Georgia dentist says state will pay for general anesthesia

Severe anxiety, phobia, severe gagging, life-threatening allergies and the inability to use local anesthetics are among the myriad of reasons that more than 100,000 Georgians are unable to receive dental care they need in a dentist’s office, says Dr. David Kurtman of Marietta, Ga.

For these people, Kurtzman says, dentistry ranges from something nearly akin to torture to a life-threatening experience — yet many want and need care.

In 1999, to little fanfare, the state senate of Georgia passed a law to help these people. Because their only alternative is to have their dental work done while they are truly and fully asleep, Senate Bill 66 mandates medical insurance to pay the additional costs of general anesthesia and hospital costs for these people.

“Once the prohibitive costs of being fully asleep in the hospital are handled, a lot more of these people can afford the dental care they really need,” Kurtzman explained.

“No one really talks about this law, certainly not the insurance companies,” says Kurtzman, who has been treating such cases for more than 20 years.

He says he had worked for years trying to get these costs paid. Even when he got to speak with people within the insurance companies he called, nobody ever mentioned it.

Not until a chance call to the insurance commissioners’ office in Atlanta led Kurtzman to the obscure bill did his office start getting more and more coverage for patients.

The law states that medical insurance must pay hospital and anesthesia fees for any person for whom a successful result cannot be expected using local anesthesia.

“Because of physical, intellectual or another compromising medical condition” of the insured patient, anyone who really needs it can now expect coverage for sedation dentistry.

“We are seeing people who have lived with pain and infection for literally years,” Kurtzman says.

Care under general anesthesia in the hospital operating room gives thousands of these people hope for a healthy, painless and beautiful smile, he says.

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(Source: PRWeb)
AGD testifies on access to care

“Over 90 percent of all practicing dentists are in the private sector, and over 80 percent of dentists are primary care providers. For this committee to lack representation from the private sector totally deprives the study of real-world input and totally goes against the committee’s charge of reaching a balanced, objective and credible conclusion,” Halpern said.

Furthermore, Halpern expressed concern that the committee’s framework would likely produce a one-sided result of championing the use of alternative or midlevel providers and neglecting commonsense approaches that utilize the full dental team concept to address access to care concerns.

Tell us what you think!

Do you have general comments or criticism you would like to share? Is there a particular topic you would like to see more articles about? Let us know by e-mailing us at r.goodman@dental-tribune.com. If you would like to make any change to your subscription (name, address or to opt out) please send us an e-mail at database@dental-tribune.com and be sure to include which publication you are referring to. Also, please note that subscription changes can take up to 6 weeks to process.

Standards for Green Dental Practice is the foundation of the GreenDOC program, providing comprehensive, eco-friendly initiatives in eight implementation categories. The GreenDOC Checklist is available to EDA members on the association’s Web site, located at www.ecodentistry.org/GreenDOC.

The GreenDOC Product Guide is a comprehensive dental industry listing of products and services that green dental offices need to go green and stay green. The EDA has sourced the products and services that share a vision for clean, green dentistry, making it easy for dental professionals to achieve earth-friendly initiatives.

Products and services appear in one or more of the following GreenDOC categories: sustainable location; waste reduction; pollution prevention; energy conservation; water conservation; patient care; workplace policies and community contribution; leadership; and innovation.

Combined, the GreenDOC Product Guide and GreenDOC Checklist provide dentists with the first key steps to greening their dental practice.

“Where do I start and what products do I use? These are the two most common requests we receive from dental professionals,” said Susan Beck, director of the Eco-Dentistry Association.

“Used together, the GreenDOC Product Guide and Checklist make the perfect going green starter kit for dental professionals.”

Additional components of the GreenDOC Program lead dental practitioners through a rigorous but attainable certification program. GreenDOC how-to guides, implementation plans and worksheets make it simple for dental professionals to meet specific goals to achieve bronze, silver or gold certification.

As a part of the program’s international launch, the EDA encourages dental offices to register to be one of the first 100 certified offices and become a charter-certified office

The EDA’s members are located in 42 U.S. states and 11 countries. The organization was co-founded by Dr. Fred Pockrass, a dentist, and his entrepreneur wife, Ina Pockrass, who together created the model for eco-friendly dentistry, and operate their own award-winning dental practice in Berkeley, Calif., recognized as the first in the country to be certified as a green business.

They formed the organization to stimulate a movement in the dental industry to employ environmentally sound practices, such as reducing waste and pollution; saving energy, water and money; incorporating wellness-based methods and incorporating the best technologi-AD

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Announcements

AGD testifies on access to care

David F. Halpern, DMD, FAGD, president of the Academy of General Dentistry (AGD), testified recently during the open session of the Institute of Medicine’s (IOM) first meeting of the Committee on Oral Health Access to Services in Washington, D.C.

Halpern protested the IOM’s failure to include a single practicing dentist on the committee roster.

“Over 90 percent of all practicing dentists are in the private sector, and over 80 percent of dentists are primary care providers. For this committee to lack representation from the private sector totally deprives the study of real-world input and totally goes against the committee’s charge of reaching a balanced, objective and credible conclusion,” Halpern said.

Furthermore, Halpern expressed concern that the committee’s framework would likely produce a one-sided result of championing the use of alternative or midlevel providers and neglecting commonsense approaches that utilize the full dental team concept to address access to care concerns.

“To those whose hands aren’t in a patient’s mouth every day, alternative delivery models look good in theory, but they are unlikely to be able to answer the question of not only whether they actually work in practice, but if they are truly also cost-effective, and not just cost-delaying,” Halpern said.

The Committee on Oral Health Access to Services is one of two new IOM committees exploring oral health policy under a contract from the Health Resources and Services Administration, an agency within the U.S. Department of Health and Human Services.

The second study committee, An Oral Health Initiative, is scheduled to hold its first meeting on March 31. Halpern is scheduled to testify again to protest the exclusion of practicing dentists on that committee and to convey concern over the study’s direction.

The AGD is a professional association of more than 55,000 general dentists dedicated to staying up to date in the profession through continuing education.

(Source: AGD)
Plasma jets capable of obliterating tooth decay-causing bacteria could be an effective and less painful alternative to the dentist’s drill, according to a new study published in the February issue of the Journal of Medical Microbiology.

Firing low-temperature plasma beams at dentin, the fibrous tooth structure underneath the enamel coating, was found to reduce the amount of dental bacteria by up to 10,000-fold. The findings could mean plasma technology is used to remove infected tissue in tooth cavities, a practice that conventionally involves drilling into the tooth.

Scientists at the Leibniz-Institute of Surface Modifications, in Leipzig, Germany, and dentists from the Saarland University, Homburg, Germany, tested the effectiveness of plasma against common oral pathogens including Streptococcus mutans and Lactobacillus casei. These bacteria form films on the surface of teeth and are capable of eroding tooth enamel and the dentin below it to cause cavities. If left untreated this can lead to pain, tooth loss and sometimes severe gum infections.

In this study, the researchers infected dentin from extracted human molars with four strains of bacteria and then exposed it to plasma jets for six, 12 or 18 seconds. The longer the dentin was exposed to the plasma, the greater the amount of bacteria that were eliminated.

Plasmas are known as the fourth state of matter after solids, liquids and gases and have an increasing number of technical and medical applications. Plasmas are common everywhere in the cosmos and are produced when high-energy processes strip atoms of one or more of their electrons. This forms high-temperature reactive oxygen species that are capable of destroying microbes. These hot plasmas are already used to disinfect surgical instruments.

Dr. Stefan Rupf from Saarland University who led the research said that the recent development of cold plasmas that have temperatures of around 40 degrees Celsius showed great promise for use in dentistry.

“The low temperature means they can kill the microbes while preserving the tooth. The dental pulp at the center of the tooth, underneath the dentin, is linked to the blood supply and nerves, and heat damage to it must be avoided at all costs.”

Rupf said using plasma technology to disinfect tooth cavities would be welcomed by patients as well as dentists. “Drilling is a very uncomfortable and sometimes painful experience. Cold plasma, in contrast, is a completely contact-free method that is highly effective. Presently, there is huge progress being made in the field of plasma medicine and a clinical treatment for dental cavities can be expected within three to five years.”

Society for General Microbiology
The Journal of Medical Microbiology provides high-quality comprehensive coverage of medical, dental and veterinary microbiology and infectious diseases. The original paper is available on request.

The Society for General Microbiology is the largest microbiology society in Europe, and has more than 5,500 members worldwide. The society provides a common meeting ground for scientists working in research and in fields with applications in microbiology including medicine, veterinary medicine, pharmaceuticals, industry, agriculture, food, the environment and education.

(Source: Society for General Microbiology)
Free yourself from the daily ‘grind’

If you dread going into the practice each day, it’s time to re-evaluate your leadership role

By Sally McKenie, CEO

Are you settling for mediocrity? Is your practice merely getting by? Do you feel surrounded by complacency? Is there a lack of excitement or enthusiasm? Perhaps it’s not that the team is outwardly negative or difficult, it’s just that “average” has become simply good enough in their minds. New ideas seldom emerge because they are shot down as quickly as they surface. Issues with systems are perpetually on the backburner, kept there by the proliferation of excuses explaining why the changes won’t work, can’t work or would simply be too much work to fix.

So there you stand having lost control of the practice you once loved. It’s become the daily grind, and it seems that you wile away the hours at the mercy of those who seemingly care to do nothing more than simply get by.

As familiarity breeds contempt, complacency breeds mediocrity. If teams are not challenged to continuously improve, then when the push is on to do things differently the shift can be unnecessarily traumatic because the staff members feel threatened and they resist any change.

They’ve settled into their way of doing things and don’t understand why what seems to have worked perfectly fine in the past is suddenly called into question.

Sounds like a major issue with the team, right? Wrong. What we have in circumstances such as this is more likely to be a major issue with the leadership. The team mirrors the leadership of the practice.

Take off the rose-colored glasses

Look carefully at your team. Do they reflect your commitment to excellence? Are they open to change? Are you willing to challenge them to make change? And are you willing to invest the time to educate them on why change is necessary?

Or, do you shun better, more efficient systems and procedures because “Mary Jane” has been there since the beginning of time and you decided long ago that it’s not worth it to challenge her negative attitude and poor performance?

You rationalize your fear of addressing the problem by telling yourself that she handles all the insurance, or she knows all the patients, or whatever the excuse.

If you’ve chosen to ignore the problem, you’ve abdicated your responsibility as the leader. You can count Mary Jane as one of your concrete blocks — as in dead weight tethering your practice to an average standing for all time.

Being the leader takes courage to examine systems, processes and staff. Change those things that don’t work, but most importantly, challenge everyone — not just yourself — to continuously improve.

They follow the leader

Your team members are taking their cues from you. If you have a Mary Jane and she is unwilling to change or do things differently, she is the shining example for the rest of the team to follow suit.

Employees are expert “boss watchers.” They are quietly watching as you look the other way, make excuses and allow employees such as Mary Jane to run the show.

The irony is that most employees want to excel, and they want to do things differently, she is the shining example for the rest of the team to follow suit.

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The irony is that most employees want to excel, and they want to do things differently, she is the shining example for the rest of the team to follow suit.

The leadership definition for small businesses is quite different than it is for large companies. The vision is to make a good living. The plan is to work hard every day delivering the best service and quality to patients.

The required communication skills consist of knowing what you want your staff to do and telling them:

The leader must explain to the staff what is expected of them, how their performance will be measured and how that performance will be rewarded. In exchange, the followers will be paid and appropriately recognized.

Rather than allowing your practice to sink under the weight of mediocre minions, choose to build the necessary communication or business skills to lead teams and steer clear of complacency.

However, dramatic leadership improvement can occur under the right circumstances if the dentist truly wants a practice that reflects the level of excellent dentistry he or she provides.

In order to improve leadership skills and avoid settling into a state of mediocrity and ultimately the loss of power and control over the practice, dentists must take three essential steps:

• Change your definition of leadership.
• Change your behavior as the leader.
• Change your expectations of the desired outcomes.

Dentists by virtue of their position as CEO of the practice are the leaders, but often they don’t take to that role naturally, and frequently they do not have leadership experience to prepare them for the responsibility.

Dentists are trained to be excellent clinicians and they are. They are not, however, trained to have
Changing dentistry 4mm at a time.

Over 10,000 new users have made SureFil® SDR™ flow one of the fastest-growing products.

Since launching SureFil® SDR™ flow in September 2009, over 10,000 dentists have tried the first and only bulk fill flowable posterior composite. What’s even more impressive is that over 90% of them said they would continue to use it. SureFil® SDR™ flow has self-leveling handling that provides excellent cavity adaptation, and it can be bulk filled in 4mm increments, dramatically streamlining your posterior restoration. Contact your DENTSPLY Caulk rep or visit www.surefilsdrflow.com to learn more.
‘Eeny, meeny, miney, mo …’
How to choose a digital camera

Part 2 of 2: switching from analog to digital

By Lorne Lavine, DMD

In part 1 of this article we discussed how to choose an intraoral and an extrasensorial camera with detailed information about how to evaluate the different aspects of the camera as well as an explanation of pixels. Now, we’ll delve into making the leap from analog to digital.

For many dentists, the transition to digital photography is exciting and opens up many new possibilities for them. The difficulty for most, however, is trying to figure out how to digitize their current photos and slides.

There are a few methods for getting your prints and slides onto a computer where they can be manipulated and output to different sources.

Photo or picture CD. For film that hasn’t been developed or with negatives, you can ask the photo developer to put your images on a photo or picture CD. These CDs can be read by all but the most ancient CD-ROM players, and the files on them can be downloaded onto your computer’s hard drive. Scanner. This is currently the only method for getting existing photos or slides into a digital format. I would recommend that when you search for a scanner, find one that has both a backlight and a transparency adapter. Models that I have found to be particularly good are the Epson V700 and V750-M. In addition, look for a scanner that has the highest dpi (dips per inch) resolution that you can afford. Better models have at least a 1,200 by 2,400 dpi. Online. Many companies offer online storage and scanning of existing photos. While these online services are an option, they are hardly the cheapest. Expect to pay from $1 to $10 per scan, which can get very expensive if you have hundreds of photos and slides to be scanned.

After it’s all digitized

Once you find a method of getting your analog or digital photos and slides onto a computer, you need to have some method of storing, cataloging and manipulating these images. The only method before true integration became a reality was to use a stand-alone image management program. Some of the better and more popular ones are XDR, Apterix and Tigerview.

As dental practice management software has evolved, there was a need to find a way to integrate these image databases with the management program so most of the developers of these programs built “bridges.” Most bridges, however, are still one-way in that you can call up the image management program from the patient screen and all the patient information will already be transferred. However, this method does not allow images that you capture to be transferred back to the patient file in the practice management program. To accomplish this, you must use a stand-alone software program that is integrated with the practice management software. This type of integration is found with some of the more prevalent programs such as Dentrix, Softdent and Eaglesoft.

Output

Once you have access to your images and have manipulated them to your liking, the final piece in the puzzle is to determine how you want to output these photos. Obviously, this will heavily depend on how you plan to utilize the images, such as patient presentations, dental lab communication, lectures, insurance documentation or online collaboration. Some of the choices include the following.

Inkjet printers. It is important to use a printer that is not only capable of printing medical quality images, but using the right paper is critical. Most bridges, however, are still one-way in that you can call up the image management program from the patient screen and all the patient information will already be transferred. However, this method does not allow images that you capture to be transferred back to the patient file in the practice management program. To accomplish this, you must use a stand-alone software program that is integrated with the practice management software. This type of integration is found with some of the more prevalent programs such as Dentrix, Softdent and Eaglesoft.

E-mail. Once you have a digital image, any e-mail program will allow you to attach files to be e-mailed. You should ensure that the images are in a standard format that can be read by other programs and, just as importantly, that the files are not large enough to congest the network.

An image created with a 10-megapixel camera can be many megabytes in size. Converting this to a JPG file (these are files that have the .jpg extension on the end) will reduce them to 500–750 KB on average. Keep in mind that many people still use a dial-up connection to access the Internet and downloading large files can be very time-consuming, so compressing the images makes a lot of sense.

Online collaboration. There are may services that will allow you and lead a team of star players. Focus initially on the following manageable steps. You will see improvement almost immediately. Those who are valuable to the future success of the practice will emerge as will those who aren’t.

Step No. 1: Get the right people into the right jobs.

Some employees are perfectly at ease asking for payment, while others feel as if they were making some extraordinarily difficult demand of the patient. In the Mary Jane example above, she may be an excellent employee who is in the absolute wrong position.

I highly recommend personal testing to place your team members in positions in which they can excel, not just get by. The Keirsey Temperament Sorter Test found at www.keirsey.com is an excellent tool to use for this process.

Step No. 2: Tell it like it is.

Develop job descriptions for each position. Specify the skills necessary for the position. Outline the specific duties and responsibilities.

Include the job title, summary of the position and its responsibilities and a list of duties. This is an ideal tool to explain to employees exactly what is expected of them.

Step No. 3: Train.

I’ve watched this mind-boggling scene hundreds of times: dentists allowing untrained team members to handle tens of thousands of dollars in practice revenues.

Nothing creates distrust, generates conflict or causes more internal problems than team members who are untrained.

They feel insecure and vulnerable because they’ve been tossed into a situation in which they are expected to perform duties and are merely guessing at how those responsibilities are to be carried out.

This is a recipe for failure. Think about it: would you hand them the instrument tray, a couple of handpieces and say, “Have at it, let’s see what you can do.” Of course not! Team members must be given the training to succeed and expected to meet specific performance standards.

Step No. 4: Encourage the best.

In addition to job descriptions and clear and specific goals, your team will also wants to know how you will measure its success.

When the time comes to evaluate your team, that too should follow specific guidelines; it’s not just a matter of assessing whether your assistant is a nice person. It is about evaluating how well she/he is able to carry out her/his responsibilities.

Used effectively, you’ll find that employee performance measurements and reviews can provide critical information that will be essential in your efforts to make major decisions regarding patients, financial concerns, management systems, productivity and staff throughout
your career.

Moreover, performance measurements and a credible system for employee review consistently yield more effective and higher performing team members.

The fact is that when we understand the rules of the game and how we can win, life and work are a lot more fun and rewarding.

Step No. 5: Celebrate.

Inspire the team with a practice vision and goals, and recognize the progress you make together in achieving those goals. Take time to pat yourselves on the back for the accomplishments that you achieve.

Create incentives for staff members to use their skills and training to develop plans to continuously improve patient services, boost treatment acceptance and build a better practice, and reward them for their efforts.

If you create a structured environment with clear expectations and a plan for total team success, then the Mary Janes and the rest of the crew will likely rise to the occasion. And you will no longer be suffering through the daily grind.

Rather, you will be leading a happy and successful team that is not only open to change and continuous improvement, it is actively pursuing it every day.

DT

to upload your digital files to a site that will store and catalog these files for viewing by other people.

The most basic ones, which are not necessarily designed for dental applications, are quite easy to use and most are free of charge. Sites that are built around online dental collaboration, such as Brightsquid and ddsWeblink, are excellent for this purpose.

The world of digital photography has continued to grow over the past couple of years, and this is to the advantage of the dentist.

Prices will continue to drop, image quality continues to improve and the products and systems are becoming even easier to use.

For any dentist considering the addition of digital photographs to his or her dental practice, the time to take the plunge is now!

DT

Dr. Lorne Lavine, founder and president of Dental Technology Consultants (DTC), has more than 20 years invested in the dental and dental technology fields. A graduate of USC, he earned his DMD from Boston University and completed his residency at the Eastman Dental Center in Rochester, N.Y.

He received his specialty training at the University of Washington and went into private practice in Vermont until moving to California in 2002 to establish DTC, a company that focuses on the specialized technological needs of the dental community.

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Does your practice extend open credits to your patients? This is an important question as veteran dental practice owners know that their practice’s fiscal health, profitability and success require balancing a prudent patient financing policy.

Balance allows the flexibility to accommodate your patients, and it needs to be firm enough to avoid cash flow/collection problems that may have material consequences for both the clinicians and staff. Even a temporary cash flow problem is stressful for a practice owner, creating the potential for uncertainty in making the payroll.

What is a dental practice’s uncollectible percentage? While this number will vary substantially (due to many factors ranging from service mix, use of practice management software, aggressive or lax payment policy compliance), when averaged, it shows the nationwide number of approximately 2.5 percent. Many practice owners think they can live with 2.5 percent. However, further inspection reveals a more in-depth appreciation of collection effectiveness on a practice.

Let’s suppose a practice grosses $1 million annually. If the practice has bad debt or “uncollectible receivables” of $25,000, that is 2.5 percent, then that write-off number would be correct (See Table 1).

Accounts receivable trends for any business, from a FORTUNE 500 company to a dental practice, are almost identical. Receivables are like gravity. You can’t resist gravity and you can’t resist receivables’ falling value over time. Table 2 shows the effects of time on receivables. Each $1 of accounts receivable at 90 days is statistically only worth $0.72.

Thus, the case can be made for dental practices to devote more focus to their “payment is due upon service” policy so the practice is not acting as a bank to patients. Offering patients (monthly, more affordable) financing options makes optimal treatment acceptance more likely, as well as removes a practice that offers selective financing from appearing as credit officers and lenders to patients.

Today, a good patient financing plan will accept from 50 to 60 percent of the patients who apply. There are patient financing companies that indicate an approval rate of 90 percent based on the total patient base being considered. That may be a misleading number as not every patient wants to be approved. Your patient-financing candidates can automatically be any who might remark:

◗ “I forgot my checkbook.”
◗ “I can pay you $100 a month until we’re done.”
◗ “Let me know the balance after the insurance pay-in.”
◗ “I forgot my checkbook.”
◗ “Just bill me.”
◗ “I can pay you $100 a month until we’re done.”
◗ “I want to have the treatment, but can’t afford it now.”
◗ “Let me know the balance after the insurance pay-in.”

It is prudent to offer patient financing when you examine what consumers are advised to pay on a graded scale. Data reveals the recommended consumer order of payments is as follows:

1) Child support. By law, credit bureaus must report any information received about overdue child support, as long as it’s verified by the proper agency and is not more than seven years old. Consumers are told this should be the No. 1 payment priority. Penalties, considered quite serious, include garnished wages, liens on property and a suspended driver’s license. Dentists should be aware that finance companies might consider an open child support lien on a credit bureau report as very negative.

2) Mortgage. After more than 90 days, late mortgage payments can end up on a credit record. Mortgages also tend to have hefty late payment fees, and if a mortgage holder misses two or more, a lender may start foreclosure proceedings.

3) Car loans. Repossession laws vary — in some states repossession happens after one missed payment. Mass transit isn’t applicable everywhere and the risk of not having a vehicle probably impedes a person’s ability to work.

4) Taxes. The Internal Revenue Service (IRS) is tough when taxpayers don’t pay on time. Penalties accrue with time and the clock keeps going from the time of the infraction.

5) Bank credit cards. Credit cards are important. Paying them on time is more important than ever as late payments give all credit card issuers the right to reprice a cardholder because of economic risk status. Recent legislation was passed about sudden rate increases from credit card companies, though the effective date isn’t until later this year.

6) Department store cards. Many will negotiate and/or accept lower payments for various periods of time.

7) Utilities (electric, gas, water). Utility companies may work out payment schedules for consumers (though security deposits for future services will be a factor). Nationwide, rules vary as regional regulators have rules protecting homeowners from losing vital services and keeping consumers safe.

8) Student loans. Federal student loans may be deferred during times of financial challenge. When
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Show Low—2 Ops, 2 Hygiene Rooms, GR in 2007 $65,000
Phoenix—General Dentist Seeking Practice Purchase Opportunity #12109
Phoenix—3 Ops - Equipped, GR $515K, 3 Working Days #12111
N Scottsdale—General Dentist Seeking Practice Purchase Opportunity #12109
Upland—6 Ops-4 Equipped, 1 Hygiene, GR $900K 12112
Tucson—1,800 active patients, GR $850K, Asking $650K #12115
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CALIFORNIA
Alturas—3 Ops, GR $611K, 3 1/2 day week work #14279
Antioch—2 Ops, 1,580 sq. ft., GR $177K #14367
El Sobrante—3 Ops-3 Equipped, 1,380 sq. ft., GR $530K #14302
Fresno—5 Ops, 1,350 sq. ft., GR $1,261,500 #14259
Greater Auburn Area—4 Ops, 1,309 sq. ft., GR $765K #14304
Madera—7 Ops, GR $1,291,467 #14285
Modesto—12 Ops, GR $1,079,000, Some location for 10 years #14289
Modesto—5 Ops, GR $884K, add'l net income of $44K #14298
N California Wine Country—1 Ops, 1,500 sq. ft., GR $595K #14296
Pine Grove—GR, nice 3 Op fully equipped office/practice #14110 #14109
Porterville—6 Ops, 2,000 sq. ft., GR $2,289,000 #14291
Red Hill—6 ops, 2,000 sq. ft., GR $3,000,000, Hygiene 10 days a wk. #14293
CONTACT: Dr. Dennis Hoover # 661-519-3458

Dixon—1 Ops, 1,100 sq. ft., GR $122K #14265
Grass Valley—1 Ops, 1,500 sq. ft., GR $771K #14272
Ontario—Owner-dissolved, 7 ops, GR $770K, 2900 sq. ft. Bldg. #14110
Redding—3 Ops, 2,200 sq. ft., GR $1 Million #14293
Solano—5 Ops, 4 days reg., 1,200 sq. ft., GR #1477
CONTACT: Dr. Thomas Wagner # 916-912-335
Rancho Mirando—3 Ops, 1,200 sq. ft., Take over lease #14401
CONTACT: Thunder Pan # 549-553-8308

CONNECTICUT
Fairfield Area—General practice doing $900K #1606
Southbury—2 Ops, GR $251K #16111
Waterford—2 Ops, GR $600K #16113
CONTACT: Dr. Peter Goldberg # 860-670-2930

FLORIDA
Miami—6 Ops, Full Lab, GR $851K #18118
CONTACT: Jim Parker # 863-287-8307
Jacksonville—GR $1.3 Million, 3006 sq. ft., 7 Ops, 8 days hygiene #18118
CONTACT: Deanna Wright # 800-730-8883

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Atlanta Suburb—2 Ops, 2 Hygiene Rooms, GR $631K #19918
Atlanta Suburb—3 Ops, 1,270 sq. ft., GR $4,388,596 #19913
Atlanta Suburb—Pediatric Office, 1 Op, GR $426K #19913
Dublin—GR $1 Million, Asking #1291
Macon—3 Ops, 1,625 sq. ft., State of the art equipment #19913
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Northeast Atlanta—4 Ops, GR $607K #19129
North Georgia—4 Ops, 1 Hygiene, Est. for 43 years #19110
South Georgia—3 Ops, 2 Hygiene Rooms, GR $722K #19133
CONTACT: Dr. Jim Cole # 404-513-1573

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CONTACT: Al Brown # 630-781-2176

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CONTACT: Shanon McCarty # 410-788-4071

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Philadelphia County—4 Ops, GR $900K, Est. for 15 years #47112
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Southern Rhode Island—4 Ops, GR $750K, Sale $468K #41102
CONTACT: Dr. Peter Goldberg # 617-680-2930

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CONTACT: Scott Carringer # 704-814-4796
Columbia—2 Ops, 1,200 sq. ft., GR $678K #49102
CONTACT: Jim Cole # 803-513-1573

TENNESSEE
Elizabeth—GR $335K #51107
Memphis—Large practice opportunity GR $2 Million + #51112
Suburban Memphis—Leading Practice in Area GR $1 Million #51115
CONTACT: George Lane # 865-41-1357

Texas
Houston Area—GR $1.1 Million w/adj. net income over $500K #52105
CONTACT: Dennis Wright # 806-739-8883

virginia
Great Valley—2500 sq. ft., GR $942K updated equipment #53111
CONTACT: Bob Anderson # 804-660-2737

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Virtual dental implant planning: the next step

By Dov M. Almog, DMD and Michael Nawrocki, DMD

Already in 2005, a report from Kalorama Information¹ estimated that the growth in implant-based dental reconstruction products would outstrip other areas of dental devices and products.

According to that report, 40 percent of the western population is missing one tooth or more; in the United States alone, approximately 10 percent of the population is completely edentulous; and every year about 2 million Americans lose a tooth due to sporting accidents. As a result, there has been a rapid increase in the number of practitioners involved in implant placement, including specialists and generalists, with different levels of expertise. Unfortunately, there has been a simultaneous raise in claims and suits involving dental implants, mostly associated with damage to the mandibular nerve and maxillary sinus perforations. This is in addition to failure associated with poor alignment.²

Therefore, considering that dental implants are the fastest growing discipline in dentistry, there is little doubt that cone-beam computerized tomography (CBCT) is the pre-eminent method for viewing and understanding three-dimensional anatomy and the foundation for successful implementation of oral implantology, one of the most important branches of dentistry today.

CBCT carries very important radiographic, restorative and surgical information for dental implant planning, taking the guesswork out of what we do, and it is rapidly emerging as the diagnostic imaging standard of care. This information includes implant trajectory, distribution, depth and proximity to critical anatomical landmarks such as the mandibular canal, maxillary sinus, adjacent roots and alveolar cortical plates and undercuts.

About the author

Keith D. Drayer is vice president of Henry Schein Financial Services. Henry Schein Financial Services represents the only 3.99 percent same-as-cash patient financing and no dedicated terminal program. Henry Schein is the leading distributor of services and products to office-based health care practitioners. Drayer can be reached at hsfs@henryschein.com or (800) 445-2756.

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DT page 8A

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Figs. 1a–c (above and below): CBCT study performed with the iCAT CBCT machine (Imaging Sciences International, Hatfield, Pa.) while the patient wore a radiographic guide (blue shadow). By utilizing ImplantMaster™ software (iDent Imaging, Foster City, Calif.), the prosthetically aligned acrylic teeth in the radiographic guide, plus the residual bone trajectory and the mandibular canal, facilitated the optimal virtual planning of implants’ trajectory, depth, length and diameter. Images are shown in two dimensions: panoramic slice (1a) and cross sections (1b, c). These cross sections correspond to the patient’s lower right and left edentulous region (Nos. 19 and 29). Note the mandibular canal illustrated by the red lines and circles.

Figs. 2a–c (at right): By utilizing ImplantMaster software, a 3-D reconstruction of a patient’s anatomy was achieved and a virtual surgical guidance template (2a, b) was designed and computer manufactured with precise drilling hole distribution and the trajectory for implants Nos. 19 and 29 (2c). Special metal sleeves were assembled in the holes that can house a series of tool inserts that accommodate a diversity of implant systems and drilling sequence as required by each implant brand.
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The collected diagnostic CBCT and the added dimension of 3-D data will result in more predictable outcomes, increasing patient satisfaction and reduced risk of potential claims. If the patient declines the CBCT diagnostic data, the practitioner should obtain and document an informed refusal.2

In 1996, Quantitative Radiology (QR) from Verona, Italy, introduced the first dental CBCT machine called the Newtom into the Italian market. This ushered in the era of 3-D dental imaging, sparking a rapid development of dental CBCT scanners by a number of companies.

To date, there are more than 30 such CBCT machines available on the market worldwide produced by a wide variety of companies.3

During the last decade, as recognition in the concept of CBCT has matured, and with the wider availability of CBCT 3-D imaging in imaging centers, mobile scanning units and private offices, our profession has been fueled further by the introduction of 3-D derived virtual planning software solutions.4

About a dozen of these virtual implant planning software solutions are used for general oral implantology treatment strategy, of which only eight are ultimately used to translate the treatment strategy into an actual physical surgical guidance drilling template, thus taking the guesswork out of oral implantology (Figs. 1, 2).

Utilization of these adjunctive state-of-the-art technologies altered the manner in which we pull together diagnostic data, plan and execute both simple and complex implant cases. These surgical guidance systems offer safer and more predictable placement of dental implants, ensuring accurate transfer of critical restorative and anatomical information to the surgical site.

Additionally, these surgical guidance systems offer an opportunity to maximize a team approach between surgeons, restorative dentists and the labs, creating greater understanding, appreciation and professional camaraderie.

Of the eight 3-D derived virtual planning software solutions that are ultimately used to translate the treatment strategy into an actual physical surgical guidance drilling template, two systems differentiate themselves from all the other systems in that no physical shipment needs to be made to the guide manufacturer.

Being fully automated, digitally manufactured solutions, only digital data is transmitted, which is enough to manufacture the guidance drilling template using 3-D printing technologies. These two systems are: NobelGuide™ (Nobel Biocare, Yorba Linda, Calif.) and Scan2Guide™ (iDent Imaging, Foster City, Calif.).

While NobelGuide can only be used in conjunction with Nobel implants, Scan2Guide is an open platform that can be used with most implant systems on the market. Because the iDent system is an open system, the company has developed a variety of metal sleeve sizes for placement in the surgical guidance drilling template and a series of tool inserts that accommodate a diversity of systems out there, including the drilling sequence as required by each implant brand.

Conclusion

This report attempts to provide an argument in favor of the utility of CBCT-image-based 3-D-derived virtual implant planning software solutions in oral implantology that are ultimately used to translate the treatment strategy into an actual physical surgical guidance drilling template.

Researchers studying these virtual surgical guidance technologies agree that the quantitative relationship between successful outcomes in oral implantology and CBCT-based dental imaging — coupled with virtual planning and, ultimately, implant placement guided by surgical guidance templates — awaits discovery through large prospective clinical trials.5

Based on a series of case reports, it has been demonstrated that using CBCT-based dental imaging along with surgical guidance templates is, without a doubt, a reliable procedure, optimizing our patients’ safety and well being.6-8

A complete list of references is available from the publisher.

(Photos/Provided by Dr. Dov Almog)
Expanded convention center for the PDC

Meeting to be held at Vancouver Convention Centre, April 15–17

By Fred Michmershuizen, Online Editor

The 2010 Pacific Dental Conference will be held April 15 to 17 at the newly expanded Vancouver Convention Centre West Building. The new facility provides many additional features to enhance the meeting’s continuing education programs and the exhibit hall under one roof.

Meeting organizers have put together an enhanced program of speakers and workshops for 2010. The brand new exhibit hall will be home to more than 500 exhibitor booths showcasing a wide range of dental products and services. More than 150 sessions will be offered on a wide range of topics.

Meeting highlights

To complement the new home for the Pacific Dental Conference, meeting organizers have announced some fresh new additions to the program as well as some enhancements to the Web site. Among them are the following:

• A brand new exhibit hall location with an Internet Café and three dining lounges.
• Extended exhibit hall hours.
• A new live dentistry stage, located in the exhibit hall.
• Up to 15 hours of C.E. credits.
• A “So You Think You Can Speak?” educational series.

Meeting organizers said they are excited to see the constant growth of the conference more than the past few years, with a new record of more than 11,600 participants in attendance last year. Partnering with valued exhibitors is important to the meeting’s continued success, organizers said.

“Our exhibit hall, known for its value, affordability and friendly atmosphere, has become the primary venue for dental professionals to experience the latest products and services,” meeting organizers said.

Special events

A number of special events will be held during the meeting.

“Life Is Too Short to Drink Bad Wine — Southern Hemisphere Edition” will be held Thursday, April 15, from 6 to 7:30 p.m. Attendees will be able to sample a variety of wines from the Southern Hemisphere at the event.

Wine expert David Lancelot from Vancouver’s popular Marquis Wine Cellars has hand-picked a fabulous selection of limited-production and hard-to-find wines from such countries as Australia, New Zealand, Chile, South Africa and Argentina.

The event will be held in the Vancouver Convention Centre’s third floor foyer overlooking the Burrard Inlet and North Shore Mountains.

This event promises “delicious wine, fresh bread to accompany it, expert viticultural advice and a knockout view.” The cost for the event is $37 plus tax.

“A Friday Night Social” will be held Friday, April 16, from 6:45 to 10 p.m. The Friday night event provides a perfect opportunity to catch up with your friends and colleagues, enjoy a light snack and cool beverage, while the techno-lit dance floor beckons you to kick up your heels to sounds of ABBA CADABRA! This performance pays tribute to the musical supergroup ABBA.

“The PDC Friday Night Social is a perfect way to start your Friday night in Vancouver,” meeting organizers said. The cost for the social is $25 plus tax.

Planning tools

To help attendees make the most of their conference experience, meeting organizers have made a number of planning tools available online.

You can create a personal schedule of sessions that you plan to attend, including first, second and third choices in each timeslot. Each person in your attendee account can have his or her own schedule.

In addition, you can create a list of “must-see exhibitors” you most want to visit in the exhibit hall, and get a floor plan map that will help you find them.

Each person in your attendee account can have his or her own exhibitor map.

To access the planning tools, and to learn more about the meeting in general, visit www.pdconf.com.

www.dental-tribune.com

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Fast and safe protecting and matrixing with FenderWedge and FenderMate

During Class II preparation there is a major risk for damaging the adjacent tooth. Research shows adjacent teeth are damaged in up to 70 percent of all cases.

Until now, protection methods have the disadvantage that the shield loosens when the approximal contact point is cut away, increasing the risk of accidental aspiration of the shield.

The need for improved protection methods led Directa to design and develop FenderWedge, a plastic wedge with an attached vertical stainless-steel band that protects the adjacent teeth and, at the same time, separates the teeth for an optimal restoration of the contact point. FenderWedge is securely held in place throughout the entire preparation.

FenderWedge is inserted into the approximal space as easily as any other wedge. As the wedge creates interdental separation, the vertical steel band automatically establishes correct positioning for a good contact point. The comfort of knowing that 0.08 mm of metal protection will help avoid needless damage to healthy teeth is simply priceless.

FenderWedge is available in four different sizes from extra small (1.0 mm) to large (2.5 mm). They accommodate all interdental spaces.

FenderWedge is available in four different sizes from extra small (1.0 mm) to large (2.5 mm). They accommodate all interdental spaces.

In Directa’s quest to design and develop high-quality useful products, the logical next step after the use of FenderWedge is the introduction of FenderMate, an innovative wedge and section matrix combined. FenderMate offers a two-in-one step procedure like nothing else in the market.

After pre-separation of the interdental space with FenderWedge, FenderWedge is removed and replaced by FenderMate. After insertion, FenderMate adapts around the tooth and holds shape without the use of a retentive ring. FenderMate’s flexible wing separates the teeth and firmly seals the cervical margin.

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Bite alteration to reduce gummy smiles

By David S. Frey, DDS

You were the first dentist to use and exploit the term, “full-mouth revitalization,” and you commonly refer to yourself as a “mouth doctor.” What does all this mean?

I did a Google search of the term, “full-mouth revitalization,” when I was writing my book, “Revitalize Your Mouth,” in 2004, and nothing showed up. Thus, I am now the proud owner of that trademark for my signature procedure.

What I mean by “mouth doctor” is that I can be one of three types of dentists for my patients: a tooth doctor, a smile doctor or a mouth doctor. Some dentists are tooth doctors, some are both tooth and smile doctors and others, like me, enjoy being a mouth doctor.

A mouth doctor is comprehensive: correcting the teeth, the smile and the bite. Correcting the bite can enhance so much more for the patient than merely restoring the teeth in the patient’s current habitual position. Patients can look healthier and more attractive if you proportionately size the lower one-third of the face.

Correcting the bite can also miraculously alleviate headaches, ear pain, jaw pain and muscle pain in the neck. It can even improve posture. In my experience, most patients with unattractive smiles got that way because of their malocclusion.

The bite is the engineering, backbone and direction. All the rest is the art. When you correct the bite, the smile corrects itself.”

Comprehensive dentistry: becoming a full-mouth doctor

An interview with Dr. David Frey

The traditional method for correcting a gummy smile with too high a gum-to-teeth ratio has been enormously invasive. It has involved cutting and lifting the gum tissue back in order to remove bone, after which the gums must be sewn back in place.

This process requires a six to eight-week healing process, which is not only painful, but esthetically displeasing during that period. Another method, which involves repositioning the lip after cutting into the vestibule, is equally invasive with an excessively long period of healing.

Today, cosmetic dentists often perform a gingivectomy utilizing a scalpel, electrosurge or diode laser in order to correct an overly gummy smile. However, these methods are contingent upon the amount of biological width available in each individual patient. Two to three millimeters of gum tissue must remain over the bone after the tissue has been removed. This biological width limitation usually creates one of two options.

Either the patient must be subjected to invasive surgical gum flaps accompanied by bone removal or the patient must be satisfied with very little change in the gum-to-teeth ratio. If the patient presents with a significantly short vertical index (measured from the CEJ of tooth No. 8 or No. 9 to the CEJ of tooth No. 24 or No. 25), the gummy smile condition may not be satisfactorily corrected when only a gingivectomy is performed.

Cosmetic dentists train regularly to adjust horizontal smile abnormalities such as over-crowding and large gaps. The idea of changing the vertical dimension of occlusion as part of improving dentofacial esthetics is not new. While occlusal philosophies may differ, most will agree that the occlusion must be given careful consideration when changing its vertical dimension, both as part of the diagnostic process and to avoid possible iatrogenic results.

When the patient presents with a significant difference between the mandibular position at habitual occlusion relative to an optimized occlusal position, increasing vertical...
Dr. Nushin Shir, owner of Artistic Center for Dentistry, is celebrating the grand opening of her practice in Santa Monica, Calif., by offering free comprehensive dental exams and basic teeth cleaning services to 120 new patients.

In exchange for free dental treatment, the practice is asking that all patients donate $10 to Heal the Bay, a local environmental outreach effort.

The monthlong promotion runs from April 1–30. “Among the great karmas to be performed, charity is the greatest,” said Shir, who is an expert in cosmetic and intricate dental procedures. “In these tough economic times where many families are hurting, the charitable contribution to nonprofits and their important missions has fallen significantly.

“This is an ideal time to repay the support I have received from the community and to give back to one of the most important causes in Santa Monica, Heal the Bay.”

The mission of Heal the Bay is to promote the importance of making Southern California’s coastal waters and watersheds safe, healthy and clean, while fostering a global value shift toward a sustainable and secure future.

Artistic Center for Dentistry subscribes to this philosophy and is doing its part to minimize its carbon footprint. The practice is thankfully and therefore paperless, thus helping to save trees. The office also reduces waste by eliminating the use of plastic products.

The center’s choice to use digital X-rays eliminates the hazardous chemicals that are used in their development from contaminating the waterways and also eliminates unnecessary radiation to its patients. The heavy equipment used is both dry and oil-less and, therefore, does not wastefully deplete water supplies. Oil-less machinery reduces the waste production of non-biodegradable materials that contaminate the oceans.

“Support from third parties, such as Artistic Center for Dentistry, are key to promoting greater awareness, broadening our member base, and generating funds to support our research, education, community action and advocacy,” said Natalie Burdick, Heal the Bay’s constituent development manager.

“We are excited to be able partner with Dr. Shir on a health program that offers free dental exams to members of our local community,” said Burdick.

We are committed to improving the local environment in our community to create a cleaner safe place to live and work. We understand the importance of making environmentally responsible decisions for a sustainable future,” Shir said.

The mission of About Artistic Center for Dentistry is to create naturally beautiful smiles and enhance patients’ overall well being by using the latest dental technologies in a stress-free, Zen environment.

Artistic Center for Dentistry offers all aspects of general and cosmetic dental services, including power teeth whitening, porcelain veneers, crowns and bridges, tooth restoration, root canal therapy, orthodontics and more. It uses digital X-rays with the lowest radiation for patients’ safety.

The center also offers a range of beauty and relaxation treatments that can bookend a patient’s dental experience, such as massage, foot reflexology, hand and facial treatments, and Botox and dermal fillers.

Shir has served many well known celebrities in addition to owning and managing several successful dental practices in Los Angeles County since 1993. She graduated from UCLA School of Dentistry in June 1993. She earned her bachelor’s degree in biological sciences from UC Irvine.

The Consumer’s Research Council of America recently selected Shir to be included in its 2010 edition of Guide to America’s Top Dentists. “Receiving this designation is an honor,” Shir said.  

More information
Founded in 1985 by Dorothy Green, the organization’s focus is on Santa Monica Bay and the surrounding Santa Monica Coastal waters. However, Heal the Bay’s efforts directly affect the water quality for California as a whole and the rest of the United States. Please visit www.HealtheBay.com for more information.

Dr. Nushin Shir treats a patient in her practice in Santa Monica, Calif. (Photo/Provided by Dr. Nushin Shir)

Why is it important to correct a patient’s bite?
If you build patients’ smile in their habitual bite, you’re confined to the size to which they’ve worn their teeth down. This is a very small area. When you incorporate bite correction into your work on a patient’s smile, you have a lot more power, and you can correct vertical abnormalities. If you just treat the smile, you’re very limited to horizontal abnormalities such as gaps, spaces and crooked teeth.

When a patient only wants four teeth corrected in the middle of the smile, I become a tooth doctor. But only correcting those four teeth compromises color and the natural flow of the smile as it diminishes into the corners of the lips.

Of course, the choice is always the patient’s, and that means I have to be able to be a tooth doctor, a smile doctor, and a mouth doctor in order to serve all of my patients.

However, the truth is that form equals function, and art equals science. Without combining the two, you can never make an incredibly gorgeous smile.

When the bite has been corrected or when I treat a patient with a healthy bite, I can create the best smile in the world because I can line it up in proportion with the patient’s face.

Would you tell me about the books you authored, “Revitalize Your Mouth” and “Revitalize Your Smile”?
The books were written to explain to patients everything they need to know about a full-mouth or full-

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smile revitalization. Because this procedure is very complex and detailed, these books have been very successful for my practice because they’re easy to read and contain several before and after pictures.

Patients show them to other potential patients, so they’ve been very strong internal marketing tools. It’s also easy for me to share these books with other dentists. I allow them to co-write my books by adding their own before and after pictures so that they can enjoy the marketing success that I’ve had. I call this the Instant Author Program [www.instantauthorprogram].

Your office is in Beverly Hills, where many people are known to get frequent cosmetic procedures. Do you find that injections in the face and lips — such as Botox, restylane and collagen — cause problems with a patient’s smile?

Yes. Women often enlarge the size of their lips to the point of sacrificing their smiles. So when they smile, they no longer show much of their teeth. In that case, these injections can create a vertical abnormality. If they want to show more teeth, they need to open the vertical dimension in their bites.

We must open the bite up so that when they close their mouth, the top and bottom teeth touch sooner. That allows more of the teeth to show and gives the dentist room to make a larger central that peeks through the lips and gives the patient a more youthful smile.

Not showing enough teeth is the opposite problem of what you call a gummy smile, correct?

Yes, a gummy smile is the opposite vertical abnormality. With a gummy smile, the patient shows too much of the teeth and gums. These patients often have a very small vertical dimension, 13 to 14 millimeters. By opening them up to their natural physiological vertical length, which might be closer to 17 millimeters, they show more teeth and less gum as the ratio between the gums and teeth is reversed. By opening the bite, you can also reduce gummy smiles, as my article [in this edition] illustrates.

What kind of patient would you consider a good candidate for what you call full-mouth revitalization?

People who have had lots of dentistry in the past or worn their teeth down, as well as people who don’t like their smile and want veneers on the top and bottom teeth. If you’re going to veneer 20 teeth, the only remaining teeth are molars.

Many of these patients already have amalgam fillings or crowns on these teeth. So it only makes sense to do the full-mouth with a corrected bite on these patients.

If you fail to correct the bite, you also fail to address the core problem of why so much dentistry is already in the patient’s mouth. By leaving the patient in his or her habitual bite, that patient is going to continue to have the same problems he or she has had for the past 50 years or more.

However, by creating a harmonious environment between the temporal mandibular joint, the teeth and the muscles of mastication, you can achieve beautiful and long-lasting restorations.
dimension can have dramatic cosmetic effects on a patient by increasing the crown-to-gum ratio and effectively decreasing the gummy smile.

The cases presented here illustrate that vertical abnormalities such as gummy smiles may sometimes be further enhanced and the need for surgical intervention minimized if the vertical dimension of the bite is altered.

In adjusting the vertical dimension, care must be taken to insure a functional occlusion in the finished case. Jankelson described the method for muscle relaxation to determine mandibular position at physiological rest as compared to no destruction of the natural dentition. In the author’s experience and as illustrated in these cases, once PRP of the mandible is established, the increased teeth-to-gum ratio is significant prior to the removal of any gum tissue. It is prudent to mention here that if the patient’s PRP does not differ significantly from habitual after TENS relaxation, very little change in vertical dimension would be available for this procedure.

Use of the Golden Proportion to establish a pleasing esthetic effect has been seen in art, architecture and various scientific fields for centuries and used in dentistry for at least 25 years. Like occlusal philosophy, some question its validity. However, it is used by many today in plastic surgery, orthodontics and esthetic dentistry as an element of treatment planning of facial esthetics and, in the author’s experience, patients are highly pleased with the outcome.

Calculations utilizing the Golden Proportion can also be applied to tooth shape and will show whether the “golden” vertical index can be reached through a combination of bite correction and gingivectomy. These simple calculations indicate whether the vertical length of the patient’s smile will be more esthetically pleasing after the corrections have been made.

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\text{Golden vertical index} = \frac{1.618}{\text{Width of central incisor}} \times \text{Length of central incisor}
\]

Based on these two calculations, an orthotic in the optimal bite position for both esthetics and function can be fitted for the patient’s upper teeth.

The orthotic is worn for a period of approximately one month to be certain that no headaches, neck pain, grinding or chewing issues ensue. This period also provides the patient with time to become psychologically accustomed to the additional tooth length that shows prior to the gingivectomy and application of veneers. If the patient is dissatisfied with the length-to-width ratio of the teeth in the orthotic, adjustments can be made to the orthotic before beginning the procedure.

Correcting the bite before performing a gingivectomy can offer a greater esthetic result, significantly reducing the amount of gum tissue that shows before a gingivectomy is performed. It should be noted that placement of porcelain on the molar teeth to increase vertical height is extremely conservative because the porcelain is lying on top of the existing teeth.

Even if the available biological width is significant, correcting the bite allows the dentist to remove less gum tissue during the gingivectomy. A frenectomy can also be performed, when appropriate, to remove a small portion of the lip frenulum with a diode laser. This allows the lip to move down slightly over the previ-
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ously exposed gums and can additionally reduce the amount of gum tissue that must be removed during the gingivectomy.

Case No. 1
A 27-year-old female presented with a 13 mm vertical index (VI) requesting that her “gummy smile” be corrected or reduced. The average VI is 17–21 mm. Therefore, her VI would be esthetically pleasing if increased by a minimum of 4 mm, reducing the gum-to-teeth ratio.

The patient’s teeth were out of proportion, with the length to width ratio of the central incisors almost identical rather than the esthetically pleasing ratio of 75 to 80 percent width to length. Her gums were inflamed and in poor condition. Therefore, she was first referred to a hygienist for cleaning, root planing, deep scaling and debriding. (Fig. 1)

At physiological rest, the K7 Evaluation System showed that the patient’s VI increased to 17 mm before any gum tissue was removed. The tooth-to-gum ratio had already been increased significantly. The Golden Proportion equations were also utilized. The patient’s golden vertical index calculated at 16.7 mm, and the orthotic gave her a VI of 17 mm (Fig. 2).

It was determined that the patient would have an even greater esthetic result by further increasing the tooth-to-gum ratio. Sounding determined that 2 mm of gum tissue could be removed safely, an additional 2 mm was burned away utilizing a diode laser.

The diode laser immediately vaporizes the tissue and causes less bleeding and less postoperative stress for the patient than other gingivectomy methods.

In the image (Fig. 5), gum tissue has been removed from three teeth, showing the additional vertical length compared to the remaining teeth. The healing process following the diode laser gingivectomy is approximately two weeks.

Sounding indicated that a gingivectomy alone would have allowed for the removal of no more than 2 mm of gum tissue. In this case, the patient’s VI would have increased only to 15 mm, leaving her with a gummy smile even after the procedure was complete (Fig. 4).

After administering a local anesthetic, a frenectomy was performed on the patient to further release the upper lip and reduce the gum-to-tooth ratio (Fig. 5).

The bite was checked again and the temporaries were applied. The final VI increase for the patient following the bite correction, frenectomy and gingivectomy was 6 mm, increasing the VI from 15 to 19 mm. While the increase could have remained at 17, the additional 2 mm was an esthetic improvement (Fig. 6).

After the veneers were applied and the gums had healed, the patient showed an exceptional reduction in her gummy smile, as well as increased gum health with proper stippling (Figs. 7a, 7b).


References

About the author
Dr. David S. Frey been in private practice in Beverly Hills, Calif. for more than 20 years. A graduate from the University of Pacific Dental School in 1989, Frey’s passion for learning and excellence has allowed him to establish a very high-end cosmetic and reconstructive practice.

He has authored two books, “Revitalize Your Smile” and “Revitalize Your Mouth,” as well as written for top United States dental journals.

In addition, Frey has appeared in People magazine for his work on celebrity idol Elliot Yamin and has made multiple appearances on the The Learning Channel’s programs “Ten Years Younger” and “A Personal Story.”

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