A new test for gum disease

Ahmed Khocht, DDS, an associate professor of periodontology at Temple University’s Maurice H. Kornberg School of Dentistry, led a team that studied the efficacy of a colored strip to detect gum disease by changing color in response to the levels of microbial sulfur compounds found in saliva. The strip changes from white to yellow, and the darker the shade of yellow the more severe the gum disease.

Khocht and his team looked at 75 patients divided into three groups — those with gingivitis, those with periodontal disease, and those that were healthy. A color chart formed the basis of scoring for the changes in the color strip, and were compared to scores for traditional assessments such as attachment levels, bleeding on probing, gingival index and plaque index. Using a color strip would be quicker and easier than using those traditional assessment methods, and would cause no pain to the patient.

Given that 80 percent of adults have some form of periodontal or gum disease, a quick and painless method to identify the diseases would save the dental practice time and money as well. A growing number of research supports the links between gum disease to blood infection, cancer, diabetes, heart disease, low birth-weight babies and obesity. Thus, early detection of periodontal or gum disease is paramount to a patient’s overall health.

(Original: Temple University, www.temple.edu)

OSAP offers resources for dentists to help prevent spread of swine flu

Researchers from New York University presented their findings about white wine and tooth staining during the recent International Association for Dental Research annual meeting in Miami, which took place April 1-4.

Using two sets of cow teeth, study results showed that soaking the teeth in white wine for one hour before exposure to black tea produced significantly darker stains than when the teeth were soaked in water for one hour prior to exposure to black tea.

(Original: New York University, www.nyu.edu)

White wine can increase tooth staining

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(Original: New York University, www.nyu.edu)

ADA names Dr. Kathleen O’Loughlin executive director

Kathleen T. O’Loughlin, DMD, MPH, has been selected by the Board of Trustees of the American Dental Association to serve as the next ADA executive director/chief operating officer, effective June 1. O’Loughlin becomes the first female executive director in the ADA’s 150-year history. The announcement marked the end of an 11-month search for a new executive director.

“Dr. O’Loughlin’s background represents the right mix of experiences we sought in an executive director,” said ADA President John S. Findley, DDS. “She has 20 years in private dental practice and public health dentistry plus 10 years experience in dental education and a decade of key leadership roles in management, strategic planning and business operations.”

“I am incredibly honored to accept this position,” O’Loughlin said. “It represents the pinnacle of my professional career. What a great opportunity to serve the profession I have loved for 50 years and what a tribute to my deceased father, who was a socially conscious practicing dentist was my role model and inspiration.”

From 2002-2007, O’Loughlin served as president and CEO of Dental Services of Massachusetts (d.b.a. Delta Dental of Massachusetts) where, through her leadership, the company doubled its reserves, increased membership by 400 percent and executed a successful five-year growth plan.
After years of biting and chewing, how are human teeth able to remain intact and functional? A team of researchers from the George Washington University and other international scholars have discovered several features in enamel that contribute to the resiliency of human teeth. Human enamel is brittle. Like glass, it cracks easily; but unlike glass, enamel is able to contain cracks and remain intact for most individuals’ lifetimes. The research team discovered that the major reason why teeth do not break apart is due to the presence of tufts — small, crack-like defects found deep in the enamel. Tufts arise during tooth development, and all human teeth contain multiple tufts before the tooth has even erupted into the mouth. Many cracks in teeth do not start at the outer surface of the tooth, as has always been assumed. Instead, cracks arise from tufts located deep inside the enamel. From here, cracks can grow toward the outer tooth surface. Once reaching the surface, these cracks can potentially act as sites for dental decay. Acting together like a forest of small flaws, tufts suppress the growth of these cracks by distributing the stress amongst them. “This is the first time that enigmatic developmental features, such as enamel tufts, have been shown to have any significance in tooth function,” said GW researcher Paul Constantino. “Crack growth is also hampered by the ‘basket weave’ microstructure of enamel, and by a ‘self-healing’ process whereby organic material fills cracks extended from the tufts, which themselves also become closed by organic matter. This type of infilling bonds the opposing crack walls, which increases the amount of force required to extend the crack later on.”

This research evolved as part of an interdisciplinary collaboration between anthropologists from the George Washington University and physical scientists from the National Institute of Standards and Technology in Gaithersburg, Md. The team studied tooth enamel in humans and sea otters, mammals with teeth showing remarkable resemblances to those of humans.


Located four blocks from the White House, the George Washington University was created by an Act of Congress in 1821. Today, GWU is the largest institution of higher education in the nation’s capital. The university offers comprehensive programs of undergraduate and graduate liberal arts study, as well as degree programs in medicine, public health, law, engineering, education, business and international affairs. Each year, GWU enrolls a diverse population of undergraduate, graduate and professional students from all 50 states, the District of Columbia and more than 150 countries.

(Source: George Washington University, www.gwu.edu)
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Leadership essentials for the ‘rookie’

By Sally McKenzie, CMC

Upon entering your first “real” dental practice either as an associate or as an owner, with the dental degree in hand and requisite experience on your resume, it’s likely that one thing became abundantly clear very early on: The learning process had only just begun. There is a whole lot more to a career in dentistry than most young dentists ever imagine.

Almost without warning, many are tossed into leadership roles seemingly overnight. And it’s that part of the job requirement that often leaves new dentists shaking their heads in bewilderment. Certainly, there is a lot to learn as a part of the job requirement that often leaves new dentists shaking their heads in bewilderment. Certainly, there is a lot to learn as a part of the job requirement that often leaves new dentists shaking their heads in bewilderment. Certainly, there is a lot to learn as a part of the job requirement that often leaves new dentists shaking their heads in bewilderment. Certainly, there is a lot to learn as a part of the job requirement that often leaves new dentists shaking their heads in bewilderment.

No. 1: Never assume

This is the common pitfall in leading employees: assuming that your staff knows what you want. Spell out your expectations and the employees’ responsibilities in black and white for every member of your team from the beginning. Do not convince yourself that because they’ve worked in this dental practice for X number of years that they know how you want things done. They don’t, and they will simply keep performing their responsibilities according to what they think you want unless they are directed otherwise.

For example, your scheduling coordinator may be very experienced in scheduling according to how other dentists want their days structured, which may, in fact, be very different from how you want your days scheduled. Most good employees want clear direction, and it’s tremendously frustrating for everyone when staff are forced to guess at what you want. So speak up.

No. 2: Staff success = your success

Recognize the strengths and weaknesses among your team members because all employees bring both to their positions. The fact is that some people are much better suited for certain responsibilities and not others. Just because Britanny has been handling insurance and collections for the practice doesn’t mean she’s effective in those areas. Look at results. Britanny may be much more successful at scheduling and recall and would be better suited for those functions. Don’t be afraid to restructure responsibilities to make the most of team strengths.

Invest in training early and often to build loyalty and ensure excellence.

No. 5: Give feedback often

Along with clear expectations, direction and guidance, employees crave feedback. Don’t be stingy. Give praise often and appraise performance regularly. Employees want to know where they stand and how they can improve. Verbal feedback can be given at any time, but it is most effective the moment the employee is engaging in the behavior that you either want to praise or correct.

If the assistant emphasizes to Mrs. Patient just how much she is going to absolutely love her new veneers and steers the patient clear of second guessing this investment she is about to make, tell her! Express your sincere appreciation and emphasize the value of the assistant’s contribution to the practice. Similarly, if employees need constructive feedback, don’t be shy with that either. If the front desk helper is talking about how gross she/he thinks that whole implant thing is, she/he needs education and constructive direction.

Nip problems in the bud or you’ll suffer numerous thorns in your side. If an employee is not fulfilling her/his responsibilities, address the issue privately and directly. Be prepared to discuss the key points of the problem as you see it, as well as possible resolutions.

Use performance reviews to motivate and encourage your team to thrive in their positions. Base performance measurements and reviews often critical information that is essential in your efforts to make major decisions regarding patients, financial concerns, management systems, productivity and staff in your new practice.

Know the numbers

Certainly, it doesn’t take long for every new dentist to realize that just as important as your role as dentist is your role as CEO. It is critical that you understand completely the business side of your practice. There are 22 practice systems, and you should be well versed in each of them. If not, seek out training for new dentists. The effectiveness of the practice systems will directly and profoundly impact your own success today and throughout your entire career.

Overhead. For starters, routinely monitor practice overhead. It should break down according to the following benchmarks to ensure that it is within the industry standard of 55 percent of collections.

- Dental supplies 5%
- Office supplies 2%
- Rent 5%
- Laboratory 10%
- Payroll 20%
- Payroll taxes and benefits 5%
- Miscellaneous 10%

Salaries. Keep a particularly close eye on staff salaries. These can mushroom out of control and send overhead into the 70–80 percent range in record time. Payroll should be between 20–22 percent of gross income. Tack on an additional 5–5 percent for payroll taxes and benefits. If your payroll costs are higher than that, here’s what may be happening:

- You have too many employees.
- More staff does not guarantee an improvement in efficiency or production. It does, however, guarantee an increase in overhead, unless you are hiring a patient coordinator who is going to make sure the schedule is full and production goals can be met.
- You are giving raises based on longevity rather than productivity/performance. If productivity is going down and overhead is going up, payroll cannot be increased. Establish a compensation policy stating that raises will be given based upon employee performance and only if the practice is making a profit.
- The hygiene department is not meeting the industry standard for production, which is 55 percent of total practice production. If the dentist steps back and takes a closer look at what is happening, he/she will find that the hygienists have far more down time than...
they should, patient retention is seriously lacking and periodontal treatment is minimal at best. The recall system, if there even is one, needs immediate attention to ensure that the hygiene schedule is full, the hygienist is scheduled to produce three times his/her salary and cancellations are filled.

Production. Hand-in-hand with practice overhead is production, and one area that directly affects your production is your schedule. Often times, new dentists simply want to be busy. Sure you want to be busy, but more important than being busy is being productive. Take the following measures to get your schedule on the path to productivity.

Start by using your schedule to meet production objectives. First, establish a goal. Let’s say yours is to break the million dollar mark. Taking 33 percent out for hygiene leaves the dentist with $670. This calculates to about $13,958 per week (taking four weeks out for vacation). Working 32 hours per week means the dentist will need to produce about $436 per hour.

A crown charged out at $950, which takes two appointments for a total of two hours, exceeds the per hour production goal by $59. This excess could be applied to any shortfall caused by smaller ticket procedures. Unfortunately, you are probably not doing crowns every hour on the hour.

Use the formula below to determine the rate of hourly production and whether you’re meeting your own personal production objectives.

1) The assistant logs the amount of time it takes to perform specific procedures. If the procedure takes the dentist three appointments, she/he should record the time needed for all three appointments.

2) Record the total fee for the procedure.

3) Determine the procedure value per hourly goal. Take the cost of the procedure — for example $215 — and divide it by the total time to perform the procedure, 50 minutes. The production per minute value is $4.50. Multiply that by 60 minutes to arrive at $270/hour.

4) The amount must equal or exceed the identified goal.

Now you can identify tasks that can be delegated and opportunities for training that will maximize the assistant’s functions. You also should be able to see more clearly how setup and tasks can be made more efficient. Thus, you’ll be well on your way to achieving your own production goals, whatever those may be.

In your practice, every system directly affects your success, as does every member of your team. Each is an extension of you. Your systems and your team will affect whether you have enough money to pay your bills. They will keep your schedule on track or off. They will tell you what you don’t want to hear when you don’t want to hear it. They will be a source of great joy and satisfaction, as well as anger and frustration. But no matter what, your success as a dentist is dependent upon your ability to lead your team effectively and manage your systems efficiently.

About the author

Sally McKenzie is CEO of McKenzie Management, which provides success-proven management solutions to dentistry nationwide. She is also editor of The Dentist’s Network Newsletter, www.thedentistsnetwork.net; e-Management Newsletter from www.mckenziemgmt.com; and The New Dentist™ magazine, www.thenewdentist.net. She can be reached at (877) 777.8151 or sallymck@mckenziemgmt.com.
Informatics and IT in dentistry: a look forward

Recently, Dr. John O’Keefe, the editor of the Journal of the Canadian Dental Association, interviewed Dr. Titus Schleyer, associate professor and director of the Center for Dental Informatics, University of Pittsburgh, about the development of health information technology in the context of the dental profession.

Dr. O’Keefe: What are the main developments you see in the areas of informatics and information technology (IT) as applied to dental practice?

Dr. Schleyer: We have gone through a tumultuous period of change and development in informatics and information technology over the last 15 to 20 years, so I think many of these trends will continue to develop. For instance, the Internet has influenced dental practice and life in general. I think we have seen changes that we could barely imagine 20 years ago.

The trends in how we use electronic technology in our lives and in managing information have emerged along with the new technology, and I think they will continue to mature and generate new surprises. In terms of concrete examples, we see that data and information are much more accessible and available than previously, and they are much better connected. We see patients having access to their medical records, looking at what physicians write about them and what they diagnose, and sometimes arguing about it, and thus taking a much more active role in their care. I think that is a development that will definitely influence dentistry.

We have almost ubiquitous information access. There are dentists who access their practice schedules through their Blackberries, cell phones and other devices. Some physicians write prescriptions from their hand-held computers. So I think ubiquitous information access will be a strong trend in the future.

Another big development I see accelerating is the move toward paperless practices, paperless being somewhat of a euphemism for “mostly computerized practices.” Paper never really goes away, even in the most highly computerized settings. Our research has shown that we see patients standing at the beginning of a rapid acceleration of computerization of dental practice with respect to pretty much everything: patient records, supply ordering, electronic communication with patients, and so on. Based on historical trends, we expect that there’ll be a rapid acceleration of dentists who will adopt these technologies in the future. You can either sit on the fence or jump off. I think times are right for more people to take the leap and jump into the fray of computer-based patient records in their practice.

What do you think are the main implications of the electronic patient record, and is there a difference between that and the electronic dental record?

Typically, people consider the electronic health record as something global that has everything related to a patient’s health in it. An electronic patient record is often used in specific reference to a health care area, for instance, as in an “electronic medical record” and an “electronic dental record.” I prefer the term, “electronic dental record,” for us because that identifies the dental component of the patient’s health. In general, the impact of electronic health records will be very significant.

As you know, the United States is targeting 2014 as the year when most Americans are supposed to have access to electronic health records. This now has been the stated goal of two successive presidents from different political parties, no less. Through this national goal and mandate, to speak, we will come to a much more transparent way of managing patient information.

As I mentioned earlier, patients now do take a look at their own health records and sometimes argue with the physicians about what’s in them. They detect errors that are in pretty much every patient record, and I think that will have a big impact. I think we will move away from patient records as incidental documents that we mainly create in order to protect ourselves from lawsuits. In the future, they will be a central tool that informs and guides how we care for patients.

When you look at how the United States conceptualizes electronic patient records, we’re not pursuing that concept as a goal in itself. The idea is to fundamentally improve patient care, as several reports from the Office of the National Coordinator for Health Information Technology have described. How do we do this? Number one, you give caregivers who need access to patient information the ability to access it. Number two, you connect personal health information to evidence-based resources in order to make sure that patients get the most appropriate care. And third, as I mentioned, you get the patients involved in their own health care through electronic access to their data.

So I think dentistry is a little bit behind here, but that is not necessarily a bad thing. However, we shouldn’t wait until a wave of patients washes over us when people march into our offices and demand the same kind of access to dental records that they have to their medical records.

Do you think that the patients having access to an electronic health record would have any impact on the relationship of a particular patient with a particular provider? Would it make patients more mobile?

In theory, patients’ mobility will be enhanced by easy access to their health information. But of course, we have to temper that view by asking whether, and to what degree, the difficulty and effort in obtaining records influences a patient’s decision to move to another dentist right now. Typically, if people are unhappy with their dentist, they’ll “pack up and go” to a new dentist. Maybe that will be slightly easier for them if they do not have to worry about getting their radiographs or particular pieces of their patient record to their new dentist. But I’ve never really felt that patients I talked to who switched dentists were particularly inhibited by the fact that they had to get a copy of the latest radiographs, for instance. So in the grand scheme of things...
Robert S. Graham, RFC, CFM
Certified Financial Manager
President/CEO

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Five of the top 10 reasons why associateships fail

By Eugene W. Heller, DDS

The “American Dream” is still to own a home. The “Dentist’s Dream” continues to be the ownership of a practice. Thirty years ago, the dream was to graduate from dental school, buy equipment, hang out a shingle and start practicing. Today the road to ownership is a little different.

Due to extensive debt, most new graduates enter practice as associates to improve their clinical skills, increase their speed and proficiency, and learn more about the business aspects of dentistry. Most hope the newfound associaship will lead to an eventual ownership position. Instead, many find themselves building up the value of their host dentist’s practice, only to be forced to leave the practice when the dentist retires or the practice is sold.

The following reveal the first five of the top 10 reasons many associateships fail to result in ownership or partnership.

Reason No. 1: purchase price
If the purchase price has not been determined before the commencement of employment, the parties find themselves on different ends of the spectrum as to what the practice is worth and what the buy-in price should be.

When purchase price is established before the commencement of employment, three out of four associateships lead to the intended equity position. Conversely, if the purchase price has not been determined, nine out of 10 associateships lead to termination without achieving the ownership intended or promised.

Reason No. 2: the details
The more items discussed and agreed to in writing beforehand, the better the chance of a successful equity ownership occurring as planned.

The written instruments should be two specific documents — an Employment Agreement detailing the responsibilities of each party for employment and a Letter of Intent detailing the proposed equity acquisition.

Reason No. 3: insufficient patient base
Approximately 1,000–1,200 active patients are required per dentist in a dental practice. If the junior dentist does not intend to restrict or cut back on his/her number of available clinical treatment hours, then the transition from a one-dentist to a two-dentist practice requires an active patient base of approximately 1,400–1,800 patients and a new patient flow of 25 or more new patients per month.

Many senior dentists count their number of active patients by counting the number of patient charts on a wall. However, the best way to estimate the active number of patients involves utilizing the hygiene recall count.

Insufficient numbers of patients and/or an insufficient new patient flow signals that all expenses relating to the new dentist are coming directly out of the bottom line. The practice then begins to experience financial pressure.

Creation and maintenance of a patient recall base is an extremely important aspect of the business. If the senior dentist is nearing retirement with the intent that, within one to two years, the senior dentist will turn over total ownership of the practice and intends to cut back shortly after the beginning of the second dentist’s employment, this problem is not as critical.

Often the senior dentist brings in an associate dentist as the answer to increasing business. A practice with insufficient new patient flow that experiences the addition of a new practitioner may result in termination of employment for the associate.

Reason No. 4: incompatible skills
The incompatibility in clinical skills between practitioners may include the possibility of one practitioner not being able to keep up-to-date more than that is currently the case. Currently, computer and information technology, whether they do it themselves or outsource it. But most dentists don’t have that much training in that and the number of dental schools who provide that training is relatively small.

This form of information retrieval is not that hard computationally. What is hard is that we have to separate the chaff from the wheat. We have to separate valid from invalid information. And, that’s a job that humans and dentists are very well qualified for, but I think a lot of the grunt work should be done by computers and there’s no reason why we can’t make them do that. Also, for dental offices, it means that the sophistication with which people look at the computer infrastructure has to rise significantly. One thing that we have to acknowledge is that dentists are the “chief information officers” for their businesses. They are in charge of managing all information technology, whether they do it themselves or outsource it. But most dentists don’t have that much training in that and the number of dental schools who provide that training is relatively small.

Look for part two of this interview in the next edition of Dental Tribune.

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 presently the national director of Transition Services for Henry Schein Professional Practice Transitions. For further information, please call (800) 730-8885 or send an e-mail to hsfs@henschein.com

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When It's Time to Buy, Sell, or Merge Your Practice

You Need A Partner in Your Side

ALABAMA
Birmingham- 4 Ops, 2 Hygiene Rms, GR $675K #11010
Birmingham Suburb- 3 Ops, 3 Hygiene Rooms #11016
CONTACT: Dr. Jim Cale @ 405-513-1573

ARIZONA
Shaw Low- 2 Ops, 2 Hygiene Rms, GR in 2007 $645,995
CONTACT: Tom Kinmel @ 602-516-3219

CALIFORNIA
Altaora - 5 Ops, GR $551K, 3 1/2 day work week #14279
Bakersfield- 7 Ops, 2,200 sq ft, GR $1,216,000 #14290
Central Valley - 4 Ops, 2,000 sq ft, GR #300K #14266
Dixie- 4 Ops - 2 Equipped, 1,100 sq ft, GR $135K #14265
Fresno- 5 Ops, 1,500 sq ft, GR $1,445,181 #14250
Fresno- In professional park. Take over lease. #14292
Lindale/Tulare- 2 practices, Combined GR $414 Mill #14240
Madera- 1,650 sq ft, 3 Ops, GR $549K #14269
Madera- 7 Ops, GR $1,921,467 #14283
Modesto- 12 Ops, GR $1,097,000, Same loc for 10 years #14283

Oroville-5 ops 3 days of hygiene 2005 GR $138K #14178
Porterville- 6 Ops, 2,000 sq ft, GR $2,290,000 #14291
Red Bluff- 8 ops, GR over $1Mill, Hygiene 10 days a wk. #14252
Redding- 5 Ops, 1950 sq ft #14292
San Francisco- 4 Ops, GR $875K, 1500 sq ft. #14288
San Marino- 6 Ops, 2,200 sq ft, GR $1,752K #14294
South Lake Tahoe - 3 Ops, 647 sq ft, 2007 GR $554K #14277
Thousand Oaks- General Prac, New Equip, Digital #14275
CONTACT: Dr. Dennis Hoover @ 800-519-3458

Grass Valley- 3 Ops, 1,500 sq ft, GR $714K #14272
Redding- 5 Ops, 2,200 sq ft, GR, $1 Million #14295
Santa Rosa- Private practice, Combined GR $214 millions #14286
Yuba City- 5 ops, day 4 hygs, 1,800 sq ft, GR $500K #14273
CONTACT: Dr. Thomas Wagnen @ 916-812-3523
Sunnyvale- 3 Pros - Potential for 4th, GR $271K #14285
CONTACT: Kelly McDonald @ 831-588-6023

CONNECTICUT
East Hartford - 2 Ops, GR $450K #16109
Fairfield Area- General practice doing $800K #16106
CONTACT: Dr. Don Cohen @ 845-460-3034

Portsmouth- 6 Ops, 2,000 sq ft, GR, $2,290,000 #14291

MASSACHUSETTS
Boston- 2 Ops, 1 Hygiene, GR $650K #30110
Boston- 2 Ops, GR $253K, Sale $197K #30122
Lowell- GR $400K #30106
Middlesex County- 7 Ops, GR $500K #30102
Somerville- GR $700K
Sturbridge- 5 Ops, GR $1,187,926 #30103
Western Massachusetts- 5 Ops, GR $1 Mill, Sale $1,516 #30116
CONTACT: Dr. Peter Goldberg @ 617-680-2930
New Bedford Area- 8 Ops, GR $650K #30119
CONTACT: Alex Lervik @ 617-240-2582

MICHIGAN
Suburban Detroit- 2 Ops, 1 Hygiene, GR $325K #31105
Grand Rapids Kentwood Area- 3 Ops, Building available. #31102
CONTACT: Dr. Jim Daval @ 586-530-0800

MINNESOTA
Crown Wing Country- 4 Ops #32104
Hastings- Nice suburban practice with 3 Ops #32103
Minneapolis- Location for associate #32105
Rochester Area- Location for associate #32106
Mankato- 6 Ops, GR $460K, Office shared with Ortho #31107

MISSISSIPPI
Eastern Central Mississippi- 10 Ops, 4,685 sq ft, GR $1.9 Mill #33101
CONTACT: Deanna Wright @ 800-730-8888

NEVADA
Carson City- 4 Ops #38103
CONTACT: Dr. Thomas Kelleher @ 603-661-7325

NEW JERSEY
Jersey City- 2 Ops, GR $216K, 2 days work #39107
CONTACT: Dr. Don Cohen @ 845-460-3034

Marlboro- Associate positions available #39102
CONTACT: Sharon Masierti @ 732-484-8071

NEW YORK
Bronx- GR $1 Million, Net over $500K #41105
Brooklyn- 4 Ops, 2 hygiene rooms, GR $1 Million, NR $600K #41108
Dutchess County- 80% Insurance, GR $200K #41106
CONTACT: Don Cohen @ 845-460-3034
Ononga- 3 Ops, Approx 1200 sq ft #41101
CONTACT: Deanna Wright @ 800-730-8883

Portum County-6 Ops, GR $1 Million #41102
CONTACT: Dr. Peter Goldberg @ 617-680-2930

Syracuse- 6 Ops all computerized, Dentrix and Dexis #41104
CONTACT: Donna Bambrick @ 315-430-0643

Syracuse- 4 Ops, 1,800 sq ft, GR in 2007 over $700K #41107
CONTACT: Richard Zalnik @ 651-851-0924
New York City- Specialty, 3 Ops, GR $400K #41109
CONTACT: Marty Hare @ 315-325-1313

NORTHERN OHIO
Ashland- 2 Ops, GR $180K, Sale $130K #42126
Lakewood- 2 Ops, GR $235K, Sale $197K #42122
Lebanon- GR $235, Sale $180K #42121
Pawling- 2 Ops, GR $235K #42124
Tibbetts- 2 Ops, GR $235K #42123

CONTACT: Dr. Peter Goldberg @ 617-680-2930
Syracuse- 4 Ops, 1,800 sq ft, GR in 2007 over $700K #41107
CONTACT: Richard Zalnik @ 651-851-0924
New York City- Specialty, 3 Ops, GR $400K #41109
CONTACT: Marty Hare @ 315-325-1313

NORTH CAROLINA
Charleston- 7 Ops - 5 Equipped #42142
Huntsville- 5 Ops #42122

FOOTNOTES
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Cosmetic periodontal surgery: pre-prosthetic soft-tissue ridge augmentation (Part 1)

By David L. Hoexter, BA, DMD, FACP, FICD

Dentists understand that patients demand outstanding esthetic, as well as physiological, results in all phases of dentistry today. This places an onus on dentists, who must therefore be able to apply the latest technologies and techniques to successfully achieve each patient’s unique esthetic desires. A successful esthetic means knowing how to create the right illusion, which is subjective for each individual. Yet, it can be measured in objective and subjective standards. How then can practitioners evaluate and achieve these goals?

To begin, there are certain basic and objective characteristics of a healthy periodontia that must first, before anything else, be observed, respected and maintained. A healthy periodontia is essential to achieving and maintaining restorative esthetics. Reddish inflamed periodontia immediately attract negative attention to the area. In contrast, a healthy zone of pink attached gingiva acts as a subtle background, providing dentists with significantly more restorative options for teeth.

Similarly, exposed gold crowns, gingival margins, exposed gingival porcelain jackets or laminate margins will draw negative attention. Also, crowns placed subgingivally in an inflamed area will probably lead to recession and an irregular gingival pattern resulting in dissatisfied patients.

After healthy periodontia has been achieved, color, hue, shape, form, symmetrical appearance and individual choice must then be discussed. At this point, the challenge of esthetic dentistry is at its zenith. Part 1 of this series is about the role of pre-prosthetic, cosmetic periodontal surgery to achieve and maintain healthy periodontia and to esthetically improve shape, color, form and appearance.

Clinicians should strive to achieve the appearance of a healthy symmetrical flow. For example, patients will not be satisfied very long with an oversized pontic placed in a large irregular edentulous area with a fixed bridge. It is unesthetic and retains food and plaque, which will lead to inflammation and periodontal disease. Often, a phonetic problem will also result. These patients will be thwarted in and frustrated by their hygiene efforts, and dissatisfied with the illusion of health and esthetics that they sought to achieve. Therefore, the relationship of a pontic and the abutment teeth to the gingival must be critically observed before the prosthetics are fabricated.

By esthetically and physiologically correcting the edentulous area with cosmetic periodontal surgery, restorative dentists are able to fabricate a correctly shaped prosthesis that enhances esthetics and function.

It is important to make an assessment before fabricating the prosthetics. In the past, large pontics were made to fill voids created by irregularly shaped, depressed edentulous ridges between abutments. The opportunity to build out and create a symetrically harmonious bridge that blends in with the abutment’s periodontia is currently available.

The following illustrates an example of how one such patient would benefit from cosmetic periodontal surgery.
Introducing Fusio™ Liquid Dentin, the flowable composite that tenaciously bonds to both dentin (25.5 MPa*) and enamel (22.7 MPa*) without acid etching or a bonding agent. By fusing together adhesive and restorative technology into a single product, we’ve created one of the most versatile materials in dentistry. Whether you use it as a dentin replacement, self-adhesive base liner, or a pit and fissure sealant, it doesn’t get any easier than this. Simply syringe into the preparation, agitate and light-cure. To find out just how Fusio Liquid Dentin can improve the way you practice dentistry, call 800-551-0283 or visit www.pentron.com.

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was assisted to an eventual harmonious and esthetically pleasing appearance.

Case 1
A 25-year-old woman presented to the office very interested in achieving a proper cosmetic look with a non-removable appliance. For years, she had been wearing a flipper removable replacement for her maxillary left central incisor (Fig. 1), which was traumatically lost during an accident (Fig. 2) when she was 15 years old. Following the accident, it was suggested by her restorative dentist (because of her young age) that she avoid a permanent splint and wait for the pulps of the adjacent teeth to mature. Years later, she was referred to me for pre-prosthetic cosmetic surgery that would allow for a non-removable, esthetically pleasing and physiologically maintained appliance.

Without the surgery, the permanent replacement would have been a large bulky pontic or physiologically sized pontic, which would have retained food and plaque because of a void between the gingival space of the pontic and the crest of the edentulous ridge. This void would then have created a dark and unesthetic contrast. If the pontic had been made smaller, there would have been a space between the pontic and the edentulous ridge in which food and plaque would also be retained.

If a removable appliance had been fabricated, the practitioner might have achieved an acrylic color that somewhat resembled the pinkish gingival area, but it would have been discernible. If a clasps partial was used for the removable prosthetics, the clasps would have been unsightly. An attachment type partial would require crowns to be prepared on the remaining abutments, and the contrast of the replacement tooth would have been detected next to the adjacent abutments. Either partial would have been an obvious replacement that contrasted with the adjacent teeth.

After consultation, it was determined that by using a combination of periodontal surgery techniques, the shape, height and form of the ridge could be corrected, enabling the restorative dentist to place a physiological crown. The edentulous ridge had a labial depression and an incisal edge that appeared concave (Figs. 3, 4). The tissue had to be built up incisally and labially, and a harmonious flow of pink attached gingivally had to be maintained.

Following a thorough evaluation, an autogenous connective tissue graft was placed subepithelialy to achieve a symmetrical look in one surgical procedure. After anesthetizing the patient, the flap outline and its reflection toward the labial were completed (Figs. 5, 6). The connective tissue donor site could have been selected from various areas. In this particular case, the tuberosity area was used. The donor tissue was de-epithelialized, and the deformed edentulous area was sculpted to the desired shape. The original flap outline was designed to prevent recession on the adjacent teeth and to provide a covering for the graft to avoid a keloid on the crest. During healing, a keloid would have been a different color, which would have detracted from the goal of harmonious color integration. The flap outline was then extended palatally to include more attached gingival, which avoided a keloid and retained the graft. When the autogenous free connective tissue graft was in the desired location (Fig. 7), the flap was repositioned and sutured for stability.

In this case, the patient had worn a flipper for years to replace a missing tooth. Following surgery, I reduced the existing flipper to allow space for the graft to heal. After an uneventful postoperative period, the patient healed and continued with good oral hygiene. The referring dentist had a choice of several restorative techniques. In this case, a fixed splint was fabricated with an acceptable pontic (Figs. 8a–e).

In a one-stage procedure, we avoided creating a dark area of labial depression and/or an irregular concave gingival crestal margin. A lengthy, unsightly pontic was replaced by a physiological, cosmetically acceptable, natural-looking pontic, and the patient was delighted.

Case 2
A second case demonstrates the use of the same technique in the posterior segment of a patient’s maxilla. An extreme buccal-incisal defect (Figs. 9, 10) was an extrac-
tion was done in a maxillary posterior area (Fig. 11). The soft-tissue ridge augmentation technique was done. A temporary provisional bridge shows the restored ridge enhancing the cleanliness and cosmetic appearance. The final prosthesis displays a prosthetic appliance that has been in her oral cavity for 20 years. This shows the longevity as well as the esthetic enhancement of the technique and its ability to enhance the prosthesis. The finished prosthesis, which is easily maintained by the patient, shows that the esthetic, umphysiologic defects were successfully corrected (Figs. 12, 13).

Summary

In these presentations, depressed concave ridges — one example in the anterior and the other in the posterior — were corrected using soft-tissue grafts. The results eliminated dark, depressed food gathering, unesthetic areas. This technique provides a pre-prosthetic treatment, thus avoiding large pontics, which as illustrated, make the area difficult to keep plaque free or cosmetically pleasing. The restorative dentist will then have a positive background to create the esthetic and physiologic prosthesis.

There must be constant communication between the periodontist, restorative dentist and the patient. Detailed techniques must be combined with artistic ideas and tempered with patience.

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Dr. David L. Hoexter is director of the International Academy for Dental Facial Esthetics, and a clinical professor in periodontics at Temple University, Philadelphia. He is a diplomate of implantology in the International Congress of Oral Implantologists as well as the American Society of Osseointegration, and a diplomate of the American Board of Aesthetic Dentistry.

Hoexter lectures throughout the world and has published nationally and internationally. He has been awarded 11 fellowships, including FACP, FICD and Pierre Fauchard. He maintains a practice at 654 Madison Ave., New York City, limited to periodontics, implantology and esthetic surgery. He can be reached at (212) 355-0004 or drdavidlh@aol.com.

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As the holiday season is a time for giving and helping others, the organi-
zers of the Greater New York Den-
tal Meeting (GNYDM) decided the 2008 meeting was the perfect oppor-
tunity to commence a new program focused on improving children’s oral
health. The program, “Greater New York Smiles,” was made possible
by joining efforts with the United
Federation of Teachers and Doral
of New York.

“We must teach our children the
importance of oral health early in
their childhood,” said General
Chairman of the Greater New York
Dental Meeting, Dr. Clifford Salm.
In order to introduce “Greater New
York Smiles” and other educational
programs, the meeting expanded its
exhibition area to almost double—ap-
nroximately 120,000 square feet.

Children from local schools in
all five New York City boroughs traveled
by special bus and field trip to last year’s 84th annual GNYDM at
the Jacob K. Javits Convention
Center. There they received oral hygiene
instruction in a child-friendly atmo-
sphere. The program emphasized
the importance of oral care in a way
that the children could understand
and showed step-by-step tooth care
utilizing proper brushing techni-
ques.

Their visit began with the children
viewing a film focused on increasing
their knowledge about the signifi-
cance of proper nutrition. One seg-
mment highlighted the effects of how
eating various foods can impact oral
health and why it is crucial to eat
healthy foods. After the film, they
watched a live demonstration that
taught them about dental floss and
showed them how to floss properly.

Finally, the children had the oppor-
tunity to practice their newly learned
brushing and flossing techniques at
sinks on the exhibit floor under the
supervision of dentists and volunteers.

Upon departure, each child went
home with a “goody bag” of dental
treats that included a toothbrush,
toothpaste, dental floss, erasers in
the shape of teeth and a dental
coloring book with crayons.

To maximize attendance, the
program ran for three school days—
Monday, Tuesday and Wednesday.

Twenty-four classes of third and
fourth grade students were able to
participate with a total of more than
950 children during the program’s
three days. Local television station
Fox News 5 filmed and broadcasted
the event on its evening news seg-
ment and made it available to affili-
ates throughout the country.

Hygiene students from the New
York University College of Dentistry
Dental Hygiene Program, the New
York College of Technology
Department of Dental Hygiene, Host-
tos Community College Department
of Dental Hygiene and members of the
Dental Hygienists’ Association
of the City of New York and the New
Jersey Dental Hygienists’ Association
volunteered their time and skills to
help carry out this new children’s pro-
gram. The volunteers said they were
 touched by the significant impact
that they were able to make on the
children.

“We are delighted that through
this program we were able to have
a positive impact on such a large
core of children by teaching them
skills that will benefit them for the
rest of their lives. We look forward
to reaching many more students this
year,” said Executive Director of the
Greater New York Dental Meeting,
Dr. Robert Edwah.

Be sure to watch the Web site,
www.gnydm.com, for information
and updates on this year’s expanded
“Greater New York Smiles” program and all the other new programs
offered at the 2009 GNYDM. Remem-
ber, there is never a pre-registration
fee. Mark your calendar for Nov.
27-Dec. 2 and come be a part of the
excitement of the 2009 Greater
New York Dental Meeting, as well as
ever experience all that New York has
to offer!

For additional information, please
contact the Greater New York Dental
Meeting at 370 Seventh Ave., Suite
800, New York, N.Y., 10018-1806; Tel.
(212) 384-6922; Fax (212) 384-6914;
e-mail info@gnydm.com.

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The Greater New York Dental Meeting has
heart, helps educate New York City’s children

It was time to spring forward in
more ways than one in March. While
many people reset their clocks that
month, DOCS Education initiated its
first Sedation Dentistry Safety Week
as an annual reminder for some
10,000 sedation dentistry dentists
and their staffs to review the proce-
dures, equipment and supplies used
with every patient.

Each day of the week focused on
a specific aspect of sedation denti-
stry such as important checklists for
dentists and patients, and the vital
role of dental assistants and staffs in
sedation dentistry procedures, and
also offered the opportunity for prac-
titioners and consumers to speak to
sedation dentistry experts. In addi-
tion, one dentist was recognized as
the Safe Sedation Dentist of the Year.

“No matter where a dentist
received sedation dentistry train-
ing, Sedation Dentistry Safety Week
is a reminder to all dentists and
their staffs that they must constantly
review every protocol, every piece
of equipment and their supplies,” said
Dr. Michael Silverman, president and
chair of Sedation Dentistry Safety
Week. Silverman, who co-founded
DOCS Education in 1989, is one of
the world’s top sedation dentistry
educators.

On March 11, DOCS Educa-
tion honored Tennessee dentist
Dr. Anthony Carrocci with the title
of 2009 Safe Sedation Dentist of
the Year, an award that recognizes
excellence in patient safety and com-
fort. Carrocci, who owns St. Bethle-
hem Dental Care in Clarksville, and
his staff have treated nearly 1,000
patients using sedation dentistry. He
has taken oral and I.V. sedation
courses at a number of organiza-
tions, and is a diplomate of DOCS
Education as well as a master of the
Academy of General Dentistry.

In addition, March 15 was des-
ignated as Talk to a Sedation Den-
tist Day by where sedation dentistry
experts answered 64 calls from
dental practitioners and patients
between the hours of 9:50 a.m. and
5:30 p.m. EST.

Please call DOCS Education at
(877) 525-5627 to speak to a sedation
dentistry expert or to get connect-
ed with a dentist practicing seda-
tion dentistry in your area because
there are sedation dentists in every
state in the U.S. state. You can also visit DOCS
online at www.DOCSeducation.com.

Effective April 12, 2009, Leonard
Osser, the founder of Milestone
Scientific, took over the CEO posi-
tion with Milestone Scientific
from his brother, Robert. Osser is back
in familiar territory as he held the CEO
position with Milestone Scientific
for 16 years.

“Mr. Osser is back in the
field. He is the founder of Milestone
Scientific and has returned to the
place where he creates the next
innovation,” said Dr. Anthony
Carrocci.

“Spring forward” into annual sedation dentistry safety reviews

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New leadership at Milestone Scientific

First Sedation Dentistry Safety Week held March 9-13

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online at www.DOCSeducation.com.

In addition, consumers with ques-
tions can call (888) 858-7972 or visit
www.seetheresponsibility.com to find
a sedation dentist in their area and
to listen to patient testimonials.

Next year’s Sedation Dentistry Safety Week will take place from
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**Bond Strength After Thermocycling**

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“I just got back from LVI and my world has changed. I can't possibly look at dentistry the same way again!”
– Dr. Balaji Srinivasan

“My LVI education has enabled me to not only survive, but to thrive.”
– Dr. James R. Harold

“There is nothing out there that even comes close to the LVI experience. The amount of enthusiasm I am bringing home with me is unbelievable. What an experience and a treat!”
– Dr. Robert S. Maupin

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DMG America launches new Web site

Consistent with its recent re-branding campaign, DMG America (formerly Zenith Dental), has launched a new, user-friendly Web site, dmg-america.com. The new site features detailed product information, company news, a convention calendar with booth information, end user specials and a representative locator for North America.

The dmg-america.com tool bar provides easy access to the product catalog, MSDS information, product literature and a Web site search engine. The product catalog is divided into logical categories including: provisional, core and bite registration material sections, and all of the other quality products. Clicking on any product brings a full description to the screen, including a list of features and benefits, as well as any special offers available. The About Us tool details DMG America’s history, mission, quality standards and contact information.

“We’ve designed dmg-america.com to showcase the products that have made DMG America such a strong leader in dental restorative products,” says Marketing Director Tim Haberstumpf. “dmgamerica.com is a great resource tool for detailed information on our entire product line.”

Perhaps the best feature is how simple it is to navigate between the Web site sections. Users can jump from a product description to a more detailed product brochure or the MSDS page or a physical properties page that lists information such as working time, setting time, flexural modulus and compression strength without losing track of where they were or planned to go next.

“DMG restorative products are among the most widely used in the dental industry,” Haberstumpf said. “Offering efficient access to product and company information, dmgamerica.com reinforces our commitment to quality customer service and our tradition of innovation.”

In keeping with its commitment to quality and excellence, dmgamerica.com will continue to expand in concert with the company’s growth. DMG America is in the process of developing a first-of-its-kind product, which officials believe represents a true leap forward in dental technology. Keep an eye on dmgamerica.com for further news.

For more information and a complete list of DMG America’s product offerings, please visit dmgamerica.com or call (800) 662-6585.
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