There are going to be rallies, there are going to be congressional visits and there are going to be tours of monuments. And that’s not even including the educational courses and hands-on workshops, the live clinical procedures or the exhibit hall teeming with new products and technology, all of which signal that the 110th Annual Session of the American Association of Orthodontists is about to get under way.

From April 30–May 4, orthodontists from across the country and the world, their staffs, orthodontic residents and guests will be taking over Washington, D.C., as the AAO pulls out all the stops to make this year’s meeting better than ever.

There will be a variety of new course topics to engage in, including an examination of how stem cells and tissue engineering may impact the future of orthodontics, a look at current issues surrounding oral bisphosphonates and a discussion regarding the issue of access to orthodontic treatment.

Other topics include the use of aligners, clinical guidelines for miniscrews, the past and future of imaging, esthetics, practice management and orthodontics for adults.

Miniscrews: a focal point in practice

I n view of the plethora of publications, courses and advertising material on this subject, it would seem that miniscrews are widely used. Once some candid questions have been asked and answered, however, it becomes apparent that the reality is quite different.

It seems evident that there are valid reasons that miniscrews are not yet in daily use in many practices. With this series, the authors intend to encourage those practitioners who are hesitant to use miniscrews to use them routinely, by providing a compendium of experiences and new findings in this field.

Anchorage in general

Moving a body requires anchorage in the form of a counter support. The force required for the movement acts on both body and abutment. In his “Third Law” (1687), Newton specified that every action has an equal and opposite reaction. In dento-facial orthopaedics, this means that the force acts on all teeth involved in the case of the dental support of a tooth movement. Thus, both bodies ultimately move.
What makes an orthodontist educated?

By Dennis J. Tartakouk, DMD, MSiD, PhD, Editor in Chief

A n orthodontic education often requires role learning. Den-
lists, for whom wholeness is so uniquely important, are almost
distinctively un-whole, a remediable consequence of their training.
Perhaps dentistry attracts indi-
vidualists or encourages them to become individual in nature. Mem-
ory objectively insists that even when the learning was without bias
and restricted to a certain workload without prejudice, it was simply more
esoteric in comparison to other brain functions. The field of orthodontics
incorporates the entire human exis-
tence. Whatever the reason, it can lead to unsuccessful behavior.

Doctors are great technicians with exceptional etiquette and skill-
ful hands, but personal philosophy should be left outside the office
doors like his or her shoes, which for the same reason would seri-
ously contaminate the realistic and theoretical nature of the business
of orthodontics. Amid intense appear-
tance. Whatever the reason, it can be
dangerous without under-
standing the fundamentals of why something occurred. Those indi-
viduals would be unable to modify
or adapt their practice skills to new
situations.

Teaching undergraduate stu-
dents ethics and morality is not
necessarily the answer. Teaching
non-medical courses at the under-
graduate level would undoubtedly
be extremely helpful. There is no
question the undergraduate cur-
culum is crowded, but if the only
way to seed exhausted and bored
brains with Plato or Aristotle is to
sacrifice a detailed and utterly irre-
levant knowledge of the origin and
insertion of the tibiae or the pre-
tis, then by all means do it.

Perhaps more could be required at the stage of selecting dental stu-
dents. Dental schools would most
likely admit that all the serious candidates have “A” grades and that
determining factors include other distinguishing character-istics
such as being president of the debate
team, captain of the baseball team or a spectacular interview. There is
no doubt the academicians would
be right, but maybe the problem is in getting the right candidates to
apply.

Other criterion might be consid-
ered or required such as courses in
civil rights, ethics and principles of
social justice. The individuals who
should be accepted must have the
will to strive to understand human
beings and behavior, and only want
to understand the DNA molecule or the function of cells in the tissue
because it’s a tiny but impor-
tant part of the human cocktail.
The moment someone sees the DNA mol-
ecule mainly as a money- or status-
generating machine, the brakes
should go on! Orthodontics can be a
self-perpetuating geek-ocracy.

Humanities and historians are
other ascending disciplines, but
until now they have been confined to
the province of a beleaguered minority of those who read such
epics as Victor E. Frankl’s “Man’s
Search for Meaning” rather than
those whose uncles were GPS. It
needs to be understood for its own
importance, receiving sympo-
thonic tribute from the secondary disci-
plines such as physiology, neuro-
logy and cardiology.

Accreditation should demand
that doctors do not smother their
way through a day of drug-company
sponsored propaganda on new NSAsDs, but rather take time to attend
local their book club or pub-
lic interest groups. The patients’
best interests are wider than his or
her “medical” best interests; they
should insist that the clinician
who conduct those best interest
resolves are doctors who work at
more than just orthodontic tech-
niques and their golf scores.

This is not a plea for a sniffl
ethical or content that requires
clinical reports. If you find a fac-
tual error or content that requires
accuracy in its news and

From the Editor

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Dental Tribune makes every effort to repor clinical information and manufactur-
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of the Royal Society of Medicine.
her or his subject matter without
to keep the company of musicians, art-
ists, writers and philosophers who
have struggled to understand the
nature of what homo sapiens are
and what makes them tick.

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involves consideration of all avail-
able evidence about human beings and
their place in the universe.

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tual error or content that requires
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k.colker@dental-tribune.com.
Going to AAO? What to know

What
American Association of Orthodontists’ 110th Annual Session

When
Friday, April 30–Tuesday, May 4

Where
Walter E. Washington Convention Center (WWCC), 801 Mount Vernon Place, Washington, D.C., 20001

Online
www.aaomembers.org/mtgs/2010-AAO-Annual-Session.cfm

Exhibit hall hours
• 9:30 a.m.–5 p.m. Saturday
• 9:30 a.m.–5 p.m. Sunday and Monday
• 9:30 a.m.–2 p.m. Tuesday

The exhibit hall is located in the WWCC Lower Level, Halls A and B. Dedicated hours are from 11:15 a.m.–1:15 p.m. daily.

Table clinics
2–5 p.m. Sunday in WWCC Hall C

Scientific posterboard exhibits
10 a.m.–5 p.m. Monday in WWCC Hall C

Attire
The official dress code of the AAO is business casual, which includes slacks and skirts.

C.E. pavilion
While attending the AAO, record the lectures you attend and print your C.E. hours report. The pavilion can be found at east registration on street level.

Shuttle schedule
Daily shuttle service will be provided between the WWCC and all AAO-designated hotels. Washington, D.C., rush-hour traffic is heavy, so make sure you leave ample time for your commute. Shuttle hours are as follows:
• 7:30 a.m.–6:30 p.m. Friday and Saturday
• 7 a.m.–6 p.m. Sunday and Monday

Shuttles operate at 15-minute intervals in the mornings from 7–10 a.m. and in the late afternoons from 5:30–6:30 p.m. and at 45-minute intervals from 10 a.m.–5:30 p.m. Friday–Monday. On Tuesday, intervals are 30 minutes all day.

Airport shuttle discounts
Two shuttle services, Shuttlefare and SuperShuttle/ExecuCar, are offering discounts to AAO attendees arriving at all three Washington, D.C. area airports. Reservations are required to receive the discounts.

To receive discounted pricing on your airport transportation, your reservation needs to be placed online through the links provided at www.aaomembers.org and you must use the coupon code at check-out.

AAOF Breakfast
Places were still available as of press time at $25 per person for the AAOF Breakfast, taking place at 7 a.m. Monday in the Renaissance Ballroom, West A. Breakfast includes the presentation of Blair Award to John Pershing for his service to the AAOF. Complimentary tickets will be offered to current orthodontic residents who sign up on site at the meeting. See the AAOF display at the meeting for more details.

Audio recordings
Pre-order an audio DVD-ROM of conference lectures for a pre-event discount price of $85. Details can be found at www.aaomembers.org.

Tours
Tickets are still available, as of press time, for many of the AAO activity programs. Choices include:
• “A Special Look at Washington,” 9 a.m.–1 p.m. Saturday, $32
• Mount Vernon with lunch at Gadsby’s Tavern, 9:30 a.m.–1:30 p.m. Saturday, $89
• Shopping in Georgetown with lunch at Filomena’s, 1–5 p.m. Saturday, $75
• “A Special Look at Washington” with boxed lunches, 9 a.m.–5 p.m. Sunday, $65
• Historic Annapolis with lunch at Treaty of Paris, 9 a.m.–5 p.m. Sunday, $126
• Arlington National Cemetery, 1–5 p.m. Sunday, $52
• “A Splashing Good Time! Aboard the DC Duck,” 1–5 p.m. Sunday, $74
• Capitol Hill, 9 a.m.–1 p.m. Monday, $66
• “Lincoln’s Life and Legacy” with lunch at Old Ebbitt Grill, 9:30 a.m.–5:30 p.m. Monday, $152
• “Monuments by Moonlight” with champagne and dessert, 8–11 p.m., $48
• Old Town Alexandria with lunch at Indigo Landing, 9 a.m.–5 p.m. Tuesday, $110.

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One course highlight is a special risk-management program that will focus on common concerns at the beginning of an orthodontic career. This seminar, featuring legal and insurance expert panelists, will take place the afternoon of April 30.

In addition, there will also be live clinical procedures by orthodontists on patients and filmed and broadcast live to both doctor and staff seminars. Topics include mini-implant insertion and application of laser technology.

The hands-on workshops are always a popular attraction. As of press time, two sessions still have openings: “New Lingual Straight Wire Method: A Look at the Future” (8 a.m. Sunday) and “TADs Applications for Invisible Orthodontics in Adults” (1:15 p.m. Sunday). You can register for these sessions online at www.aaomembers.org.

Social activities
The AAO Annual Session is full of activities that will keep you busy when you aren’t attending classes or checking out the exhibit hall. One such activity is the AAO Opening Ceremonies on Saturday, May 1. Come listen to the music of Frankie Valli and the Four Seasons and see a performance of the comedy “Defending the Caveman,” the longest running solo play that has ever appeared on Broadway, where it opened in 1995.

There is also still plenty of space available for many of the AAO tours. Activities include such things as a “Monuments by Moonlight” tour, shopping in Georgetown, a ride on the DC Duck, a congressional visit and a tour of historic Annapolis.

For a complete description of all AAO’s tours and to register, visit www.capitalcityevents.net/aoa2010.

Exhibit hall and more
More than 300 companies will show off their newest and best products in the exhibit hall from Saturday to Tuesday, and you don’t have to skip class to go shopping. Each day, 11:15 a.m. to 1:15 p.m. has been set aside as dedicated exhibit hall time.

Many companies are offering discounts, launching new products or putting on entertainment, such as political rallies, in their booths. (For more information on what will be in the exhibit hall, turn to Page 16.)

One company you’ll want to check out is Alliance Tech, which is providing smart phone applications that will enable attendees to review conference information and create schedules on their phones. Alliance Tech will rent iPod Touches to those who do not have smart phones but wish to use the technology. See www.aaomembers.org for details.

Ortho Tribune at the AAO
For plenty more information on this year’s AAO, including a look at new products and can’t-miss events, don’t miss the Ortho Tribune Daily Edition, available exclusively during the AAO Annual Session.
Finding something to do in Washington, D.C., is not a problem. Everywhere you look you can find an array of museums, monuments, outdoor activities and more. The real question is how to narrow it down.

Here are some destinations you might want to consider as you take in the sights of our nation’s capital.

**Passport D.C.**

Dozens of embassies and cultural centers open their doors to showcase their traditions, art, music, dance and cuisine in Cultural Tourism D.C.’s annual international celebration. It kicks off May 1 with 30 embassies offering various events and programs through Around the World Open Houses.

**Celebrate Elvis**

In honor of Elvis and the 75th anniversary of his birth, the exhibition, “Elvis! His Groundbreaking, Hip-Shaking, Newsmaking Story,” at The Newseum tells the story of Presley as he was portrayed in the news media and explores how his music and physicality pushed the boundaries of mainstream taste and free expression during a time when America was experiencing deep generational shifts. Produced in collaboration with Elvis Presley Enterprises, the display includes rare objects from the Graceland vaults that have never before been publicly displayed.

**Millennium Stage performance**

Take in a free performance at The Kennedy Center’s Millennium Stage every evening at 6 p.m. Acts include everything from performances by the National Symphony Orchestra to gospel groups to jazz musicians to poetry slams.

**Making money**

Make money (or see money made) with a free tour of the Bureau of Engraving and Printing.

**Gargoyle Tour**

Explore the beautiful grounds of the National Cathedral, then take a Gargoyle Tour ($10/adult, $5/child or $30/family), and see how these whimsical creatures reflect history in stone. There’s even one fashioned after Darth Vader.

**National Archives**

See the original Declaration of Independence, U.S. Constitution and Bill of Rights at the National Archives, then stick around to research your own family’s immigration records.

**Relive history**

Sit in the lobby of the Willard InterContinental Hotel to imagine history unfolding. The hotel is where Julia Ward Howe wrote “The Battle Hymn of the Republic,” where President Ulysses S. Grant popularized the term “lobbyist” and where Rev. Dr. Martin Luther King Jr. wrote his “I Have a Dream” speech.

**Neighborhood exploration**

Get out into D.C.’s neighborhoods to learn about history beyond the National Mall by experiencing Cultural Tourism D.C.’s free self-guided walking trails. They are marked with illustrated signs revealing the stories behind Washington’s historic neighborhoods.

**D.C. from above**

For a great and inspiring aerial view of the city (without the wait you’ll find at the Washington Monument), visit the Old Post Office Pavilion on Pennsylvania Avenue.

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**Head out into Washington, D.C.’s neighborhoods to see sights such as these rowhouses on Capitol Hill. (Photo/Destination DC)**

(Source: Destination DC)
The extent of movement and countermovement does, however, depend on the anchorage strength of the individual teeth, i.e., on the number and length of the roots, the root surface, and the structure of the surrounding bone.

Anchorage quality can be divided into three categories:
1. minimum anchorage;
2. medium anchorage; and
3. maximum anchorage.

These three categories can be described using the example of a conventional canine retraction after removal of a first premolar (Fig. 1).

In the case of minimal anchorage, the support is provided by the individual teeth. Figure 1a shows that a single premolar is not sufficient as an abutment to distalise a canine. The premolar is clearly mesialised in reaction to the application of force. Figure 1b shows how two, equally strong, anchorage segments are formed. Action and reaction are comparable in this case; the result is reciprocal tooth movement.

In the case of maximum anchorage (Fig. 1c), the posterior group of teeth is secured and held stationary by using a miniscrew. The canine can be retracted by the complete force vector, as the reactive force is completely absorbed by the anchorage block formed.

Apart from anchorage quality, the basis, i.e., the type of anchorage location, plays a role:

Dental or desmodontal support:
- use of additional intra-oral devices (nance, palatal arch, lingual arch, lip bumper);
- modification of fixed appliance (buccal root torque, blocking);
- incorporation of the teeth of the other jaw (Class II or III elastic bands).

Extra-oral support:
- headgear; and
- face mask.

Enossal support:
- implants, miniscrews, etc.

This article only deals with anchorage in bony structures. The terms skeletal or cortical anchorage are used interchangeably in this case.

History and overview of skeletal anchorage
Bony anchorage has its roots in Gainsforth’s unsuccessful attempt to insert screws into the jawbone as load anchors in 1945. Many later experiments were unsuccessful and the method had become obsolete by the late 1970s.

From 1980 onward, various research groups (such as Creekmore, Roberts, and Turley) took up the subject once more. Creekmore published the first, clinically successful patient treatment case.

There are now numerous options for cortical anchorage: gap closure (Fig. 2), including (artificial or pathologically) ankylosed teeth on the basis of miniplates normally used in cranio-maxillo-facial surgery and the use of prosthetic implants.

In recent years, the requirements for cortical anchorage techniques have been defined in the literature. However, upon closer inspection, only orthopaedic mini-implants met these requirements favourably, in terms of:
- biocompatibility;
- small size;
- simplicity of insertion and use;
- primary stability;
- immediate load capacity;
- adequate resistance against orthodontic forces;
- usability with standard orthodontic appliances;
- independence of patient cooperation;
- clinically superior results in comparison with standard alternatives;
- ease of removal; and
- cost-effectiveness.
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**Mini-implants**

Any form of skeletal anchorage, including miniscrews, is by definition an implant: “An implant is an artificial material implanted into the body, which is to remain there either permanently or for an extended period.”

More than 30 different terms for orthodontic screws are used in the international literature. The most common of these are mini-implant and miniscrew, while the terms minipin or pin are preferred when speaking to patients.

At present, there are more than 30 manufacturers of miniscrew systems (Fig. 5a–h). The number of screws per system ranges from two to 154 different types.

In order to assist practitioners in selecting such devices according to their practice’s needs, the most important decision-making criteria for choosing implant systems are discussed below.

**Material**

All miniscrews are made from pure titanium or from an alloy of titanium with aluminium or vanadium. The biocompatibility of such materials, the metal surface of which is in direct contact with the bone, has been firmly established.11–14

**Osseointegration**

Brånemark was the first to define the concept of osseointegration, which he described as “a direct functional and structural link between living bone tissue and the surface of a force-absorbing implant.”15–17

Several authors, such as Costa and Maino, view anchoring a miniscrew not as osseointegration, but as a skeletal resistance block.18,19 In the opinion of Cope and Bumann, miniscrews are anchored by mechanical stabilisation and not by osseointegration.20,21

**Diameter of the miniscrew**

The diameter of the miniscrews on the market varies between 1.2 and 2.5 mm. Diameter specifications of a screw normally refer to its outer diameter, i.e., the size of the shaft, including the thread.

For secure and primarily mechanical anchorage, a certain amount of bone is required around the screw. To date there have been no studies on the amount of bone actually required; the information available suggests 0.5 to 2 mm. At an interradicular level, the amount of space available prescribes the maximum diameter of the screw. Poggio et al.22, Schnelle et al.23, and Costa et al.24–25 provide some suggestions as to the vertical space required, i.e., the space between the enamel/cement interface and the mucogingival line. These investigations clearly indicate that the diameter of a miniscrew should not exceed 1.6 mm. It should be noted that the stability of a miniscrew in the bone depends on its diameter and not on its length.26–27

**Length of the miniscrew**

The length of the miniscrews on the market varies between 5 and 14 mm. Length specifications of a miniscrew usually refer to the shaft, i.e., the threaded section.

Like the diameter, the length of the screw selected depends on the amount of bone available. Depending on the region, the total thickness of the bone is between 4 and 16 mm.28

The length of a screw is of secondary importance to the diameter when it comes to secure anchorage, as mentioned above. Various studies have shown that it is the thickness of the cortical section that plays a more important role.29 As far as the distribution of force over the body of the screw is concerned, FEM analyses have shown that the load is applied only in the region of the cortical bone.30–31

When selecting the length of the screw, the depth of the gingiva must also be taken into account, with an average layer depth of 1.25 mm. Thus, the ratio between the length of the head (the part of the screw outside the bone) and the length of the threaded section (the part of the screw inside the bone) should be at least 1:1.

Poggio et al.22 recommend lengths of 6 to 8 mm. Costa24–25 suggests miniscrews with a length of between 6 and 10 mm. Based on these studies, it would appear that it’s not necessary to use longer screws. This has been confirmed by numerous clinical studies.

Easy identification of length and diameter through colour-coding of the screws can be accomplished by means of anodisation, using for example, Ortho easy (FORESTA-DENT).

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**Fig. 6: The stress resistance (fracture level in N/cm) depends on the diameter of the miniscrew (according to Kyung, modification by the authors).**

**Figs. 7a, 7b: Interradicular X-ray image showing spatial ratios.**

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**AD**

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**Fig. 5: Miniscrew systems.**

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**AD**
A positive side effect of this is that the oxide layer formed results in firmer anchorage of the implant in the bone.34

Screw head
Some suppliers have a special head variant for each potential application in their range, such as:
• hook tops;
• ball-shaped heads;
• eyelets;
• simple slots;
• cross-shaped slots; and
• universal heads (Figs. 8a–8d).

The screw head should be very small and compact, to ensure that the patient experiences minimal discomfort. However, it must be large enough for the coupling elements to be securely fastened to it (Figs. 9a, 9b).

Transgingival portion
The transgingival portion, also known as the gingival neck, is the most vulnerable part of an implant or a miniscrew. Perforation of the gingiva provides a potential access point for microorganisms, posing the risk of peri-mucositis or peri-implantitis. This is one of the main causes of the premature loss of miniscrews.35–36

During the immediate post-operative phase, the mucosa should be as close as possible to the screw, to seal the area.35 The most advantageous shape transgingival collum is that of a cone, as this shape naturally results in safe sealing without a pressure zone. This makes it more difficult for micro-organisms to penetrate, thus preventing infections. The cone shape also seals the perforation wound, as if a cork would seal a bottle, thus reducing bleeding.

Conclusion
The correct method of anchorage with regard to shape and quality is crucial for successful treatment. Maximum anchorage is not necessary in all cases, and thus, neither is the use of a miniscrew necessarily essential.

From an historical point of view, the cortical anchorage system is, in common with other jaw orthodontic techniques, not new at all. The idea was conceived more than 75 years ago.

Of all forms of skeletal anchorage, the mini-implant is the most universally used and is the most suitable for routine use.

However, before practitioners can select the most appropriate miniscrew for use in their practice from the large range on offer, they will need to review the literature thoroughly.37

Editorial note: A complete list of references is available from the publisher. This article first appeared in Dental Tribune Asia Pacific, Nos. 1 & 2, 2009. The next edition of Ortho Tribune will feature “Part II — Basic information on the insertion of miniscrews.” All photos were provided by the authors.
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Embracing online communities

Find patients on Facebook

By Angela Weber, OrthoSynetics

Can an orthodontist build a practice without word-of-mouth? It’s not likely.

At Orthosynetics, a business service firm for orthodontic practices, we find that at least half — and often much more — of our clients' new patients come from personal and professional referrals. As Americans increasingly gravitate to online communities for their social connections, the word-of-mouth referral stream is moving online, too.

Orthodontists need to position their practices within social networks in order to make referrals easy to pass along.

LinkedIn is a good platform to network among other professionals, and Twitter is for more involved users. But because of its widespread popularity, Facebook is the ideal place for orthodontists interested in social networking to start.

More than 100 million Americans had Facebook accounts at the end of last year, representing a 141 percent annual growth.

Although Facebook focuses on connecting people with their friends, families and colleagues, businesses are welcome, too. The site allows companies large and small to set up their own Facebook pages for free. Somewhat different than profiles, which are for individuals, Facebook pages are designed especially for businesses to interact with their customers in a new way.

Before the Internet, the advertising model was top-down. Companies controlled the message and hoped to convince consumers to think great things about a product or service. Now, social networking encourages conversations across the business-customer divide to create personal ties and forge connections.

Your office won’t be just a place for your patients to come every so often; it will become part of the fabric of their lives.

Once you set up a page for your orthodontia practice, your next step is to build a following. Through Facebook, patients can become a “fan” of your practice, and once they “fan” you, their friends will become aware of your page. They may choose to become fans, too. Even if they don’t right away, Facebook pages allow your patients to give your practice a seal of approval.

It’s simpler than a traditional referral in which two parties have to have an actual conversation about your practice. With Facebook, a prospective patient looking for an orthodontist can happen upon your practice even when the referral source is off doing something else.

A bit of effort is needed to build a sizable following, however. We recommend adding Facebook page links to your Web site and e-mails. Mention it in your mailings, on print advertisements and when talking with patients on the phone or in person.

What’s more, simply having a Facebook page isn’t enough. For it to work as a marketing tool, you need to actively update it. On individual profiles, users type in status updates about what they’re doing or thinking, and the same goes true for a business’s page.

Dental tips and practical reminders work well as content, but we recommend mixing it up with casual comments. It is social networking after all, so keep things social.

You and your staff should feel free to post vacation pictures and to use a conversational tone. And your practice’s daily updates might include, “The office is ordering pizza for lunch” or “We saw that Target is having a sale on Water-piks.”

Your patients can respond to your postings (and their networks will all know about it). Also, the next day when patients come in, you might be asked about how that pizza lunch went or thanked for posting about that sale.

Some orthodontists worry that bringing Facebook into their offices will distract from their practice. A professional approach can manage this concern. One idea is to assign a single staff member to be in charge of the page and to confine all Facebook activity to certain times of day.

At Orthosynetics, a business service company in the orthodontic and dental industries, we have more than 10 years experience in health-care marketing, working with practices throughout the United States. She knows her way around a profit-and-loss statement; the focus of her marketing strategies is to make a positive impact on the practice’s profitability.

OSI has helped numerous practices achieve marketing success through strategy, creativity and implementation. Expertise includes generating new patient revenue through Internet, mass media and traditional marketing efforts.

At the AAO

Interested in learning more about how social networking can help your practice? Visit Orthosynetics at booth No. 1813. At the booth, learn how to set up a Facebook page for free. Not attending the AAO? Call Angela Weber at (888) 622-7845 for a one-on-one tutorial.

About the author

Angela Weber is the director of marketing for Orthosynetics, Inc. (OSI), a business service company in the orthodontic and dental industries. She has more than 10 years experience in health-care marketing, working with practices throughout the United States. She knows her way around a profit-and-loss statement; the focus of her marketing strategies is to make a positive impact on the practice’s profitability.

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At the same time, bear in mind that Facebook might also spur productivity. Social networking can be a more effective communication tool than a round of phone calls.

When used properly, social networking is an inexpensive way to generate referrals while strengthening ties between your patients and your practice. Right now, some orthodontists may see it as a nice but unnecessary component of a marketing program; however, as social networks continue to move online, a presence on these platforms will become essential.
Did you survive the 2009 Google Maps restructuring?

By Mary Kay Miller

In September 2009, the Google Local Business Center (Maps) began a major overhaul that kicked more than 50 percent of all local businesses off the maps, including orthodontists, eliminating a large source of free advertising in local areas. However, over a period of months, those listings returned, sometimes in their town or city.

Today, six months later, a strategic reduction in local listings is still taking place. The dust hasn’t yet settled on local business listings on the maps. With a half billion searches occurring every month in local areas, you can’t afford not to pay attention to local business Internet marketing.

Since September, I have spent more hours than I want to count researching the aftermath for my clients. This is what I found:

• All practices lost exposure in surrounding areas on the maps.
• Most survived the cut in local areas, you can’t afford not to pay attention to local business Internet marketing.
• All practices lost exposure in surrounding areas on the maps. If originally set up correctly for top orthodontic consumer keywords: orthodontist, braces, invisalign and orthodontics. Many practices are not so lucky.
• Some practices lost ground with a few major new patient orthodontic patients visiting its site for information and research, you must play by its rules, which change constantly, without notice, to stay ahead of professional spammers. Google prospers with pay-per-click advertising

Google and the other search engines are in business to make money, just as you are. Business advertising is their main source of income. By reducing the exposure of businesses on the maps, it encourages more businesses to advertise with pay-per-click (PPC) campaigns, especially in metropolitan areas, as a way to obtain a page one listing. If you are already on page one of the maps and natural page ranking in your area, PPC programs are redundant.

The update was an attempt to appease current PPC customers upset with free local listings competing with their paid advertising. Statistics report that at least 70 percent of consumers will not click on a “paid for ad” when searching in local areas.

However, the maps area is one of the first areas visitors see and use as a research tool. From a business standpoint, restructuring solved multiple issues and forces more businesses to sign up for PPC advertising to gain exposure.

How was Google Maps restructured?

Google originally reduced the number of listings from 10 to seven or less in all local areas throughout the country. Over a period of a few months, in some areas, the maps listings were reduced from 10 to three or less. This was a 70 percent or more reduction (see examples). If your practice was one of the practices are not so lucky.

The map is the first area visitors see when searching in local areas. It is the No. 1 source of information for top orthodontic consumer keywords: orthodontist, braces, invisalign and orthodontics. Many practices are not so lucky.

Your best strategy to be competitive in Internet marketing is to proactively stay on top of the ever-changing Internet marketing opportunities.

• Whether you do it yourself, or outsource services to Internet marketing vendors, regularly test for success using major consumer keywords to determine Internet visibility in your local area.

Free video training on how to test your Web site and local business maps listing is available on www.orthopreneur.com and www.youtube.com/user/OrthodonticMarketing.

Continual monitoring of your Internet marketing presence is critical to your online marketing success today and for the future growth of your practice. Don’t be left in the dust by your online competitors. Be proactive for maximum Internet-marketing results.

To learn more about Internet marketing, stop by the Orthopreneur booth, No. 517, during the AAO.

For more information, call toll-free (877) 295-5611 to schedule a free half-hour consultation to review your Internet marketing efforts or visit Miller’s blog at www.orthopreneur.com for free training.

Local business services worth their weight in gold

The map is the first area visitors see when searching in local areas for businesses.

You have no control over your positioning on the maps, and I have found SEO not to be a major factor. Listings are based on location, correct setup, reviews and other unknown factors known only to Google.

Count your blessings if your listing is visible on “page one maps” for top orthodontic consumer keywords: orthodontist, braces, invisalign and orthodontics. Many practices are not so lucky.

• What are your marketing results.
• Whether they are in business to make money, just as you are. Business advertising is their main source of income. By reducing the exposure of businesses on the maps, it encourages more businesses to advertise with pay-per-click (PPC) campaigns, especially in metropolitan areas, as a way to obtain a page one listing. If you are already on page one of the maps and natural page ranking in your area, PPC programs are redundant.

During information gathering, they also check out competitors, opening the door for other practices to grab the attention of interested new patients.

Your Web site, whether accessed off the maps, natural page ranking or through PPC, is the first contact new patients have with your practice. The first contact is no longer the new patient phone call. It is the Internet. Your local map listing is an important piece of the Internet marketing puzzle.

Online business services worth their weight in gold

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Preparing for the Total Ortho Success Practice Makeover

By Jennifer Van Gramins and Cheri Bleyer

T
he process of practice transformation has begun for Dr. Michelle Gonzalez, a San Rafa-
el, Calif., orthodontist who won the second Levin Group Total Ortho Success Practice Makeover. She and her team are ready to implement Levin Group’s patented management and marketing systems that lead to increased production, starts and referrals while improving efficiency and reducing stress.

“I have an amazing practice,” Gonzalez said. “I feel very fortunate to have won this opportunity to learn how to improve my practice. I love what I do, and I want to be the best I can be.”

For the next 12 months, we will be taking a journey with Gonzale-
ze and her team, guiding them to reach their practice’s full potential. During this yearlong process, Jen Van Gramins will work with the team to incorporate documented management systems throughout the practice. Cheri Bleyer will concentrate on implementing a consistent referral marketing program and devising appropriate strategies.

Participating in both management and marketing consulting programs simultaneously will dramatically enhance the practice’s ability to increase production while reducing stress. Gonzalez and her staff will be actively involved in making the critical management and marketing changes to grow the practice. Throughout 2010, Gonzalez’s progress will be profiled in the pages of Ortho Tribune, allowing readers to get an insider’s view of the consulting process and its positive impact on orthodontic practice success.

As the months go by, we will give you an in-depth look at Gonzalez’s practice. It is the hope of Levin Group and Ortho Tribune that the strategies and ideas that we share with you will inspire you to jump-start your own practice makeover. Let us introduce you to Dr. Gonzalez and her practice.

Location profile: San Rafael, Calif.
- Type of community: suburban
- Population: 55,602
- Median household income: $69,452
- Description: Northern suburb of San Francisco

Office profile
- Locations: One
- Location: Since 1996
- Orthodontists: One
- Staff: Six — Four full-time, two part-time team members. Full-time staff includes two clinical assistants and two front desk coordinators.
- Treatment chairs: Four
- Days open: Three — Practice is open on a fourth day to complete administrative paperwork.

Orthodontist profile
- Dental school: University of California, San Francisco
- Years in practice: 18
- Years in this practice: 15
- Status: Married with two children
- Practice aspirations: More efficient operations with additional referring dentists, leading to greater productivity and increased profit in a low-stress environment.

Gonzalez’s chief concerns
- The economy: The area has been hit by slowdowns in several employment sectors, though things have improved in the last year. Still, orthodontics is a significant investment for any patient or parent, and a sluggish economy can cause potential patients to postpone treatment.
- The schedule: A more balanced and efficient schedule to create less stressful days.
- Collections: A more effective system that reduces overdue account receivables, which have grown recently in the slower economy.
- Stress: Some days (or parts of days) are extremely stressful. Implementing step-by-step systems, including Power Cell Scheduling”, will go a long way toward reducing unnecessary stress.
- Marketing: Referral marketing is often inconsistent and only occurs at certain times of the year. A structured referral program is crucial to expanding the referral base and increasing production.

Gonzalez’s 12-month program consists of three phases with each phase featuring interactive workshops and private conferences to discuss individual practice issues. Her practice will benefit from Levin Group’s Practice Production Generators™ — state-of-the-art practice management tools that allow offices to smoothly implement high-performance systems.

This month, Gonzalez’s office will begin Phase I of her consulting program.
- Develop a vision for the practice
- Learn Levin Group’s Power Cell Scheduling
- Identify the goals to achieve during the yearlong program
- Create an Ortho LifeMap™ Begin implementing Practice Production Generators

In our next article, we will document our two-day visit to Dr. Gonzalez’s office. On the first day, we observe a normal day of practice operations to evaluate first-hand the office’s assets and challenges. The second day is devoted to teaching the critical systems and processes that will lay the groundwork for a year of growth and success.

Conclusion
Gonzalez starts her Total Ortho Success Practice Makeover in a great position. She already has a successful practice and a strong team. With Levin Group’s expert management and marketing systems, she is in position to become even more successful.

She opened her practice nearly 15 years ago and has a strong reputation in the community. The next 10 years are prime years for growing her practice, but this period is also a time when many orthodontic practices hit a plateau. Some clinicians rely on the same systems they had when they were starting out.

Unfortunately, as practices mature, systems age and become inundated with inefficiencies. Practice management consulting can help practices avoid the pitfalls of outdated systems and maintain steady growth for years to come.

Gonzalez realizes that she and her team have not tapped into the practice’s full potential. “The foundation is there — we just need guidance and systems in place to take us to the next level so that we can practice more effectively.”

To jumpstart your own Total Success Ortho Practice Makeover, come experience Dr. Roger Levin’s next Total Ortho Success™ Seminar being held June 17-18 in Las Vegas. Ortho Tribune readers are entitled to a 20 percent courtesy. To receive this courtesy, call (888) 973-0000 and mention “Ortho Tribune” or e-mail customerservice@levingroup.com with “Ortho Tribune Courtesy” in the subject line.

(“U.S. Census.”

About the authors
Cheri Bleyer, Levin Group senior consultant
Bleyer joined Levin Group in 2005 as a Levin Group orthodontic management and marketing consultant. As a senior consultant, Bleyer has played a key role in the development of Levin Group’s ever-expanding marketing program, and she regularly lectures at the Levin Advanced Learning Institute.

Jen Van Gramins, Levin Group consultant
Van Gramins has spent the last four years working as a Levin Group orthodontic management consultant. Prior to that, she managed medical and dental practices for 12 years. She served as practice manager for Oral Health
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One-beam radiography is steering orthodontists in the right direction — leading straight to the most effective diagnosis for the patient. Treatment planning can only begin if the practitioner has a true picture of all of the facts, and one-beam radiography provides those details that may be missed on 2-D images.

For diagnostics and treatment planning, 3-D images can be sliced and rotated to discover such vital information as precise tooth positions and bone dimension and quality. Many orthodontists report extraordinary findings that alter the original perception of necessary treatment. The scope of information gained from a 3-D image is not available with 2-D radiography.

The opportunity to capture these dental structures with such precision is also invaluable for a range of dental practitioners — oral surgeons, periodontists and general dentists.

Here are some eyewitness examples of how cone-beam scans uncovered the “truth” of the patients’ dental mysteries, avoiding the possible “consequences” of alternative treatments.

Bradford Edgren, DDS, MS, (Orthodontic Associates of Greeley, PC, Greeley, Colo.)

“In this case [Fig. 1], before starting phase II treatment, we were waiting patiently for the second permanent molar to erupt. Between finishing phase I treatment and the time at which the other three second molars erupted, we acquired our 3-D cone-beam scanner (i-CAT™) and took an EFOV [extended field of view] scan as part of our progress records.

“The scan showed that an impacted third molar was impeding the eruption of the maxillary right second molar. The fourth third molar was not evident on previous pan X-ray because of its perfect superimposition palatally to the second molar. This second molar may never have erupted, or worse yet, could have been presumed to be anklylosed. To date, all four thirds have been extracted and the right second molar has fully erupted.”

Edward Y. Lin, DDS, MS, (Apple Creek Orthodontics, Appleton, Wis.)

“This patient [Fig. 2] lived with an abscess that had gone undetected for some time. I received this 2-D panoramic X-ray because of its perfect superimposition palatally to the second molar. The third molar was not evident on previous pan X-ray because of its perfect superimposition palatally to the second molar. This second molar may never have erupted, or worse yet, could have been presumed to be anklylosed. To date, all four thirds have been extracted and the right second molar has fully erupted.”

John Graham, DDS, MS, (Graham Orthodontics, Litchfield Park, Ariz)

“This patient [Fig. 2] was referred to my office for an orthodontic evaluation by her general dentist. Her 2-D panoramic X-ray demonstrates an impacted maxillary right cuspid located horizontally above the incisors. CBCT cross-section images reveal the relationship between the impacted and adjacent teeth, as well as any associated root involvement. “While the 2-D pan shows the impaction as a mere superimposition, with the i-CAT scan, it is possible to discern the exact location of the tooth relative to the surrounding teeth and bone as well as the pre-existing apical root resorption. This vital information allowed for a less-invasive surgery and guided me to the most appropriate treatment plan.”

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 feedback@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 six weeks to process.

Get rallied up for OrthoBanc at AAO

If you are going to the American Association of Orthodontists Annual Session in Washington, D.C., you’ll want to stop by the OrthoBanc booth (No. 2535). OrthoBanc, a payment drafting and management company, always creates a buzz at the AAO with its city-themed booth activities.

Last year, OrthoBanc’s Boston Tea Parties were standing room only. Clever giveaways and attention to detail landed OrthoBanc’s Marla Merritt an All Star Award in Exhibitor Magazine, a national publication directed at the trade show industry.

Merritt says D.C. promises to be even more exciting and informative as she delivers campaign promises in a political rally setting. “OrthoBanc can provide real change for a practice looking to become more efficient and profitable. We love telling our story in a fun setting, and we have some great plans for our D.C. rallies in the ‘Choose OrthoBanc’ booth.”

At the AAO

For a presentation schedule and to reserve a space at one of the rallies, call OrthoBanc at (988) 738-0585, then be sure to stop by the booth, No. 2535, during the AAO.
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To learn more, call us at 888.851.0533.
Invisalign Teen helps orthodontist brand practice

Dr. David Carter considers himself a pretty savvy marketer in these times of digital communications and social media. He uses the Web a lot, advertising on AOL and other channels. He knows that a modest investment with Google Ads can attract a more-than-modest number of people to schedule a new-exam appointment. He’s also very active on Facebook and Twitter.

But Carter realizes the most powerful tool in his marketing arsenal is his offering of Invisalign Teen™, which effectively makes his practice the place for adolescents to go in the Augusta, Ga., area. The kids, after all, see Carter’s ads on TV, and current patients refer many of their friends and classmates at school.

“Think about it,” Carter says. “How many orthodontic products that appeal to teens have the word ‘teen’ in it?”

Carter finds that if there’s any initial resistance to the product, it tends to come from parents, who — knowing their own kids — may be skeptical that their children will wear Invisalign aligners as much as they’re supposed to, or that they’ll brush and floss regularly. But in Carter’s experience, for those who have chosen Invisalign Teen, the opposite has been the case.

“The compliance indicators work like a charm,” he says, “putting just a little bit of fear into the kids, because they know I’ll know. And when it comes to hygiene, the teens feel like they’ve got something to prove to their parents. I haven’t had any problems, in either their dental health or their compliance, with my Invisalign Teen patients.”

Carter is also sold on Invisalign Teen’s efficacy, which he believes is just as good as that of traditional braces. One advantage of Invisalign Teen has been the introduction of the product’s power ridges, a feature that allows Carter to get better torque on a tooth, making it easier to change to the proper angle in the gum.

He also takes full advantage of Align’s Best Practices Protocol, a program that allows him to access tips and techniques from orthodontists around the country on a variety of technical aspects, from how much to move a particular tooth to how quickly — or slowly — it should be moved.

All of this has allowed Carter to discover his own innovative best practices in the case of a recent case in which he employed the aligners to help pull down, using reciprocal force, a permanent eye tooth in the top palette. He covered the resulting cosmetically unattractive gap by placing a fake tooth in the aligner — a simple yet elegant solution that would not have been possible with traditional braces.

In the course of his normal work, Carter says he notices significant efficiencies in speed (“I can see three Invisalign Teen patients in the time it takes to see one patient with traditional braces”), he notes) and time, because there are some of the emergencies that accompany metal braces, such as having to repair wires and brackets.

Add to this the discount he receives based on his Invisalign Teen volume, for which he gets preferred placement on the doctor locator feature of Invisalign’s Web site, and the result has been a 10 percent increase in his business over the last year.

It’s branding that works.

OTO
We interviewed 4000 teeth

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Orthodontists who have incorporated Picasso into their practice are enthusiastic about the results. “The Picasso is a great laser for orthodontic use,” said Dr. Lou Chmura, DDS, Marshall, Mich. “With it, you can do all the normal procedures an orthodontist would normally perform. The pulse lengths are adjustable, which makes it easy to produce great results in a shorter time.”

Picasso and Picasso Lite offer the perfect solution to creating exposure for bracket placement. Another application of use includes the removal of hyperplastic tissue in cases where the patients’ gums grow over the existing bracket. Orthodontists also appreciate Picasso’s ability to perform gingivectomies with no patient discomfort and no post-operative sensitivity. On occasions when patients experience issues with their brackets creating gum irritations, Picasso can be utilized as a desensitizing device.

Why have Picasso and Picasso Lite become the world’s best-selling lasers? Many orthodontists claim the unit’s success is due to its portability as the Picasso’s streamline design makes it easy to migrate from operatory to operatory.

For those orthodontists making the transition to lasers, many report the Picasso is easy to learn and easy to use. The unit offers 7.0 watts of power and eight customizable presets. The Picasso Lite offers 2.5 watts and three customizable presets.

As a result, AMD LASERS has created a laser that is safe, easy-to-use and quite affordable. Orthodontists can integrate the Picasso into their practice for $4,995 and the Picasso Lite for $2,495.

“Pricing is a key part of our strategy, and we certainly pride ourselves on the outstanding value offered by Picasso and Picasso Lite,” said Bart Waclawik, COO of AMD LASERS. “Yet, as much as offering the best price of any laser manufacturer is important, our commitment to quality is equally important.”

Picasso is supported by an industry-leading, three-year comprehensive warranty, and the Picasso Lite is supported by a two-year warranty.

AMD LASERS ensures that each office is properly trained upon purchase of the laser unit. Training is facilitated by the International Center for Laser Education (ICLE), and additionally, each dental practice is assigned a company dental professional to contact for clinical advice and instruction.

AMD LASERS’ most recent accomplishment is the introduction of disposable tips, which positions the company as the only laser manufacturer to offer orthodontists the choice of utilizing strippable fiber or disposable single-patient use tips.

To learn more about AMD LASERS’ Picasso and/or Picasso Lite laser units, visit the company’s booth, No. 907, during the AAO. You may also visit AMD LASERS online at www.amdlasers.com or call (317) 202-9550 or toll-free at (866) 999-2655.
Orthodontic highlights on the Seine

FORESTADENT offers two events this September

FORESTADENT would like to invite you to not just one but two advanced training events this September. The third FORESTADENT Symposium will be held Sept. 24–25 in Paris — right in the heart of the metropolis. In addition, the first International 2D Lingual User Meeting will take place on Sept. 23, giving you three days packed with orthodontic highlights in one of the most beautiful cities of the world.

Following on the great success of the first two FORESTADENT Symposiums in Palma de Mallorca and Athens, the third symposium will be held under the motto "The Aesthetic Smile". Internationally renowned speakers such as Dr. Seong Hun Kim (Korea), Dr. Elie Amm (Lebanon) and Prof. Dr. Gero Kinzinger (Germany) will focus particularly on aspects of diagnosis, levelling, main treatment phase and finishing.

Participants can look forward to the presentation of the latest findings and in-depth knowledge regarding the use of the most modern treatment techniques as well as the latest materials.

There will also be the chance to take part in an exchange of ideas on the topic of miniscrews in an expert forum.

If you are a user of the 2-D lingual bracket system from FORESTADENT or would maybe like to become a user, then you are also cordially invited to the first International 2D Lingual User Meeting.

The venue for the two events will be the Les Salons de la Maison des Arts & Métiers between the Arc de Triumph and the Eiffel Tower in the center of Paris. A social program with a dinner cruise on the Bateaux Parisiens, disco party in the Palace Élysée and a golf tournament also will be available.

Increase Production Now


For more than 25 years, Levin Group has provided thousands of practices with the proven systems to increase orthodontic production. In this economy it is more important than ever before.

Take advantage of the opportunity to join Dr. Levin at his next breakthrough seminar, The Principles of Maximum Ortho Production in Las Vegas on June 17-18, 2010.

Or Call 888.973.0000 to speak with a Senior Practice Analyst and determine your production potential.

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