Orthodontic treatment generally follows esthetic, functional, and prophylactic objectives, where individual aspects of isolated cases are accorded varying importance as they arise. Increasing esthetic expectations and awareness of modern dental treatment options disseminated by the media have resulted in increased interest and greater willingness of adults to consider orthodontic treatment. Esthetic orthodontics is thus primarily adult orthodontics.

Ortho surgery and esthetics

By Prof. Nezar Watted, Prof. Josip Bill, Germany & Dr. Ori Blanc & Dr. Benjamin Schlomi, Israel

Orthodontic treatment generally follows esthetic, functional, and prophylactic objectives, where individual aspects of isolated cases are accorded varying importance as they arise. Increasing esthetic expectations and awareness of modern dental treatment options disseminated by the media have resulted in increased interest and greater willingness of adults to consider orthodontic treatment. Esthetic orthodontics is thus primarily adult orthodontics.

Celebrities embrace braces

By Fred Michmershuizen, Online Editor

Who says braces are just for kids? More and more adults are getting them — even celebrities. Actors, professional athletes and pop stars, such as San Antonio Spurs player Manu Ginobili, actor Tom Cruise and singer Gwen Stefani, are putting hardware in their mouths to improve their smiles. And these high-profile ortho patients are being noticed, as well.

“These adults are successful,
Systems thinking rather than linear thinking

By Dennis J. Tartakow, DMD, MEd, PhD, Editor in Chief

Linear thinking can be defined as simplistic, cause-effect thinking. According to Ollhoff and Walcheski (2002), most individuals think in straightforward, cause-effect and short-term fashion; it is called linear thinking, or attention to content over process.

Understandingly, there is a great deal of reinforcement that must transpire in order to not think linearly. This is because work ethics and patterns typically remain the same. It is difficult to change one’s thinking, especially because most of us are preoccupied with content and objectives taking center stage in our minds.

These interactive patterns can be seen everywhere, and most people think and act on a linear level, considering only the end-point of the content rather than the process. Once we are pressed to consider the process of differentiation including both functions (relationship development and integration), we better understand our own social behaviors and with greater appreciation.

Of course, most individuals never associate their learning process with systems thinking, but unconsciously live their lives systematically.

By breaking down the concept of a system and its variations, we begin to identify with our impressions of how this is integrated within our practices. When the system is interdependent, all parts of the system can be interrelated with all other parts. Systems can vary, such as: (a) open systems, where the system shares information with its environment; and (b) closed systems, where the system is self-contained.

Other key concepts in complex systems include: (a) homestasis, where the push of the system is to stay the same; (b) anxiety, where the feeling of dread or inadequacy exists toward a particular issue; (c) differentiation, when you have your own goals and can define yourself, but are still able to stay in relationships, even with individuals of differing opinions; (d) emotional triangle, when two people are in disagreement and draw in a third to stabilize the conflict (This is not mediation, attempting to solve the conflict); (e) forces of togetherness, which is the push to think alike, to reduce creativity and the diversity of thought; and (f) identifying the patient, or the scapegoat.

In summation, the most important thing to remember is to recognize the differences between (a) linear thinking, considering only the content; and (b) systems thinking, considering the processes and the interactions.

Of course, this is not to imply that linear thinking is bad or wrong, but rather that it is only one level of thinking that is not seeing the big picture of the world and reality that is our environment.

To paraphrase the words of philosophers Edmund Burke (1729-1797) and George Santayana (1863-1952): Individuals who ignore history are doomed to repeat it; individuals who ignore history are doomed to know it is repeating.

Book review: ‘The Practitioner’s Credo: 10 Keys to a Successful Professional Practice’

By Gregg A. Tartakow, Associate Editor

Dr. John B. Mattingly, a practicing orthodontist for four decades, was concerned that orthodontic residents and young practitioners were not exposed to what it takes to conduct a successful practice. Motivated by a sincere commitment and genuine dedication to the “new-bees” of orthodontics, Mattingly provides a cookbook approach to the basic principles of office management by presenting the following 10 keys to a successful practice:

• The first key — practice leadership
• The second key — enthusiastic, effective staff
• The third key — practice ethics
• The fourth key — pursuit of excellence
• The fifth key — positive practice image
• The sixth key — cutting-edge technology
• The seventh key — working environment
• The eighth key — essential and non-essential expenses
• The ninth key — marketing your practice
• The 10th key — “Ego”: Don’t get the big head

In addition to these 10 keys, four appendices are used to demonstrate the values of the (a) office manual, (b) sexual and environmental harassment policy, (c) exit survey prototype and (d) evaluation and letters related to association [AAO] membership revocation.

The Practitioner’s Credo: 10 keys to a successful professional practice.
International Cone Beam Institute: educating, training, connecting

Organization wants every dental professional to become a cone-beam expert

The International Cone Beam Institute (ICBI) is an independent organization of cone-beam computerized tomography (CBCT) experts who provide the highest level of education, training and product information for 3-D technology to dental professionals worldwide at www.ExploreConeBeam.com.

As a vendor-neutral organization, this is an industry first — where a company is providing information to the dental professional, future imaging centers and the vendor on an international level.

General information such as the different cone-beam scanners available in the United States and international markets, as well as general information about available third-party software, is available to everyone without charge. ICBI provides in-depth and customized vendor analysis to help practitioners understand this comprehensive technology.

ICBI’s educational faculty has the industry expertise to consult with dental professionals looking to incorporate CBCT into their practices, and to ensure that every question is answered during the decision-making process, including questions about medical billing and ROI (return on investment). For those who are already CBCT users, ICBI provides training to maximize the power of this technology and to help them achieve an expert level of confidence.

ICBI Web site members are able to review case studies and get advice from CBCT experts.

In addition, ICBI offers a connection to oral-maxillofacial radiologists who can provide reading services to aid in the interpretation of CBCT scans. ICBI also has a blog where users can exchange case studies, ideas and techniques about how to capture the highest quality images.

ICBI members have access to special consulting services, online training and training seminars.

The International Congress of Oral Implantologists (ICOI), the world’s largest implant education organization, fully endorses the ICBI. Additional partners of ICBI include Dental Tribune International (www.dental-tribune.com) and Dental Tribune Study Club (www.DTSStudyClub.com).

The ICBI wants every dental professional to become a CBCT expert. Upcoming seminars include Atlanta on Sept. 25–26, and Charlotte, S.C., on Oct. 9–10. For more information about these seminars, visit www.ExploreConeBeam.com.

beautiful and total metal-mouths and brace-faces,” blogger Lindsay Mannering recently wrote.

“And they don’t care who knows it!” Mannering, who was stressed out about an upcoming visit to the dentist, posted a slideshow of famous people with braces on The Huffington Post.

The trend is not just for Americans, either. The British Society of Orthodontists is reporting a significant rise in the number of adults seeking orthodontic treatment.

“The British are supposedly famous for having ugly, snaggled teeth, which perhaps explains why people are seeking aesthetic improvements in greater numbers — we now spend £360m a year on cosmetic dentistry,” the British newspaper The Guardian wrote recently.
A peculiarity of orthodontic treatment in adults compared with pediatric or adolescent orthodontics is the age-associated involution of the connective tissues that leads to a reduction in cell density, thickening of the fibre bundles, delayed fibroblast proliferation and reduced vascularisation.

These are the causes of slower dental movement and delayed tissue and bone reactions.

Absent sutural growth, the age of the periodontium, specific periodontal diagnoses and tissue atrophy also make treatment in adults particularly challenging.

As a rule, esthetically oriented adult orthodontics therefore has an interdisciplinary inclination.

Occlusion, function and esthetics are considered to be equivalent parameters in modern orthodontics and particularly here in combined orthodontic-maxillofacial surgical treatment.32,33

This was achieved through optimisation of diagnostic tools and further development and increasing experience in orthopaedic surgery.4

Nowadays, treatment of adult patients with dental malposition and mastication impairment is one of the standard tasks of the orthodontist. If the discrepancies in spatial allocations of the upper and lower dentition are particularly pronounced and where the cause is primarily skeletal and not only dentoalveolar, conventional orthodontic therapy is limited, and combined orthodontic-surgical therapy is indicated for remodelling of the jaw bases.

Treatment for a skeletal dysgnathia (Class III) using combined orthodontic-maxillofacial surgical correction is discussed in this article.

Development of maxillofacial surgery of the mandible

The first orthodontic-maxillofacial surgical procedure on the mandible described in the literature was that of the American surgeon Hullihen in 1848.13 This procedure was a segmental osteotomy of the anterior mandible (a posterior shift [retraction] of a protruding mandibular process, following a burn injury).

Toward the end of the 19th century, the method of orthodontic-maxillofacial surgical correction of dysgnathias by surgical retraction or protrusion of the mandible was revisited. Jaboulay14 described resection of the Processus condyliaris and Blair4, osteotomy on the Corpus mandibulae.

The continuity resection in the horizontal branch by Blair was the first surgical prognathism procedure.

The patient first visited the dentist Whipple in St. Louis in 1891 and was referred to the then most renowned orthodontist Dr Edward Hartley Angle2, who ultimately recommended the surgical procedure mentioned above.

Six years later, the procedure in this osteotomy on the Corpus mandibulae was also published by the Hamburg surgeon Floris.11
Parallel with this development in the United States, Von Auffenberg in Europe conceived a step-by-step osteotomy for correcting a mandibular retrusion, which was performed by Von Eiselberg in 1901.

The era of orthodontic surgery in Europe began only after World War I. The experience gained there led to a substantial extension of the indications for orthodontic-maxillofacial surgical procedures, as well as to the transferral of this surgical technique to the area of elective procedures.

In the early 1920s, Bruhn and Lindemann set transversal osteotomy of the Ramus mandibulae as the standard method at the time for the surgical correction of mandibular prognathism. This method, which continued to have many adherents well into the 1960s, is today known as the Bruhn–Lindemann procedure.
In 1935, Wassmund, who saw its drawbacks in a possible dislocation of the proximal segment by the muscles inserted there, described a modification of the Bruhn-Linde- mann surgical technique.\textsuperscript{26} In the early 1950s, a new era in orthodontic surgery of the mandible was begun with Kazanjian’s resumption\textsuperscript{12,15,23} of the technique of transverse, oblique severing of the ascending ramus, first performed by Perthes in 1922.\textsuperscript{22}

Shuchard modified this method in 1954 by enlarging the bony insertion surface, and in 1955 Obwegeser introduced sagittal splitting at the horizontal ramus of the mandible. He shifted the buccal osteotomy line obliquely from the last molar to the posterior margin of the jaw angle.\textsuperscript{19–21}

In 1959, Dal Pont moved this buccal osteotomy line from the last molar to the inferior margin of the mandible.\textsuperscript{8,9} Since then, this method of sagittal split at the mandible has been called sagittal split according to Obwegeser–Dal Pont (Fig. 1). Epker\textsuperscript{10} developed the incomplete sagittal split into a routine method.

Clinical case presentation: history and diagnosis

A 25-year-old patient presented on his own initiative. He complained of functional (impairment of mastication and jaw joint pain) and esthetic impairment (sunken face with facial asymmetry). He had undergone orthodontic treatment between the ages of 8 and 15 and reported pain in the area of the anterior mandible.

The lateral image showed a retractive lower face inclined forward with mid-facial hypoplasia — regio infraorbitale — a flat upper lip and an elongated lower face compared with the mid-face — 47\%:53\% instead of 50\%:50\%\textsuperscript{29} (Table I; Fig. 2a).

Owing to the negative sagittal overjet, there was a positive lower lip step. The frontal image shows mandibular deviation (laterognathia) to the right, which can be traced to growth asymmetry in the jaw (Fig. 2b). In addition, there was a Class III dysgnathia angle with conspicuous mandibular midline deviation to the right, frontal and right lateral crossbite, anterior mandibular labial tilt and a steep anterior mandible. Tooth 26 had been missing for some time (Figs. 3a–e).

FRS analysis (Table I, II) clearly shows the strongly sagittal and relatively weak vertical dysgnathia both
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in the soft-tissue profile and in the skeletal region. The parameters indicated a mesiobasal jaw relationship and a growth pattern with an anterior course: the vertical grouping of the soft-tissue profile showed a disharmony between the mid-face and the lower face (G'-Sn:Sn-Me'; 47%:53%). This was relatively weakly expressed in the bony structures (N-Sna:Sna-Me; 44%:56%). In the region of the lower face there was also mild disharmony (Sn-Stm:Stm-Me'; 31%:69%). Complementary assessment of the mandible showed that the area from the subnasal-labral inferius to the soft-tissue chin (Li-Me'), which should have been 1:0.9, was shifted in favor of the Li-Me' part (0.9:1; Fig. 4). The panoramic image showed a lucency of teeth 31 and 41. A root canal procedure followed by root apex resection was thus performed (Fig. 5).

Therapeutic objectives and treatment planning
The objectives of this combined orthodontic-maxillofacial surgical treatment were:
1. The establishment of neutral, stable, and functional occlusion with physiological condylar positioning;
2. The optimisation of the facial esthetics;
3. The optimisation of the dental esthetics, considering the periodontal situation;
4. The assurance of the stability of the results achieved;
5. Meeting the patient’s expectations.

The improvement of the facial esthetics, not only in the sagittal axis in the region of the lower face (the mandibular region) but also in the region of the mid-face (hypoplasia) and in the transverse axis, should be noted as specific treatment objectives. The change in the region of the mid-face was intended to affect the upper lip and the upper-lip vermilion. These treatment objectives were achieved by two procedures:

1. A dorsal extension of the mandible with lateral sweep to the left for correction of the sagittal and transverse defects, as well as occlusion and the soft-tissue profile.
2. Bone augmentation in the mid-face for harmonization of the face. It would not have been possible to achieve the desired treatment objectives with respect to function and esthetics using orthodontic procedures alone.

Therapeutic procedure
Correction of the pronounced dysgnathia was done in six phases:

1. Splint therapy: a flat bite guard splint was installed for six weeks in order to determine the physiological condylar position or centrics before the final treatment planning. By doing this, the forced bite could be demonstrated to its full extent.
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2. Orthodontics for forming and adjusting the dental arches relative to each other and decompensation of the skeletal dysgnathia (Fig. 8a, b).

3. Splint therapy for determining the condylar position. This was performed in the four to six weeks prior to the surgical procedure. The objective was registration of the jaw joint in a physiological position (centric).

4. Oral surgery for correction of the mandibular deformity after model operation, determination of the transposition path and production of the splint in the target occlusion, the surgical mandibular translocation using sagittal split according to Obwegeser-Dal Pont was done. Augmentation in the mid-facial region was done using autologous bone.

5. Orthodontics for fine adjustment of occlusion.

6. Retention: 3-3 retainers were cemented in the mandible. Mandibular and maxillary plates were used as the retention appliance. Prosthetic care was provided after six months.

Results

Figures 7a–c show the situation after the conclusion of treatment and after extraction of tooth 51 and subsequent prosthetic treatment, neutral occlusion and correct mid-line with physiological sagittal and vertical bite.

The extra-oral images show a harmonious profile in the vertical as well as in the sagittal axis (Figs. 8a, b).

The oral profile is harmonious. The upper-lip vermilion is distinct to each other and decompen-

sation of the skeletal dysgnathia. Fig. 10: Orthopantomogram after conclusion of treatment and before the prosthetic treatment and before the prosthetic treatment.

Table 1: Proportions of skeletal structures before and after treatment.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Mean Before treatment</th>
<th>After treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNA</td>
<td>82°</td>
<td>90°</td>
</tr>
<tr>
<td>SNB</td>
<td>80°</td>
<td>93°</td>
</tr>
<tr>
<td>ANB</td>
<td>2°</td>
<td>3° (incl. 4.5°)</td>
</tr>
<tr>
<td>WITS-Wert</td>
<td>1 mm</td>
<td>-8 mm</td>
</tr>
<tr>
<td>ML-SNL</td>
<td>32°</td>
<td>20°</td>
</tr>
<tr>
<td>NL-SNL</td>
<td>9°</td>
<td>4°</td>
</tr>
<tr>
<td>ML-ML</td>
<td>23°</td>
<td>16°</td>
</tr>
<tr>
<td>GMom&lt;</td>
<td>130°</td>
<td>120°</td>
</tr>
<tr>
<td>SN-Pg</td>
<td>81°</td>
<td>93°</td>
</tr>
<tr>
<td>PPH/AFH</td>
<td>63%</td>
<td>74%</td>
</tr>
<tr>
<td>N-Sna/N-Me</td>
<td>45%</td>
<td>44%</td>
</tr>
<tr>
<td>Sna-Me/N-Me</td>
<td>55%</td>
<td>56%</td>
</tr>
</tbody>
</table>

Table 2: Proportions of soft-tissue structures before and after treatment.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Mean Before treatment</th>
<th>After treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>G–SnG’–M’</td>
<td>50%</td>
<td>47%</td>
</tr>
<tr>
<td>Sn-Me’/G’–Me’</td>
<td>50%</td>
<td>53%</td>
</tr>
<tr>
<td>Sn-Sml/Sml’–Me’</td>
<td>33%</td>
<td>31%</td>
</tr>
<tr>
<td>Sn–Li/Li’–Me’</td>
<td>1.0–9</td>
<td>0.9–1</td>
</tr>
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Fig. 9: The cephalometric image after conclusion of treatment shows a harmonious ratio between the skeletal structures, as well as in the sagittal axis and the vertical axis, and harmonisation in the soft-tissue profile between the upper and lower face.

Fig. 10: Orthopantomogram after conclusion of the orthodontic treatment and before the prosthetic care.

References

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A first glance, the Pacific Palisades in Southern California looked like heaven. Blanketed with luxurious movie star homes built on top of mountains overlooking the crashing waves of the Pacific Ocean, it felt like a dream. But like any good dream, it had to end … or did it?

In 1990, the Moalej family left their homeland of Iran to immigrate to America. Uncle Kian had finally convinced Dad that a better life awaited his family. Dad had always wanted to give his children the hope and opportunities he never had, and America would give that chance for success, prosperity and, most importantly, education.

Upon arrival, we lived with Uncle Kian in the Pacific Palisades, one of the most affluent and rich districts of Los Angeles, a far cry from the former world in Iran. While on the outside the surroundings were beautiful and the land seemed like paradise, I quickly learned that not everything was as it seemed.

Unbeknownst to anyone in the family, my brother Pouya was born with a Class III malocclusion. As a child growing up in his family, this would not have been an issue. However, in Pacific Palisades, being “normal,” if not perfect, was the standard in order to be included among his peers, and the teasing and exclusion was unmerciful.

Pouya spent years after immigrating to the United States, sitting in with his fellow classmates, whose perfectly engineered smiles were absolutely beyond Dad’s financial circumstances. He woke up every day dreading school — not because the teachers were unfriendly or the curriculum was exceptionally difficult, but because he had immigrated to a society in which a Class III malocclusion was reasonable cause for being teased.

Children can be cruel. That’s a simple fact of life. When one comes from a distant country and has teeth that do not resemble everyone else’s, they can be even crueler. When one’s teeth are not as white and seemingly perfect as the rich, privileged elite classmates of the school, that individual will hear about it — over and over.

Thus began a daily tumultuous cycle of abuse for Pouya. Teased and mocked for his “subnormal” physical appearance, he found it hard to adjust and feel comfortable, losing a bit of his inner pride each day. Pouya’s transformation was shocking. Within weeks, a confident, bright boy had turned into a moody recluse.

The Moalej family, like most immigrants, had come to America with almost no money. After years of humiliation, Dad had saved enough money to get Pouya orthodontic care. Finally after being miserable and hopeless for so long, Pouya had found his light.

Once shy, self-conscious and insecure, he soon became confident, assured and outgoing. When the process was complete, not only had a new man emerged, but I had discovered a passion that would shape my personal, academic and professional life — a desire to care in relation to orthodontics.

Pouya’s situation is not unique and untold numbers of similar cases exist, wherein people suffer from unaddressed dental problems due to financial constraints or lack of knowledge. Perhaps one of the greatest obstacles to treatment is that orthodontics is considered a luxury that can be postponed. This is often defined by dental insurance not being universal and having deductibles and co-pays that are so high that families use the insurance only in dire circumstances. The result is that beyond a basic cleaning, not much else is covered. Misalignments and deeper cleanings are not even considered, thus setting the stage for a lifetime of poor dental hygiene habits.

The responsibility of health-care professionals does not end once the crown is placed or the braces are removed. Instead, their duty is never-ending. It is an ethic of individual choice to assure that all patients are cared for with benevolence and equality regardless of financial status.

In today’s society, health-care professionals can be viewed as members of an extended community; thus, their decisions can ultimately impact their communities. As health-care providers are accountable for educating patients as well as communities about the impact of dental care. In this way, orthodontists can fulfill their obligation of virtue and social justice for the community welfare.

Social transformation can be achieved through giving additional time to patients, advocating for changes in dental insurance or lobbying for expanded dental coverage to poorer patients. In this manner, orthodontists can easily become mentors of social justice reform for all individuals, his or her community and society.

An orthodontist’s career provides an opportunity to form lifelong relationships between practitioners and patients and the ability to enhance an individual’s self-image through non-invasive methods. However, being an orthodontist not only concerns aligning teeth, but also representing faithfully the needs of all patients, including those in need of financial or educational assistance in achieving superior dental care.

The day Pouya walked out of the orthodontist’s office, smiling and holding his head high for the first time in years, it had a profound effect. At that moment, I vowed to make a difference in this world, realizing that if even one person was protected from humiliation, all the hard work and time entailed in reaching that position would be worthwhile. My goal as a future orthodontist is to remember those who have provided inspiration and guidance for this challenging profession.

The spark that was ignited within me as a young girl has continued to burn, fueled by the patients who have allowed me the privilege of providing them care. In the future, my goal will be to rely on the skills and knowledge I have built, as well as genuine care and commitment to improving the lives of those patients in the surrounding community.

The day Pouya walked into the orthodontist’s office, timid and scared, neither of us expected the spark of life that would be ignited within me. It is that spark that has encouraged me each day of training thus far, and it is that spark that will continue to fuel, motivate and provide guidance throughout my career as I witness the transformation of my patients’ lives.

As Sir Winston Churchill stated, “We make a living by what we get. We make a life by what we give.” Practitioners earn their living through monetary payments, but true fulfillment in life arises from what is given back to the community. Orthodontics may not only be about making a living, but also about making a life.
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Total Ortho Success™ Practice Makeover winner Dr. Brian Hardy of Hardy Orthodontics in Grove City, Ohio, looked at his monthly gross production recently and saw something extraordinary — his numbers were up 80 percent from the same month a year ago. Referrals were up 56 percent for the same month as well.

In this economy, these are amazing results — even more so considering Hardy Orthodontics had only completed six months of its year-long management and marketing consulting program. Obviously, Dr. Hardy is pleased to see the first of many concrete results. One reason for the improving numbers is undoubtedly the work his practice has done implementing Levin Group’s Greenlight Case Presentation™ and PowerScripting™.

Greenlight Case Presentation

When orthodontists walk into a consultation, they should always be:

• Knowledgeable
• Confident
• Motivational

That applies to every patient, every day.

To present more effective ortho cases, practitioners need to step into the shoes of patients and their parents. People come to an orthodontist because they are seeking beautiful smiles. Orthodontists and staff must earn their trust, validate their desire for a more attractive smile and guide them toward agreement to ortho treatment.

While the desire for a great smile is a powerful motivator, the issue of price is a major obstacle. Most parents are well aware that orthodontic treatment is a significant expense. Their chief concern is how to pay for it.

In a difficult economy, the anxiety about cost is only amplified. In one of our earliest meetings with Dr. Hardy, he had concerns about parents being more reluctant to start their child’s ortho treatment because of the economy.

Top-producing ortho practices successfully handle the price issue by providing several financial options so patients/parents can choose one that is comfortable. This is more important than ever.

Levin Group recommends these options:

• Five percent pre-payment courtesy. The entire treatment fee is paid in advance, including the insurance portion. Orthodontic practices can benefit by collecting the fee upfront without having to set up a monthly payment schedule.

Confident
Knowledgeable
Motivational

Levin Group Consultant Emily Ely and Dr. Brian Hardy.

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• In-house payment plan. Twenty-five percent of the fee is paid as a deposit with the remaining balance divided into monthly payments. Ortho practices must maintain an excellent focus on accounts receivable. Any patient who is one day overdue for payment should receive a call that day. The office should be careful to have some level of flexibility to help patients in difficult financial situations.

• Outside financing. An outside financing company, such as CareCredit (which Dr. Hardy works with), approves the parent or patient for a line of credit or a loan. These approvals can be achieved within minutes.

PowerScripting

When we first discussed the idea of scripting with Dr. Hardy, he had somewhat conflicted emotions. Although his practice had traditional patient compliance issues that were genuinely distressing both to himself and the team, he was apprehensive about scripting, stating:

• “Is scripting difficult to implement?”
• “Will it involve memorizing thousands of phrases?”

It is impossible to overstate the importance of superior verbal skills. Every practice system in his office — scheduling, customer service and case presentation, to name a few — depends on clear, effective and consistent communication. The better Dr. Hardy and his team communicate with patients, the more successful his practice is likely to become.

Scripts can be created for different aspects of the ortho practice, but all scripts should always be customized to maximize the capabilities of team members. These factors helped Dr. Hardy create and implement effective scripts in his practice:

• Consistency. Scripting provides Dr. Hardy’s patients with consistent messaging. One of the most frustrating experiences for patients is hearing conflicting answers from the staff regarding the same question. It diminishes trust in the practice. Such an experience undermines case acceptance and leads to unsatisfied patients who aren’t likely to refer others.

• Power words. Power words are enthusiastic words that create positive energy and are used many times at the beginning of sentences. Words such as great, terrific, wonderful, fantastic, super and awesome are examples of power words. It is important for Dr. Hardy and his team to be upbeat and motivating, especially when dealing with a patient’s compliant issue.

• Customization. Scripts should never be recited word-for-word, as if a team member had memorized a speech. Rather, Dr. Hardy’s staff members are being encouraged to use their own words, paraphrasing the scripts, so that the essential information is communicated to patients in a natural and positive way.

• Role-playing. Team members read over the scripts and “act them out,” or role-play. This training process reinforces the messages and helps team members see the practice through the eyes of patients. Role-playing can take place at morning meetings. It can be a fun and informative activity for the whole team.

• Positive communication. When an orthodontist and the team use verbal skills to present themselves in an upbeat way, patients respond better. As a result, Dr. Hardy, his staff and patients find themselves more motivated and more positive.

The state of the practice

At Hardy Orthodontics, things are headed in the right direction. In a down economy, Dr. Hardy is seeing nearly double the number of starts compared to a year ago. These results are doing a great deal to bolster the team members’ enthusiasm as they work to revamp systems and strategies.

Dr. Hardy’s office is currently focused on:

• Front presentation skills, scripts and techniques.
• A concerted effort to open consult and treatment start slots to ensure they see as many patients as possible.
• A more efficient approach to collections. This has already yielded results — this year they are up 38 percent.
• Better and more flexible methods for working with patients on financial issues in this economy without having to resort to in-house financing.

Join us in our next installment when we explore Dr. Hardy’s accelerated practice growth.

About the authors
Levin Group Senior Consultant Kevin Johnson has spent the last eight years working as a Levin Group orthodontic management and marketing consultant. He manages a team of consultants and is a frequent lecturer at the Levin Advanced Learning Institute. Johnson earned his degree from Towsen University in 1996.

With many years of marketing experience, Levin Group Consultant Emily Ely joined Levin Group in 2005. Ely uses her unique knowledge and experience to provide marketing solutions for orthodontic practices. She earned her degree in business from Towson University.

Both Ely and Johnson are members of the Ortho Expert Team, a specialized group of consultants who are trained in the needs of orthodontic practices.

For more than two decades, Levin Group has been dedicated to improving the lives of orthodontists. Visit Levin Group at www.levingrouportho.com. Levin Group also can be reached at (888) 973-0000 and by e-mail at customercare@levingroup.com.
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- Dr. Jay Gerber
Director of Orthodontics
One of the most common questions orthodontists ask me today is, “Why doesn’t my Web site show up on the Internet?”

The first thing I do is compliment them. At least they’ve taken the time to check out their Web site on the search engines and determined something is wrong. Unfortunately, most small-business owners have no idea if their Internet marketing program is a finely tuned Mazarati or a Hugo unavailable in the eyes of consumers on the search engines.

When designing a Web site and Internet marketing program, most professionals have no clue that the search engines, such as Google, Yahoo and MSN (now Bing), can’t read the written words in a Web site or determine if it is outdated or new. The search engines scan your site using a sophisticated mathematical algorithm. This is where SEO (search engine optimization), keywords and meta tags come into play.

You have to tell the search engines who you are, what you are all about and where you want to target new patients in your local demographic in order to be found. The search engines dictate the rules of engagement, and you must follow them.

Does all this sound like Greek to you? It did to me — until I spent hundreds of hours mastering the subject of Web 2.0 Internet marketing.

SEO and keywords relate to the words and phrases prospective patients type into the search engines to find you. Your Web site is the hub of your Web 2.0 marketing campaign. Once a new patient finds you with keywords, you can engage them with your marketing message to visit your Web site or contact your office for a new patient exam.

The focus of your Internet marketing program is to drive new patients to your front door. In order to accomplish this, one hand must wash the other with correct SEO, engaging design and a powerful marketing message.

How do you determine if consumers in your local area are finding your Internet marketing efforts? Simple. Test it!

1. Go to Google and in the search box type in patient keywords — orthodontist [your city name and state]. Orthodontist is the No. 1 key word new patients use to search for treatment providers.
2. Repeat the same steps again with the key words braces (No. 2) and Invisalign (No. 3).
3. Do your Web site, blog posts, Facebook page, e-zine articles, etc., show up on page one of Google?
4. Does your practice name and Web site URL show up correctly on Local Google Maps?
5. Now go through all the steps again, but this time, one by one substitute the names of all the surrounding towns in your area where you target new patients. Are you visible?

No matter how great the design of your Web site and Web 2.0 marketing program, you may be missing a wealth of new patient opportunities to build your practice due to limited local visibility on the Internet. This can translate into hundreds of thousands of dollars you may be losing to your competitors online over the years.

Your Web site and Web 2.0 marketing program are very powerful marketing tools if set up correctly, start to finish. You don’t know what you don’t know till you know it! Find out from an orthodontic Web 2.0 Internet marketing specialist what you don’t know today.

Mary Kay Miller of Orthopreneur™ Marketing Solutions is an Internet marketing coach specializing in SEO (search engine optimization) and Web 2.0 Internet Marketing solutions. With more than 30 years experience in orthodontic marketing and practice management and 10 years in Internet marketing, she has mastered the attitudes, skills and knowledge necessary to take your practice to the next level. Access her free marketing e-Guide, “Marketing Your Practice Through Different Eyes,” at www.orthopreneur.com. You may contact her by e-mail at marykay@orthopreneur.com or call toll-free (877) 295-5611 for a complimentary demographic evaluation of your Web site.
Why orientation is more important than you think

By Pat Rosenzweig

S

he seemed so great at the interview. Why didn’t she work out?

Lately our days are always too short, with never enough time to accomplish everything before it’s time to close the laptop, get some sleep and start all over again. This lack of time is translating into every aspect of our offices, including the training of new staff members — and that’s getting to be a real problem in many practices.

Hiring someone with orthodontic experience and knowledge of our office software should be only the beginning of the new employee experience, not the entire process. Carefully oriented and trained staff members are able to get much more accomplished in much shorter time frames than those who are always hunting around for the correct instruments, procedures or keystrokes.

So what makes up good orientation training? We can actually sum it all up in one word: planning.

Prior to hiring any new employee, we need to have a clear job description for the position, preferably in writing. We need to know what the specific job duties are, when and how they need to be performed and what additional side or shared duties are also parts of the job. This is now our roadmap to set up training for our new employee. We can’t create an outline of the exact skills and protocols that need to be mastered to accurately perform the required tasks if we don’t know what they are.

From there, we need to choose the right staff member to act as a trainer. The trainer needs to be well-trained herself, as well as being a good and patient teacher. Frequently, the type of personal- ity who makes a great lead assistant or treatment coordinator isn’t the best teacher, so we need to choose the most qualified person for our trainer — which is not necessarily the staff member who’s been with us the longest. This is a place where we need to keep egos out of the mix; training is all about teaching, not about who has what place in the office hierarchy.

Our trainer should discuss the training outline with the orthodontist or office manager to be sure she’s clear on what information and materials we need to present and then create a plan for training.

Ideally we should begin our first training day on a day with no patients. This gives time for a basic orientation of where everything can be found, how everything works and what our software has to offer.

I know many trainers would disagree with me on this, as they feel that hands-on is always the best type of training. I’m all for hands-on training, but when it begins on an employee’s first day, it’s frequently more like sink-or-swim than hands-on.

A first day with a full patient load can be incredibly overwhelming, and when a step in the training gets missed, it’s usually gone forever. I’ve been in many offices where one poorly trained staff member has trained the next and so on down the line.

This results in huge gaps in systems and knowledge and a less-than-stellar experience for staff and patients.

Our training plan needs to be in the form of a written checklist so we can check off completed items as we go. Also, the ideal training plan contains frequent stops to test or use the acquired skills on sample patients.

While this type of training plan sounds time consuming, it only needs to be created once, then can be used over and over as we add new team members or make adjustments for staff who are leaving.

Begin orientation at the beginning. Show the new staff member how to turn on all equipment and what procedures we set in place at the start of the day.

We’ve all had the experience of wasting time going into the office on our own for the first time and fumbling to find the light switches and the power switches for electronics. Use some orientation time to actually orient the new staff member to the environment.

If you’re exposing the new hire to software for the first time, have a program set up to train on the software as well as the systems. Go over the icons and procedures in a step-by-step logical fashion and allow lots of time for note taking.

Next, do a walkthrough of the initial phone call for desk staff or patient seating for op staff. Use a “cheat sheet” for the initial call, even if the current front desk staff usually enters patient information directly into the computer. Having a template gives a new staff member confidence that he or she is getting all the information required and gives less than perfect typists a chance to get it right.

Patient seating for the op seems simple enough, but every office has its own special dynamic and its own individual learning curve, and that’s getting to be a real problem in many practices.

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Patient seating for the op seems simple enough, but every office has its own personality and we want our new hire to reflect who we are. I can still clearly remember a very low-key, quiet doctor cringing as his newest assistant went to the edge of the waiting area and literally bel- lowed out the patient’s name.

She had been taught to be “loud and clear” in her previous office, but it certainly wasn’t the style the new office wanted.

Review the front desk systems and the operatory setups. Have a written manual in place that details these areas for reference. No one will remember it all the first time around.

Again, these manuals take a bit of time to create, with details and photos of tray setups, but they’re invaluable both for new hires and temps (if the need should ever arise.) Remember, however, these manuals are a supplement to orientation, not a substitute for it.

Finally, be patient. Every new staff member will have his or her own individual learning curve, and some of the best assistants and front desk staff I’ve worked with took a bit of time to get the hang of the software and the systems.

It’s as true in offices as it is in every other aspect of our lives — a good foundation creates a strong product, and a good orientation creates a great staff member.

If we take the time to build that good foundation, we’ll have a better, happier staff and patients who never feel a lack of continuity or professionalism in their office expe- rience.

Pat Rosenzweig is co-founder of Mosaic Management Professionals, providing management and business consulting for orthodontic offices, as well as general dental and other specialty offices. Mosaic Management Professionals functions on a belief that every office is unique, with its own special dynamic and its own consulting and systems needs. Mosaic is committed to creating an individual plan for each client that puts the office’s particular strengths into play to keep the office at the top of its game.

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With summer coming to a close, a slower economy, fewer starts and less than ideal cash flow, many orthodontic practices are wondering how they will survive the coming months as they approach what typically is the slowest time of the year for business.

Many orthodontic offices have already experienced a significant decline, not only in their summer starts but also in their overall production numbers for the year. Regardless of how grim the picture might seem, there are still opportunities for growth.

So, where are all the starts?

The starts are out there, but they are becoming more challenging to find and require a lot more effort to capture. What it takes now is strategically leveraging all resources to achieve a higher level of success and maintain a healthy and positive cash flow within the practice.

Most orthodontists still can experience tremendous growth within their practice, but it will require much more work and effort. Sitting back and hoping for the best never creates results. You have to be willing to do whatever it takes in harder times to achieve your goals and stay on track.

You also must be willing to adapt and work differently. The practitioners who are willing to reinvent their approach to running their practices can still achieve higher levels of success and continue to be at the top of their profession. Rather than relying on the same handful of referring general dentists, it’s time to branch out and establish new relationships. It may now take 15 general dentists to get the number of referrals you would normally get from your top five in previous years.

The “will call back system” is another important area to concentrate on during these challenging times. Unfortunately, some offices still don’t know what a “will call back system” is. They never had a system and never did make calls to any of their past non-starts.

The truth is, in a healthy and growing economy of the past few years they did not have to. They were meeting their objectives without putting in any extra effort.

Well, now times are different and it will require a different approach in order to be successful. What you do in this area can generate a tremendous amount of revenue if the techniques are executed properly.

For example, in one of my client’s offices, I suggested mailing out letters to all past non-starts, offering them a $500 “troubled economy courtesy.”

As a result, they generated more than 32 new contracts, signed within two months from sending out the letter. There are ways to continue to generate starts, but you must be willing to think outside the box to make it happen.

For the recall patients who are “too young to start,” instead of waiting for a few more permanent teeth to erupt and placing them on a four- to six-month recall, recommend starting now. There may be much to accomplish while you are waiting on the eruption pattern to be complete.

Willing to step outside the norm is what creates positive results. Doing the same things over and over and hoping for different results is the recipe for failure.

What worked 10 years ago may not work today. Being stuck in repetitive tasks is like a hamster on an exercise wheel that runs endlessly but ends up right where it started.

As the market toughens, more and more orthodontist must be willing to reach out differently to the prospective patients in ways they never would have considered. Direct mail marketing is becoming a fast growing and effective method of prospecting for new business.

With fewer general dentists referring and an overall decline in revenue, some orthodontist are willing to try new avenues in ways they never would have considered. Direct mail marketing is becoming a fast growing and effective method of prospecting for new business.

Creating a new mission statement with your employees that is based on creativity, drive for success, passion for growth and unlimited levels of higher achievement can be the beginning in finding your new starts.

A fresh and renewed sense of working toward a mission can motivate and energize you and your team, paving the way for great success in the coming months and years.

For more information on creating new starts within your practice, I invite you to attend my upcoming webinar on “Marketing For Success” on Sept. 25. For more information regarding this webinar and many others, please visit orthoconsulting.com.

Scarlett Thomas is an orthodontic practice consultant who has been in the field for more than 25 years, specializing in case acceptance, team building, office management and marketing. As a speaker and practice consultant, she has an exceptional talent to inform, motivate and excite.
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Weak economy, strong practice

By Roger P. Levin, DDS

The economy is not strong. This is no surprise to anyone. The problem is that orthodontists do not typically receive training in business, much less on how to deal with a slow economy.

Levin Group’s expert solutions have helped orthodontists grow their practices by 15 percent or more regardless of the economic conditions.

The following action steps are critical components of our Total Ortho Success™ — Management and Referral Marketing consulting programs. These practice management principles, when properly implemented, can make the difference between steady decline and continual growth.

Replace outdated systems

The right systems mean the difference between growth and decline. Implementing high-performance systems results in expanded scheduling capacity, increased starts, decreased no-shows and reduced accounts receivable, to name just a few.

Updated systems are your best defense against a fluctuating economy. If you are experiencing a slowdown, there is no better time to replace outdated systems than right now.

Implement an explosive referral marketing program

Referral marketing is the best way to grow your practice in this, or any, economy. Levin Group clients use a system called The Science of Referral Marketing™ that directs a minimum of 15 targeted strategies at both referring dentists and patients.

In good economic times, you may be able to do well with a majority of referrals coming from patients. However, in a downturn, that single strategy can lead to a precipitous drop in starts and production.

Highly successful practices receive a steady stream of referrals from both dentists and patients. These offices also run strong community programs that create awareness about the practice in local schools.

Develop your team

Your staff is a key factor in practice success. Many orthodontists are not investing in staff training due to the economy. This is a mistake. A strong team increases efficiency, boosts production and lowers stress.

Even though we’re in a tight economy, don’t put off team training. It’s an investment that pays dividends immediately and for the long-term.

Conclusion

It’s time to start growing your practice again! Our Total Ortho Success clients continue to experience robust growth by using these action steps.

Don’t let the recession stop you from reaching the next level! Be stronger, work smarter, practice better!

Ortho Tribune readers are entitled to receive a 20 percent courtesy on Dr. Roger Levin’s next Total Ortho Success” Seminar being held Oct. 8-9 in Cambridge, Mass.

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.

Dr. Roger P. Levin is founder and chief executive officer of Levin Group, Inc., the leading orthodontic practice management firm. Levin Group provides Total Ortho Success™, the premier comprehensive consulting solution for lifetime success to orthodontists in the United States and around the world. Levin Group’s clients have grown their practices by an average of 15 percent or more regardless of the economic conditions.

Advocate for your patients. Don’t let cost stand between them and the treatment you recommend. With no interest payment options and credit lines starting at $5,000, patients can overcome most financial barriers and select the best care.

At Norman Orthodontics no one waits behind a velvet rope. Because here, everyone is a V.I.P. This was Dr. Florman and Dr. Gailani’s goal when designing their state-of-the-art orthodontic office in Los Angeles. Patients’ V.I.P. experience starts with an internet café, video game room, giant aquarium and LCD TVs — and that’s just the waiting room. The treatment area features some of the most advanced seating, lighting and orthodontic equipment available. And, even more TVs to offer patients more comprehensive treatment options.

Dr. Florman and Dr. Gailani worked hard to make every patient feel like a star, which is why Florman Orthodontics is an Advance Practice.

For more than two decades, Dr. Levin and Levin Group have been dedicated to improving the lives of orthodontists. Levin Group may be reached at (888) 973-0000 and customerservice@levingroup.com.
The TRAINER System in the context of treating malocclusions

By Dr. German Ramirez-Yañez, DDS, MSc, MDSc, PhD

Part 1 of three

Functional maxillary orthopedics (FMO), also known as dentofacial orthopedics, is the subject in dentistry that studies the treatment of malocclusions by stimulating or inhibiting the activity of the masticatory and/or facial muscles. Doing so stimulates modeling and remodeling of the maxillaries, permitting a better tooth alignment.

FMO helps to correct and treat all the functional problems that can be associated with incorrect positioning of the teeth (Ramirez-Yañez and Farrell, 2005) due to erroneous force delivered on the teeth by the muscles (Fujiiki et al., 2004). Consequently, teeth tend to position better and to align correctly.

Therefore, the first matter that must be understood is that FMO’s goal is to correct the position of the teeth, similarly to fixed orthodontics. However, traditional orthodontics only moves the teeth, and it is expected that the entire craniofacial system (CMS) is going to adapt to the new position of the teeth.

FMO, on the other hand, produces a balance between the muscles of the CMS, followed by improving the relationship between the upper and lower maxillaries. Consequently, the teeth tend to position better.

In other words, orthodontics and FMO have the same goal — the way that goal is achieved is totally different.

There is a huge variety of removable appliances that may be classified as FMO appliances. However, they do not all produce the same effect on the CMS.

Some work by increasing the muscular activity of the masticatory muscles by positioning the mandible forward (e.g., Monoblock and Bionator); others stimulate the mandible forward (e.g., Monoblock and Frankel’s Function Regulator).

More recently, new appliances have been developed that stimulate the masticatory and facial muscles and furthermore re-educate the posture of the tongue, bringing the CMS into a physiological equilibrium of the force delivered on the maxilla and teeth. Some of these new appliances are the Simoes Networks 2 and 3, as well as all the appliances composing the TRAINER System.

It is very important to understand the modus operandi of each of the FMO appliances that are available to treat malocclusions. This permits the health professional to understand the philosophy behind each appliance, what the successes are and what the limitations that can be expected are when treating with each of them.

The TRAINER System

The TRAINER System is composed of various appliances that can be used accordingly with the age of the patient, including the Infant TRAINER, the TRAINER for Kids (T4K®) (Fig. 1), the TRAINER for Adolescents/Adults (T4A®), the TRAINER for Brackets (T4B®), the TRAINER for Class II malocclusion (T4CI®), and the TRAINER Lingual® and the MYOBRACE® (Fig. 2). Although their indications may vary, all appliances within the TRAINER System, including the MYOBRACE, work in an identical way.

The goal of this paper is not to give the indications for each of the trainers, but to explain the way that all the appliances in the TRAINER System produce their effect when treating the various types of malocclusions. Those readers not familiarized with these appliances may find the indications for each of them and the appliances manuals at www.myoresearch.com.

Many orthodontists tend to see the MYOBRACE as a different appliance as it does not have the name TRAINER attached to its name. The MYOBRACE works similarly to the other trainers, stimulating the muscular balance of the facial and masticatory muscles, as well as re-educating tongue posture.

The only difference is that the MYOBRACE has a structure added (inner-core) to increase the resistance of the buccal shields, therefore counteracting the force delivered by the buccinators on the posterior teeth when the activity in those muscles is increased. This is further explained later. Also, the MYOBRACE includes additional channels at the area of the anterior teeth, which can deliver a direct force on the teeth improving their alignment.

Otherwise, the MYOBRACE maintains the specifications and features of the other trainers, and therefore, all the information provided regarding the modus operandi and the scientific evidence regarding the trainers is applicable to the MYOBRACE.

Thus, the purpose of this document is to explain how the appliances comprising the TRAINER System produce the changes observed in thousands of patients treated with these appliances around the world and to explain why the TRAINER System appliances guide the facial and masticatory muscles to work properly, as well as correct the imbalance of the force produced by an incorrect posture of the tongue.

This document also shows scientific evidence supporting the use of FMO appliances and, particularly, the scientific research gathered from using the TRAINER System.

Modus Operandi of the TRAINER System appliances

As suggested by the name, the appliances of the TRAINER System just train or exercise the muscles at the CMS to physiologically load the bones, stimulating growth and development in the structure composing the CMS. Through development of the maxilla, the mandible and the dental arches, as well as by re-educating tongue posture, the teeth tend to position better and align correctly.

The effects produced by the trainers on the maxilla and mandible have been demonstrated through scientific studies (Usunuz et al., 2004; Ramirez-Yañez et al., 2007), as well as through clinical cases successfully treated with these appliances and reported in the literature (Ramirez-Yañez GO and Faría P., 2008; Kano et al., 2009).

Currently, there is ongoing research with the TRAINER System appliances focusing on understanding their effect on the muscular activity of the masticatory and facial muscles, as well as further investigating the positive effect the appliances can have in mouth-breathing patients and on some altered oral functions, such as swallowing.

In the next two parts of this article, the modus operandi of the TRAINER System appliances will be explained, considering separately their effect on the three dimensions of the mouth: sagittal, transverse and vertical.

Scientific literature supporting the physiological concepts involved on the effects produced by the trainers will be presented to further support the concept that the TRAINER System appliances (including the MYOBRACE) are a viable alternative to treat malocclusion.

Look for Part 2 of this article in the October issue of Ortho Tribune. References will appear at the end of Part 3.

About the author
Dr. German Ramirez-Yañez, DDS, MSc, PhD, is an assistant professor on the faculty of dentistry, Department of Preventive Dental Science at the University of Manitoba in Winnipeg, Canada. Contact him at german@myoresearch.com.
Overcome the economy: time to build your practice

All across the country, the economy has been the never-ending topic of conversation. We’ve heard it all. Many orthodontists are saying this is the first time in their practice they are struggling. For patients, it’s no more waiting three weeks for an appointment. There seems to be open slots all over the books.

Good for the patients, bad for the practitioners. But on the other hand, for the practitioners willing to think outside the box and really make you stand out.

an economy: really make you stand out.
can do all of the legwork for you and ing firm that knows your industry, with a trusted ad agency or market-

ing options and get the attention of perspective patients.

With so many others cutting back, you need to take this oppor-
tunity to stand out from your com-
petition. Invest in your practice by keeping your name out there. Work with a trusted ad agency or market-
ing firm that knows your industry, can do all of the legwork for you and really make you stand out.

Announced Sept. 1, Ortho2 launched a new corporate brand identity that is an expression of its innovative orthodontic management, imaging and communication solutions.

“We are excited to introduce the new look and feel of Ortho2,” says Dan Sargent, president and co-founder. “Our challenge was to create a modern brand identity that represents our technologically advanced software, yet maintains continuity with our proven, established reputation as a leader in orthodontic practice management solutions.

This comprehensive transformation coincided with the release of the ViewPoint 7 software and will debut later in 2009. ViewPoint 7 practice management software delivers improved efficiency and convenience with new advanced features designed to increase office productivity and cost-effectiveness.

By incorporating the latest technologies, the system is designed to easily integrate and support both local and remote networking needs, ensure fast and secure access to your data, improve Internet and e-mail communication, and provide advanced system tools. Features such as wizards, graphical screens and accelerator keys make ViewPoint easy to understand, navigate and use.

“What remains unchanged is the stellar, top-ranked customer service and support for our clients; that is integral to the Ortho2 mission,” Sarg-
gen said.

“Our team is continually explor-
ings and working to bring exciting new technologies and products to improve orthodontic practice efficiency. This is the culture we have at Ortho2 — a group of individuals dedicated to our orthodontic partners and passionate about making significant contributions to the orthodontic community.”

About Ortho2
Ortho2 is a leader in providing comprehensive practice management, imaging and communication solutions for orthodontists. Founded in 1982, Ortho2 is the largest private, held orthodontic practice management software provider in the world, serving 1,300 orthodontists from countries around the globe. For more information, visit www.ortho2.com.
Collaborative software connects
dental professionals on a global scale

By Robin Goodman, Group Editor

At the end of June, Modulus Media — a Toronto-based technology development and marketing company — announced the release of www.DentalCollab.com. Company founder Shane Powell sat down for an interview to highlight what this unique service has in store for the dental community.

DentalCollab.com is a prime example of “cloud computing,” but what does cloud computing mean? We use cloud computing services all the time, such as Twitter, Facebook, SalesForce.com and LinkedIn. Dental Collab.com is a software program that runs on the Internet through your Web browser. It doesn’t care whether you are using a Mac or a PC, if you are a technological wizard or a regular computer user. All you need is an Internet connection. It simultaneously scales to meet the demands of each individual user, so you don’t have to worry about costly software and hardware upgrades. It’s all upgraded automatically, and for free.

Can you trust this online “cloud” with your information and, more importantly, your patient’s information?

Just as you trust online banking with your finances, Facebook with your personal information and Gmail with your e-mail correspondence, Dental Collab.com has built a security system that protects your data. At rest or at play, your data is being secured with 256-bit encryption — just like what the banks use — 24/7 system monitoring and redundant storage. Yes, it’s secure, and yes, it can be trusted.

Why isn’t all of our day-to-day dental software running in the “cloud”?

Most dental software was built to run directly on your personal computer. This includes everything from your word processing to your practice management software. You can imagine that it’s not easy, or cheap, to “rewrite” software to run in the “clouds,” also known as the Internet.

The vast majority of dental professionals have been using their practice management software for years. Because of this, there are massive numbers of users that are ostensibly tied to their desktop computers.

What’s the ideal solution? It’s simple. Continue using your desktop-based software and use DentalCollab.com to bridge your offline practice with the online global dental community.

Significant examples of software trending to the “clouds” include Microsoft Office Live bringing its office products into the online cloud and Google Docs — its online office suite was the catalyst for Microsoft to start bringing its office products into the online clouds.

What about all the other programs dentists are currently running on their practice computers? Does all this have to be replaced?

DentalCollab.com doesn’t replace your desktop software; it will extend your reach. DentalCollab.com actually adds to the practices that need a collaboration tool. An online workspace, an information hub that can be securely accessed and easily shared online. Connect with your team, specialists, referrals, any other dental professionals or groups of professionals from around the globe.

Most dental offices are using legacy software that does a great job of managing their day-to-day practice, but it ties them to their desktop computer. We all know it isn’t practical to replace your practice management software; therefore DentalCollab.com acts as the intermediary, intuitively extending the reach of your offline applications, or “in the clouds” as we say.

How exactly does DentalCollab.com’s cloud computing service help dental professionals?

Now that dental professionals know that they can still use their existing software, they can relax. DentalCollab.com is designed to be super easy to use. Taking this approach, we offer a much shorter learning curve to effectively collaborate online. It’s quick and it’s easy to get started and is exceptionally versatile.

There are tremendous benefits for enhancing patient care through extending one’s expertise through a professional network of local specialists, as well as dipping into the vast global talent pool. Benefits include: open up treatment mentorship opportunities, write up industry experts worldwide; better manage your referrals by inviting labs, specialists, etc.; request second opinions, something some companies love; and provide patients with access to their treatment plans, X-rays and follow-up information.

How can DentalCollab.com actually save time and money?

Time savings is realized through improved organization and better communication between team members, suppliers, referrals and even sales representatives, thus saving you time and headaches. Whether you are learning new procedures, training with new instrumentation or sharing your own particular expertise, DentalCollab.com is perfectly suited for learning and mentoring.

Enhanced patient health has tremendous short- and long-term benefits for your practice. No longer are you limited to your local specialist. With DentalCollab.com, you can access world-class opinion leaders to enable you to make the best decision possible.

A happy patient means more referrals. Your insurance company will love you. Managing your second opinions through your Treatment Workspace means that you automatically maintain a secure history of all your collaborations. Think of it as record-keeping insurance that helps to protect you against patient problems.

e-Consultations are becoming a requirement as many patients have less and less time. Common treatment planning and follow-ups can be done over the Internet. Securely invite patients to view their complete treatment plan past, present and future.

How is charting handled?

We’re enabling you to connect any of your existing software with the online DentalCollab.com network. Quickly upload, organize and share your charts, X-rays, photos and all related files. Once you start working with the system, you won’t know how you did without this fabulous resource tool.

So would you walk us through a visit to the site and what a dentist would see once he begins using DentalCollab.com?

Once inside, you’ll see right away how easy it is to create a patient file, create a new Treatment Workspace and invite collaborators to join in.

1. Log in to your account.
2. Manage patients: As easy as filling out a form. Invite patients to view their treatment information anytime.
3. Create treatment workspaces: Upload X-rays and supporting files, create treatment plans, set priorities and organize your tasks between collaborators.
4. Invite collaborators: Invite office staff, doctors, specialists, mentors, sales support staff from manufacturers and patients. Any of these invitation-only “treatment collaborators” can review/edit treatment plans, set second opinions or simply provide a follow-up e-Consultation.
5. How to manage collaborators: Revoke access at any time; subscribe to daily, weekly and monthly reports; and schedule reminders.

DentalCollab has a solid developmental roadmap. Looking into the future we see many opportunities for extending our functionality. However, it’s important that we develop in the right places.

We welcome your feedback and have set up a special offer. Enter code “DTCLOUD” for one free month’s access. You’ll see why we believe that collaboration makes the world a better place.

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Nite-Guide: an interceptive first-phase ortho procedure for the 5- to 7-year-old

By Earl O. Bergersen, DDS, MS, MD

The Nite-Guide technique is a practical clinical solution to first-phase early treatment and has the potential to prevent future relapse. The technique involves various sized appliances that have preformed sockets arranged in ideal Class I occlusions. These sockets serve as templates that gradually guide erupting adult teeth into their proper positions.

In this process they exert lateral forces against adjacent teeth, which significantly increases the arch, after which adult periodontal fiber formation takes place and stabilizes this ideal occlusion. This procedure mimics the natural eruption process described by Moorrees for normal dentitions.

At the same time, the adult incisors are prevented from super-erupting into an unacceptable overbite and creating mandibular advancement when the overjet is excessive. It has been shown that 95 percent of children are candidates for this procedure, as determined in a major study of 489 subjects at 5 years of age.

There are specific signs in the deciduous dentition that will lead to malocclusions at a later age. These signs serve as indications for the Nite-Guide procedure and are as follows:

- **Closed incisal contacts or slight crowding of the incisors to 1 to 2 mm**
- **Deciduous overbite of 1.25 mm or more**
- **Deciduous overjet of 3 mm or more**
- **TMJ sounds of clicking or crepitus that have an accompanying overjet and overbite**
- **A gummy smile in excess of 2.5 mm with an accompanying overbite**

Research has shown that the Nite-Guide procedure can eliminate or greatly minimize all of the above potential characteristics that can result in later malocclusions. In the event a second phase of fixed orthodontics is needed, the treatment is usually of minor complexity.

Results from a study of 107 5-year-old patients using the Nite-Guide technique from 5.1 to 8.4 years showed successful correction of the overbite, overjet and crowding in the 69 percent of patients who wore the appliance to completion. No treatment fees were charged for the procedure and patients wore the appliances only while sleeping.

Mandibular length (CO-GN) in the treatment group (N=115) increased 34 percent more when compared to the control sample (N=104).

In another study of 45 Nite-Guide patients, it was shown that the treated sample experienced a 540 percent decrease in TMJ symptoms by 14 years of age when compared to the control group. Need for further treatment after Nite-Guide use in 117 patients when compared to a non-treated control group of 104 individuals was 1 percent for mandibular crowding (47 percent for controls), 2 percent for maxillary crowding (32 percent for controls); 0 percent for overjet (greater than 5 mm) (50 percent for controls); 1 percent for overbite (greater than 5 mm) (58 percent for controls); and 2 percent for overbite and open-bite (74 percent for controls).

In conclusion, there was little treatment needed at 8.4 years of age when compared to the control sample while there were no differences between the two groups initially. The results from these studies indicate the Nite-Guide interceptive technique can be a viable stand-alone or first-phase procedure.

The Nite-Guide method involves appointments of five to 10 minutes every three months during the corrective phase, lasting about two years. Retention visits, following the active stage until patient dismissal at 12 years of age, are at six-month intervals.

Usually two appliances are used, both larger than the dentition, followed by crowding, is anticipated to guide the larger erupting adult teeth into a perfect occlusion. The first appliance (“C” series) is usually two half-sizes larger than the measurement and is worn passively for about five months while the lower central incisors erupt.

The second and last appliance used (“G” appliance) is usually three half-sizes larger than the first and is used until the patient is dismissed. The “G” series is a closed version of the “C” series and encourages nasal breathing. The Nite-Guide technique involves only nighttime passive wear while the child sleeps.

A patient with a 5 mm deciduous overbite and an excessive deciduous gummy smile is shown in the figures above. The final result shows significant correction during nighttime-only wear for 15 months and a retention period of 16 months.

Conclusion

The Nite-Guide procedure is a viable interceptive technique using natural eruptive forces and normal jaw growth to produce an ideal occlusion. Crowding, rotations, excessive overbite, overjet, TMD and gummy smiles can be prevented, resulting in healthier permanent dentitions.

For more information, visit www.ortho-tain.com or call (800) 541-6612.

References


Cadent, the leading provider of 3-D digital solutions for the orthodontic and dental industries, is celebrating the 10th anniversary of the introduction of OrthoCAD iCast™ digital study models. iCast broke new ground through the electronic storage and retrieval of cases, enabling practitioners to visualize cases electronically without the need to create and store plaster models.

The first case was submitted by Dr. John Martin of Augusta, Ga. on Aug. 16, 1999. “The hassles associated with creating and storing plaster casts make it very difficult to share treatment goals and progress with patients,” said Dr. Martin, who continues to be an active OrthoCAD customer. “Digital study models not only save time and money, but also serve as a vital tool in evaluating pre-treatment and post-treatment cases. iCast, which is standard of care at my practices, has significantly increased office efficiencies and improved workflow.”

With more than 1.7 million cases processed and 1,800-plus customers, OrthoCAD iCast is a world leader in orthodontic digital modeling, said Timothy Mack, chief operating officer of Cadent. “Our commitment to continuously improve upon iCast’s functionality has led to a growing number of new features and benefits,” he said. “For example, recent upgrades ensure extensive compatibility with nearly all management and imaging software programs, state-of-the-art diagnostics not found on other digital study models, enhanced jaw alignment tool with more options to make occlusion adjustments and a computerized discrepancy index updated to new American Board of Orthodontics specifications.”

OrthoCAD iCast enables orthodontists to assess case complexity on pre-treatment digital models and review clinical treatment results instantly through multiple sites, saving time. With iCast, a digital file copy of all data and measurements for future reference is created and saved at Cadent’s service center for a period of 14 years, ensuring data is backed up. As part of the certification process, the American Board of Orthodontists now accepts digital study models submitted by orthodontists in lieu of pre-treatment hard casts. In addition, the OrthoCAD iQ™ system allows orthodontists to go beyond study models to simulate treatment strategies and select and execute the most appropriate treatment plan that includes more optimal positioning of orthodontic brackets. OrthoCAD iQ services reduce the treatment time and number of patient visits by an average of 25 percent, benefiting patients and orthodontists alike.

For more information, please visit www.cadentinc.com.
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Tru-Pan for i-CAT

Imaging Sciences introduces Tru-Pan”, another breakthrough in cone-beam technology for the award-winning i-CAT®. Tru-Pan is revolutionary software that yields precise “true” panoramic views from 3-D scans. Developed to meet the needs of dental professionals who require quick and easy pan creation from existing 3-D scans, Tru-Pan delivers anatomically accurate and precise panoramic images with optimal clarity and detail, plus time savings over traditional arch detection methods found in today’s 3-D imaging programs.

Tru-Pan’s advanced reconstruction of unique anatomic landmarks automatically creates a custom, optimized focal trough specific to each patient. This focal trough detection reveals a new level of detail that delivers consistently crisp and clear views of root tips and crowns, including the incisor regions, and sinuses—all within one panoramic image.

Tru-Pan’s panoramic images are created with just one click of the mouse. The automatic custom focal arch detection works in conjunction with the patient’s 3-D data to quickly and efficiently extrapolate “true” and precise panoramic views. These consistent and optimal results save minutes of valuable clinical time over manual and semi-automatic arch setting techniques.

Time savings extends to Tru-Pan’s easy integration. Available as an optional feature in the i-CATVision™ software, the easy, one-click function triggers automatic reconstruction with no additional training for clinicians or team members.

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www.Tru-Pan3D.com
Video: www.tru-pan3d.com/trupanvideo.htm
Those who see the ‘big picture’ gather for two days of 3-D education

By Fred Michmershuizen, Online Editor

Are you using 3-D imaging yet? Or are you stuck in the 2-D X-ray world? If you haven’t yet ventured into the new visual frontier of cone-beam imaging, you have no idea what you might be missing. Just ask those who attended the third International Congress on 3-D Dental Imaging, held in Chicago from June 19 and 20. The event was hosted by Imaging Sciences International and Gendex Dental Systems.

 Practitioners in a variety of fields gathered for two full days of intensive education and panel discussions. The theme of the meeting was “An Interdisciplinary Approach to Treatment Planning,” and an impressive roster of speakers shared their knowledge and expertise in how they incorporate 3-D technology in general dentistry, implantology, orthodontics and endodontics.

In addition, almost two dozen companies were on hand to showcase their offerings, including new products, software and ancillary services.

“Cone-beam 3-D technology has emerged as the superior treatment planning tool throughout the industry,” said Rob Joyce, president of KaVo Group Imaging, in remarks welcoming attendees to the congress. “As practices around the globe transition from 2-D to 3-D imaging, we realized the need to provide dental professionals with the information and expertise to successfully bring 3-D dentistry into the everyday practice.”

Dr. Scott Ganz, who served as moderator for the event, kicked off the meeting with welcoming remarks and an introduction. His advice to attendees: If you have cone-beam in your practice, scan every patient regardless of what kind of treatment they need. “Technology is our friend,” he said. “Embrace technology.”

Ganz was joined by Dr. Jack Krauser for the first session, “Lessons Learned: Incorporating Cone-Beam CT and 3-D Implant Planning: The Good, the Bad and the Ugly.” They presented cases that had been treated beautifully with 3-D imaging, and many others that did not turn out so well when using traditional 2-D images.

Krauser, who said his cone-beam machine is the single most important device he’s ever gotten for his practice, pointed out that while the data collected for a patient can be useful for things such as guided surgery, it is ultimately the dentist — not the software — who must interpret the data to determine the best plan of action.

“Installing the cone-beam machine is just the beginning,” Krauser said. “It’s not the scan, it’s the plan.”

Krauser said the technology can be used by dentists to look back at past cases that failed to find out what went wrong and why. Such insights are valuable, he said, in preventing future mistakes.

Later in the day, orthodontist Dr. Ed Lin presented “Taking 21st Century Orthodontics into the 3-D World.” He said while the software can be difficult to learn, the improved results for patients makes the investment of both time and money worth it.

“With these tools we don’t have to guess anymore,” Lin said. “It is our responsibility to learn this.” Also presenting on the first day of the congress were Dr. James Mah on “Lies, Damned Lies and Cone Beam;” Dr. Michael A. Pikos on “Interdisciplinary Esthetic Zone Reconstruction: Synergy of Interactive CT HARD and Soft Tissue Grafting;” and Dr. Walter Chitwood on “Creating Better Communications with Technology.”

Dr. W. Bruce Howerton Jr., who offered “A Systematic Approach to Interpreting DICOM Data Within the Field of View,” was among the presenters on the second day. Howerton took attendees on a “tour” of the human facial anatomy, from top to bottom and left to right. He showed fellow dentists what to look for in data sets. He even revealed how to detect things such as sinus infections and excessive ear wax buildup in patients, which is quite common.

Later in the day, Art Carley, an attorney, offered up some of the legal ramifications involved in using — or not using — 3-D imaging. Also presenting on the second day of the congress were Dr. Alan Wong on “3-D Endodontics: The Final Frontier;” and Dr. Steven A. Guttenberg on “Cone Beam CT: Can You Afford to Not Have One in Your Office?”

The meeting was made possible by Imaging Sciences International and Gendex Dental Systems, the corporate hosts for the event. Also supporting the meeting was gold sponsor 3D Diagnostix.

Sponsoring companies were 360imaging, 3MD, Anatomage, BeamRiders Diagnostic Services, BioHorizons, CanCAD, Dental USA, DEXIS, Dolphin Imaging & Management Solutions, Dimensions Imaging, KaVo Dental, Materialase Dental, Nobel Biocare, nSequence, Ormco, Pelton & Crane, RLMS Radiology Lab Management System, SureSmile Digital Orthodontic System, Sybron Implant Solutions and The Bottom Line Comprehensive Course.

During breaks between presentations, meeting attendees were able to visit all of the sponsoring companies in the exhibit area.

Plans are already under way for the fourth International Congress on 3-D Dental Imaging, to be held June 25-26, 2010, in La Jolla, Calif. For more information and to register, visit www.i-CAT3D.com.
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