive, which contains not one but two powerful monomers. Pictured are Ricardo Youngblood, left, Lynne Calliott and Lenny Sulkis.

Are you prepared should one of your patients have a medical emergency while being treated in your office? Lewis Soraich of HealthFirst Corp. can set you up with an emergency preparedness kit and a training DVD.

Those who stopped by the Owings Corning booth could enter a contest to win a basement finishing system (and say hello to the Pink Panther of course!).
• At the Shofu Dental booth, interest was high in the Beauti-Bond adhesive, which contains not one but two powerful monomers.
• At the VOCO America booth, there was lots of interest in Amaris Gingiva, a light-cured composite system in gingival shades. It’s an alternative to surgery for patients with severe gum recession.
• At the Zila booth, attendees learned about Rotadent, which is described as much more than just a power toothbrush. Rather, it is a whole system for home periodontal therapy.
• At the Henry Schein Dental booth, attendees learned more about the R4D technology and how it can be incorporated into a dental practice.

Attendees were also treated to a glimpse of the future of dentistry at Yankee Dental Congress 35.

The exhibit hall is bustling with activity at Yankee Dental Congress 35. (Photo/Robin Goodman, Group Editor)

Gil Frelick discusses the features and benefits of the CEREC AC CAD/CAM system during a presentation on the exhibit hall floor at Sirona’s booth. (Photo/Fred Michmershuizen, Online Editor)
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Hinman 2010 offers new highlights

The 98th Thomas P. Hinman Dental Meeting will take place March 25–27 in Atlanta. According to organizers, the 2010 meeting is where excellence will abound. In fact, the Hinman meeting is known for its world-renowned reputation of excellence — bringing together the highest quality programming from the foremost authorities in the field of dentistry.

Some of the highlights at Hinman 2010 include the following:

• More than 60 leading experts in the field of dentistry will offer presentations.
• More than 25 percent of courses offer the opportunity for hands-on participation.
• New, all-day educational tracks will be offered for dental hygienists, assistants and business office personnel.
• Also new this year is Art in the Hall. Hinman and The Foundation for Hospital Art will combine forces to create murals for medical facilities in need. Meeting attendees can stop by and paint for a few minutes or stay until a mural is finished.
• Two hours on Saturday will be dedicated exhibit hall time, with no education held during this period.
• The exhibit hall will offer courses for assistants and doctors, interactive artwork and the return of the popular Hinman Eatery.
• The meeting also offers plenty of networking opportunities and social events.

Educational opportunities
This year, Hinman has designed special, full-day courses for each team member. A “Prevention Convention” for hygienists will be held on Thursday, a “Business Office Bonanza” and an “Assisting Extravaganza” will be held on Friday.

These special courses are offered so that each team member can get a variety of information on different topics from six of the most respected lecturers in their specific areas of expertise.

In addition, there are separate speaker “tracks,” highlighting all the speakers who might be of interest to hygienists, business office staff and assistants, respectively.

Each lecture is 50 minutes with a mid-day break for lunch and to visit the exhibit hall. These special courses are offered at a special fee of $75 for the full day.

A variety of lunch options are available at the Hinman Eatery in the exhibit hall.

This year’s keynote session not only presents an esteemed roster of expert speakers, but also features one of Hinman’s more unique keynote speakers in recent history. Frank W. Abagnale is one of the world’s most respected authorities on the subjects of forgery, embezzlement and securities documents. His name might sound familiar. The movie “Catch Me If You Can,” starring Leonardo DiCaprio and Tom Hanks, was based on his life and book.

In addition, an auxiliary reception will be held on Friday night and a dentist reception on Saturday night. With live music and buffets filled with appetizing foods, attendees will get to spend time catching up with friends and colleagues and dancing into the wee hours of the night.

Technical exhibits
Hinman’s 90,000-square-foot exhibit hall will feature the leading dental industry companies, sharing the latest products and services in the dental field.

More information on the Hinman meeting is available online at www.hinman.org.
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Grow your dental practice
Three ways to start doubling your growth right now, even if you’ve hit a plateau

By Jay Geyer

How would you like to double your practice growth? How would you like to double your net income? Of course you would! But what we want and what actually happens are two different things.

When you first started your dental practice, you felt the excitement. You experienced large percentages of growth for the first few years. Then your dental practice became stagnant.

You’re not seeing growth in your dental practice now. Your “adjusted gross income” and “net income” decreased to the point where it depresses you to look at the numbers on your tax return.

You have hit a plateau and it is commonplace for all businesses, including dental practices, to hit a plateau at some point in their life. Many will hit multiple plateaus. Now I completely understand why hitting a plateau or even a decline in business would depress you. It’s because you’re seriously feeling the squeeze. You discovered that your expenses don’t plateau just because your income has flattened or declined.

• Your staff wants more money.
• You need more space.
• You need to purchase updated and emerging technologies and equipment.
• It takes more money to run your practice.

Not only do your expenses rise at the office, but they rise at home too. You’ve got kids, private schools, bigger houses, insurance, higher taxes. So how can you as a dental practice owner get off the plateau, take your business to the next level and make more money?

Get the right training, skills and resources you need to build your business.

Look, you’re either on plan, off plan or you don’t even have a plan. If you have been in practice for any significant amount of time and you are not investing heavily in your practice, I wouldn’t be surprised if you’re experiencing a plateau in your business right now.

See, if you’re not learning better ways to build your practice then you are just doing the same thing over and over again. How is that going to solve your problem and take your practice to the next level? It isn’t.

Get the right employees: implement a ‘no mediocre employee’ tolerance policy

With so many people unemployed today, you can find top talent. There is no reason why you have to accept mediocre performance. Remember, you get what you deserve. If you hire mediocre employees or if you keep mediocre employees, then you deserve to get mediocre or sub-par results along with the gray hair you’ll get for dealing with these people.

In addition, it doesn’t take much effort to hire the right staff. In fact, I have a hiring system that allows you to hire new staff with less than 60 minutes of your time.

Get a ‘no excuse’ mindset

If you want to shorten the lifespan of your plateau, then you need to stop being your own worst competitor. I mean this in the most caring, loving way. You make and accept too many excuses for why you can’t get new patients.

For example, you blame the recession. Yes, many small and large businesses are failing. However, we’ve doubled our business in this economy. I have clients who’ve been practicing dentistry for 55 years and they had their best year ever in 2009. A few of these top performers are in the state of Michigan — one of the hardest hit states during the recession.

The adjacent tooth is innocent

By Prof. Dan Ericson, Malmö University, and President of the Academy of Minimally Invasive Dentistry

Minimally invasive dentistry has evolved as a concept in preventive and restorative dentistry during the last few decades. The concept involves “a systematic respect for the original tissue” (Ericson 2004). It means that dental diseases preferably should be prevented, and that restorative dentistry includes a minimum of removal of healthy tooth substance to access and restore a caries lesion.

Under this concept, prevention of iatrogenic damage is, of course, essential. Several researchers have clearly demonstrated that, during preparation of a Class II restoration, the adjacent tooth is damaged up to almost 70 percent.

Damaged teeth develop caries at least twice as often compared to undamaged teeth (Qvist et al. 1992; Lussi and Glyax, 1998; Medeiros and Seddon 2000). This certainly calls for protection of the adjacent tooth during preparation for the dentist to be able to work safely and time effectively.

A number of devices have been used for this, ranging from a steel-matrix band to interproximal guards of various kinds and thickness. Until now a common difficulty has been application and retention of such devices during preparation.

It is urgent that the industry provide uncomplicated devices that would warrant increased safety and efficacy in operative dentistry. To avoid iatrogenic damages should always be the priority (Hippocrates).

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References
• Medeiros VA, Seddon RP. Iatrogenic damage to approximal surfaces in contact with Class II restorations. J Dent 2009; 29:105–110.

Minimal invasive dentistry in reality

Swedish company Directa has developed FenderWedge®, a new product that protects adjacent teeth during Class II preparation.

FenderWedge:
• is easy to apply,.
• is retained during preparation by the wedge,
• results in pre-wedging before placing the matrix for restoration,
• can also be used for protection during crown preparation.

Data from 145 cases indicates that FenderWedge® is simple to apply and effectively protects the adjacent tooth.

For more information about FenderWedge and other Directa products, please visit Directa online at www.directadental.com.

Directa representatives and partners are currently operating in more than 90 countries worldwide, and attend most major dental meetings.

Please call +46 (8) 506 505 75 or e-mail info@directadental.com for additional information.

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Are you a Fully Certified Dental Hygienist?
You Have The
FREEDOM
TO BE SOMETHING BETTER
In the truest sense, freedom cannot be bestowed; it must be achieved.
— Franklin D. Roosevelt

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AMD LASERS: one of the most affordable soft-tissue dental lasers

In January, AMD LASERS announced the introduction of the Picasso Lite soft-tissue dental laser.

Priced at $2,495, offering 2.5 watts of power and three customizable presets, Picasso Lite is the most affordable and easy-to-operate dental laser in the world, according to AMD LASERS.

It was designed specifically to replace the archaic use of scalpels and electro-surge in the treatment of soft tissue.

"With Picasso Lite, we accelerated the paradigm shift in dentistry that began with the introduction of the Picasso line of soft-tissue lasers in 1997," said Alan Miller, president/CEO of AMD LASERS.

"We have ‘One Vision, One Goal’ — equipping every operatory with a laser. Record numbers of dentists are purchasing Picasso, and I’m sure that accepts no excuses. I haven’t made an excuse about your offensive language, and I adopt the policy that you get what you deserve; there are no excuses. I haven’t made an excuse in 20 years. Thus, unlike most dentists who let all of the negative energy ooze into their office and into their existence, I reject it like the plague.

I adopted the policy that you get what you deserve; there are no excuses. I haven’t made an excuse in 20 years. I get a bad result, I probably deserved a bad result. It’s that simple. So, I don’t make excuses. I just say, ‘I got what I deserved, and I need to figure out why and how I’m going to fix it so I get a better result next time.’

If you can figure out what actions and efforts it takes to deserve more, then ‘Bingo!’ you can get it.

If you make excuses about your ability to generate new patients, such as your town or the economy or whatever other pathetic, whiny excuse you might have made in the past, you literally cannot do anything. It immobilizes you.

Want to start growing your dental practice?

Here are your next steps:

• Get the training you need.
• Adopt a “no mediocrity” tolerance policy.
• Don’t make or accept excuses.

"We have ‘One Vision, One Goal’ — equipping every operatory with a laser. Record numbers of dentists are purchasing Picasso, and I’m sure Picasso Lite’s more attractive price and ease of use will quickly make it the most popular laser in the world.

"Picasso Lite was designed specifically for first-time laser dentists and hygienists, and at one-fifth the cost of other lasers, it’s truly affordable. We’ve shipped Picassos to more than 50 countries, and the number of dentists and distributors interested in Picasso is truly amazing. I think the real winners are the patients."

"Picasso Lite cuts and coagulates tissue with reduced trauma, bleeding and necrosis of tissue and is used for soft-tissue surgery, including troughing, gingivectomies, frenectomies, exposing implants/teeth/ortho brackets and treating aphthous ulcers and herpetic lesions.

"Featuring an ultra-compact, lightweight and sleek design, Picasso Lite comes with an easy-to-learn set-up DVD, online laser certification, accessories, world power adapter and a two-year warranty.

"Another first for the laser industry is Picasso Lite’s ability to use convenient disposable tips or a low-cost strippable fiber.

"We are proud to offer Picassos and now Picasso Lites free of charge to universities and dental schools, globally illustrating our commitment to education and charity," said Miller.

About AMD LASERS

AMD LASERS is a global leader at providing ultra-affordable laser technology for dental professionals preparing to take their practice to the next level.

The integration of the Picasso line of soft-tissue dental lasers enables every dental practice to provide treatment for soft-tissue surgery, periodontal/endo treatment, and laser whitening.

AMD LASERS is ISO 15485 and C.E.-certified for worldwide distribution.

For more information about AMD LASERS, please call (866) 999-2655, (317) 202-9550 (for overseas dialers) or visit www.AMDLASERS.com.

J. Morita to introduce low-speed air motor at Chicago Midwinter

J. Morita will be introducing the new Air Torx, low-speed air motor at the Chicago Midwinter Meeting in February. Air Torx offers efficient, powerful and constant torque with operational speeds up to 20,000 rpm.

Its innovative fluid dynamics generate about twice as much torque compared to a conventional low-speed motor in the 5,000 to 10,000 rpm range.

Air Torx is comfortable to operate: it is lightweight, perfectly balanced and delivers smooth power control. Versatile, it can be used for a wide range of tasks such as grinding, polishing restorations, and for tooth polishing with a prophylactic angle.

Air Torx is designed for enhanced durability and offers an extended working life.

Other features include: forward/reverse drive with continuous speed control, double-lock connection, autoclave-safe design and compatibility with standard ISO attachments.

For more information, call J. Morita USA at (566) 7485 or visit www.JMORITAU.SA.com.

About J. Morita

J. Morita USA services North American dental professionals on behalf of one of the world’s largest manufacturers and distributors of dental equipment and supplies, Japan-based J. Morita Corporation.

The North American office was established in 1984 and is headquartered in Irvine, Calif. J. Morita USA is one of the leading companies in the dental market offering innovative and high-quality 3-D/pan/ceph imaging units, delivery systems, handpieces, small equipment and consumable dental supplies.
This interactive DVD is written, directed, and narrated by Dr. Stanley Malamed, dentistry’s leading expert in the management of medical emergencies.

“You don’t get a chance to save a life you’ve lost. So get it right...the first time.”

- Contains 14 different situations that can and do arise in the dental office including Cardiac Arrest, Seizure, Allergic Reaction and many others...
- Dr. Malamed breaks down these scenarios using high definition 3D animations and stunning dramatizations.
- Great for in-office training sessions or individual training.
- 7 Continuing dental education credits available.

Visit us at the Chicago Dental Society Midwinter Meeting, booth #2610.

ORDER YOUR MEDICAL EMERGENCY TRAINING DVD TODAY