‘I’m fortunate to have found a career that I’ve embraced’

Dr. S. Jay Bowman talks about how he got started (blame his father), where he’s been in his career and why he feels so lucky

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

Annual session offers continuing education, social activities and more

By Kristine Colker, Managing Editor

Going to Hawaii is normally considered a treat. But going to Hawaii and having access to a myriad of continuing education sessions, a slew of companies showing off their newest wares and an array of social and networking events is even better.

This year, the Pacific Coast Society of Orthodontists is taking its 74th annual session to the shores of Oahu and the Hilton Hawaiian Village Beach Resort & Spa. The festivities are set to begin Saturday, Oct. 9, and last until Tuesday, Oct. 12.

According to organizers, some changes have been implemented to attract more PCSO members and their staffs. For instance, the doctor program will begin with a president’s lecture from Past AAO and PCSO President Dr. Don Joondeph and will continue with a lineup of U.S. and international speakers, most of whom are new to PCSO meetings.

In addition, the staff program has been changed to introduce new speakers to PCSO and to provide more useful information for experienced staff.

By Kristine Colker, Managing Editor

A view of Waikiki Beach from Kapiolani Park. (Hawaii Tourism Japan)
Ethics in ortho

By Dennis J. Tartakow, DDS, MSed, PhD, Editor in Chief

“Do no harm” is assumed and is an ethic that is expected. In general, there are at least two ways to do harm: sins of commission and sins of omission. A dentist can harm a patient with the knowledge that he knows and with what he does not know.

The words excellence, ethics, professionalism and leadership are just a few of the terms emphasized by the American College of Dentists in its mission statement that applies to every dentist.

This mission statement is a great start for each of us to consider, reflecting the purpose of the services that we provide to our patients and staff; it should guide our actions, spell out our goals, provide a sense of direction and guide our ultimate decision-making.

It should provide the framework or context within which our objectives are formulated, proposed and performed.

A fundamental and basic aim of orthodontic education is to explain and demonstrate comprehensive approaches to communicating, diagnosing and treatment planning.

An interdisciplinary approach to learning involves psychology, sociology and other behavioral sciences, all of which must be considered in order to provide our students with an enhanced and enigmatic knowledge base.

This requires the cognizance of pragmatic realities for time/motion constraints, insurance limitations and all other office issues that are central to treating our patients.

Orthodontic educators and administrators must also have a fundamental understanding of human behavior and motivation and present these human rights issues and relationships to our residents.

This will help the students develop a greater understanding of the cultural differences and boundaries of our diverse patient population.

A chain is as strong as its weakest link, and in order to provide optimal health care for our patients, the orthodontist and staff must strive to work in concert with each other. However, the heart of our concerns should be focused on compassion, understanding and empathy for the patient’s comfort, health and best interest.

Only through thoughtful supervision, planning, congruity and focus can these needs and objectives of the orthodontist be achieved at the highest level.

Reference

Tongue piercings linked to teeth gap

Playing with a pierced tongue stud could lead to a gap between front teeth, according to a new study. The research, which was carried out at the University at Buffalo in New York, suggested tongue piercings could be a major cause of unnecessary orthodontic issues.

The report claimed those with tongue piercings were likely to push the metal stud up against their teeth and consequently cause gaps and other problems to arise.

Dr. Nigel Carter, chief executive of the British Dental Health Foundation, said the study highlighted the risks that tongue piercings have on oral health. “As well as causing an apparent gap, oral piercings can also lead to chipped teeth and infection,” Carter said.

Lead author of the study, Sawsan Tabbaa, said that “force, over time, moves teeth” and that the effects of people playing with their studs crop up in a “very high percent of the cases.”

A professor of orthodontics at the University at Buffalo School of Dental Medicine, Tabbaa explained that tooth damage was common in both past and current case studies.

The study featured a 26-year-old female patient and showed that a space between the upper front teeth had appeared during a period of seven years, during which the metal bar was pushed against and between the teeth.

The patient provided researchers with photographs to show she had no diastema before having her tongue pierced. It was strongly thought that positioning the tongue stud between the maxillary central incisors caused the midline space between the front teeth.

The results of the study were published in the Journal of Clinical Orthodontics.

(Ad: Keep your tongue free from piercings and your teeth free from gaps. (Photo/Serghei Starus, Dreamstime))
Welcome to Hawaii! Now that most of us have flown here, from across the country or even from across the world, you don’t want to miss this opportunity to see the best of what Hawaii and Oahu have to offer.

With Waikiki as a central hub, you can explore the legendary North Shore one day and spend the next on the east side snorkeling at Hanauma Bay, a protected marine sanctuary with tons of colorful fish. Thrill seekers can skydive at Mokuleia while daydreamers can relax peacefully on the beach.

Here is a closer look at some activities you’ll want to be sure you check out.

The North Shore
If there is such a thing as a perfect wave, you’ll likely find it on the North Shore. The big, glassy winter waves of this legendary surf mecca attract the best surfers in the world. Stretching for more than seven miles, the beaches of the North Shore host the world’s premier surfing competitions including the Super Bowl of wave-riding, the Vans Triple Crown of Surfing.

To get to the North Shore, drive along northwestern Kamehameha Highway (Highway 83) from Haleiwa to Sunset Beach. From Waikiki, it takes about 45 minutes to get to Haleiwa and an hour to get to the beaches. Some places to visit:

• Waimea Bay: Waimea Bay is the birthplace of big wave surfing and is the venue for the Quicksilver in Memory of Eddie Aikau Big Wave Memorial. This surf competition pays homage to legendary surfer Eddie Aikau and only takes place when the epic Waimea waves are at least 20 feet high.
• Banzai Pipeline (Ehukai Beach): The merciless waves of Pipeline break just 50 to 100 yards off the beach over a shallow reef, making this one of the most dangerous surf spots in the world.
• Sunset Beach: The northernmost surf spot on the North Shore is Sunset Beach. The long wave-breaks here are the setting for the O’Neill World Cup of Surfing, the second contest in the Vans Triple Crown of surfing.
• Haleiwa: This laid-back surf town with a country feel is the gateway to the North Shore, filled with great restaurants and shops.

Waikiki
World-famous Waikiki was once a playground for Hawaiian royalty. Known in Hawaiian as “spouting waters,” Waikiki was introduced to the world when its first hotel, the Moana Surfrider, was built on its shores in 1901.

Today, Waikiki is a gathering place for visitors from around the world. Along the main strip of Kalakaua Avenue you’ll find shopping, dining and entertainment.

At Waikiki Beach, a statue of Hawaiian hero Duke Kahanamoku welcomes you with open arms. Regarded as the “Father of Modern Surfing,” Duke grew up and surfed in Waikiki during the turn of the century. Discovered as a swimming sensation, he won Olympic gold medals in the 100-meter freestyle in 1912 and 1920, then went on to act in Hollywood and use his fame to spread the popularity of surfing.

Waikiki has a variety of beaches. The main stretches include:
Topics for doctors include advances in cleft and craniofacial surgery, evidence-based approaches and, geared for those new to practice, becoming a 3-D practitioner. For staff, topics include such things as harnessing the power of the Internet, financial considerations and case acceptance.

Throughout the weekend, there will be numerous events, such as:

• Welcome reception, Oct. 9: This kick-off event takes place on the Grand Lawn of the Hilton Hawaiian Village. Grab a cocktail and a bite to eat while listening to music and participating in activities.

• Component breakfasts for California, Nevada, Oregon and Washington, Oct. 10: Network with colleagues and catch up with what’s happening in your component society.

• President’s lecture, Oct. 10: Joondeph will speak on “Traverse the Transverse.”

• PCSO awards and opening luncheon, Oct. 10: Dennis Snow, an alumnus of Walt Disney, will speak on “Lessons From the Mouse — A Guide for Applying Disney World’s Secrets to Your Organization, Your Career and Your Life.”

• AAOF reception, Oct. 11: Sponsored by Ultradent, this event celebrates the foundation programs that support continuing research in the orthodontic profession.

• Alumni receptions, Oct. 11: Receptions will be held for those from the University of Alberta, UCLA, UCSF, University of the Pacific, Loma Linda University and the University of Washington.

To learn more about Waikiki’s history, take a stroll along the Waikiki Historic Trail, which highlights 23 historic sites, 19 of which are marked by bronze surfboards with a wealth of historical information.

The trail begins at the Royal Hawaiian Center in the heart of Waikiki. The Royal Grove in historic Helumoa was once home to 10,000 coconut trees. The trail continues to the sacred Wizard stones off of Kuhio Beach; King’s Village, a shopping center that was once the residence of King Kalakaua; and the Duke Kahanamoku statue.

Pearl Harbor
Pearl Harbor, named for the pearl oysters once harvested there, is the largest natural harbor in Hawaii and the only naval base in the United States to be designated a National Historical Landmark. The aerial attack on Pearl Harbor resulted in 2,390 dead and hundreds wounded, and drove the United States into World War II. Today, these attacks are honored by memorial sites.

• Battleship Missouri Memorial: General MacArthur accepted the unconditional Japanese surrender that ended WWII on Sept. 2, 1945, on the Surrender Deck of the Battleship Missouri Memorial. Today the massive “Mighty Mo” is a living museum, with exhibits spanning three wars and five decades of service. Explore the decks of this 60,000-ton battleship, three football fields long and 20 stories tall. Stand on the Surrender Deck and view the documents that ended the war. Take a tour and get special access to restricted areas. And don’t miss the ship’s most stunning feature: towering 18-inch guns that could fire a 2,700-pound shell 23 miles.

(Source: Hawaii Visitors and Convention Bureau)

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• USS Arizona Memorial: At 8:06 a.m. on Dec. 7, 1941, the USS Arizona was hit by a 1,760-pound armor-piercing bomb, which ignited its forward ammunition magazine. The catastrophic explosion that resulted sank this massive battleship in nine minutes, killing 1,177 crewmen. Begin your tour at the Visitor Center where you can view a film about the attack and view plaques honoring lives lost on that fateful day. You’ll then take a boat shuttle to the USS Arizona Memorial, a floating memorial built over the sunken hull of the Battleship USS Arizona, the final resting place for many of the ship’s crew. In the shrine room, a marble wall exhibits the names of the men who lost their lives on the Arizona.
What motivated you to become an orthodontist?
I grew up thinking I would either be a family physician, like my father, or a rock musician. When I was a senior in high school, my dad pulled me aside and suggested that I consider orthodontics. He had a lot of foresight, predicting managed care and potential socialization of medicine.

It was not until I was in my third year of dental school that my attention did turn to orthodontics. Years later, I was having dinner with Buzz Behrents, chairman of Saint Louis University, and it suddenly struck me that it was because of Buzz that I had the seed of an orthodontic career planted in my head.

Buzz’s father and my dad were physicians at the same hospital in Galesburg, Ill. Although, Buzz and I had never previously met, our two fathers must have been talking about their sons’ future plans. Behrents told my dad that his son was entering into an orthodontic career; later I was advised to do the same.

As if by design (or just plain coincidence), we were both accepted by the same chairman, Lysle Johnston: Buzz at Case Western and me at Saint Louis University, 10 years apart.

When and how did you open your orthodontic practice?
During my orthodontic residency, my wife and I were looking for a place to settle “somewhere in the Midwest.” We’re both from the same rural area, and although we enjoyed our time in St. Louis, we were anxious to return to a smaller community. Consequently, we looked at a variety of practices that were for sale in many different states. We finally settled on a small practice in Kalamazoo, Mich.

Lysle Johnston’s influence was felt again as he is the one who suggested the community would be an excellent fit for us, and he was, as usual, correct.

What special areas of education, research or clinical activities are you most interested in and why?
I had never originally intended on ever standing up in front of an audience to speak, or to invent anything, or to write any papers. It seems that all of this happened by accident to some degree. My wife and I never imagined that we would have the unique opportunities to travel the world or that anyone would be interested in anything I would have to say about orthodontics.

My first lectures involved the controversial issues of extraction/nonextraction treatment and a critique of Phase I treatments. I also had been combining methods of molar distalization with fixed functionals from a very early stage in my practice to deal with patient complaint issues. I decided I would document these methods, especially because many of the dentists in my area were not familiar with the devices I was using. Consequently, the first papers I wrote were descriptions of these mechanisms and reviews of controversial and contentious issues in our specialty.

I’ve been involved in research examining the effects of molar distalization and reducing enamel demineralization, and I am one of four doctors on the Invisalign Teen Research Team.

About 1996, I was asked by the president of American Orthodontics to develop a low-profile v-slot bracket system with associated auxiliaries (the Butterfly System), and that lead to creation of numerous devices, including the Monkey Hook and Kilroy Springs for impacted canines; the TAD Bite Opener, Ulysses Spring and Propeller Arm for mini-screw applications; the patented Bowman Modification Distal Jet and Horseshoe Jet (supported by mini-screws); Aligner Chewies and Retainer Retrievers for Invisalign, and several other simple solutions to everyday clinical problems.

How did you get involved in teaching at orthodontic residencies?
More than 10 years ago, I received a call from Lysle Johnston at the University of Michigan. He said, “Doc, I’d like you to create a straightwire typodont course for the troops.”

After I pulled my jaw off the floor, I did what most folks do when Lysle asks for something: I simple said “Yes — but how much time do I have?”

He told me “a couple months,” so I dropped everything and created a manual and typodonts, and I’ve been giving this course for first-year residents ever since.

Lysle always impressed upon us as students to “give a little something back to the specialty.” It could be donations of money, time and expertise in the form of teaching, writing, inventing or being part of organized orthodontics. It just turned out I have done a little of each of them.

In your opinion, is there a need to change the way higher educational programs in this country educate their orthodontic residents?
I don’t think the majority of orthodontic programs are specifically a concern, although we are experiencing the accelerated loss of some of our most influential leaders in recent years. More importantly, practitioners do have a choice to make. We read that there is an emphasis on evidence-based care; however, in the same breath, we flippantly ignore the evidence as seemingly unimportant when it doesn’t square with what we have often chosen to provide as “treatments” for patients. There appears to be more concern for the appliance than the science.

So, unless orthodontists choose to value the “products” generated by academia (namely, research), over the unsubstantiated claims of those selling something (often, whose only duty is to their shareholders), then the specialty will likely devolve into simply a “trade,” as the impetus to teach/research is lost.

To paraphrase my mentor, Lysle Johnston, “Scientific evidence is not just a theoretical nicety, it is a necessity,” the life-blood of a learned calling.

As an educator and clinician, what orthodontic techniques do you teach?
At the University of Michigan, I was fortunate to have been asked to teach a straightwire typodont
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About Scarlett
Scarlett Thomas is an orthodontic practice consultant who has been in the orthodontic field for over 23 years, specializing in case acceptance, team building, office management and marketing. As a speaker and practice consultant, Scarlett has an exceptional talent to inform, motivate and excite.

After implementation of her concepts into your practice, Scarlett invites you to experience not only tremendous growth and increased income but a well organized practice.
course that includes the application of vertical slot auxiliaries, molar distalization and fixed functionals. I intend for students to expand their "tackle box" armamentarium and consider a "loose-leaf" reference manual, rather than a cookbook philosophy.

Specifically, I’d like them to consider at least three options for most any clinical situation. I hope to instill an interest in exploring all aspects of our specialty with an open but critical and skeptical mind — perhaps less cynical than mine.

What hobbies do you enjoy? I’m fortunate that my avocation is also my vocation. I have enjoyed teaching, creating lectures, sharing experiences and travels around the world with family while making new friends and all-the-while thinking about problems and creating simple inventions to help to solve them.

On another note, I was recently able to reunite our rock band from high school to play two shows for our class reunion, 35 years after our last performance — at the very same venue. We worked for about three years to pull this off, and it was very satisfying to be able to perform the same three sets of music again with the same guys from back-in-the-day. As rock musician Pete Townshend said, “I may be old, but I ain’t borin’!”

Looking back at your career, would you do anything differently? I suppose I might have made things easier by simply following the path of least resistance: flavor-of-the-month orthodontic fads and popular gurus during the past 25 years. But I didn’t jump on routine functional appliances, early aggressive treatments, slippery braces, the avoidance of extraction-at-all-costs, the selling out of my practice to some management group or the adoption of hard-sell marketing.

I decided to become immersed in research-based concepts and focus on looking for innovative solutions. As a result, I was able to design my own orthodontic offices, develop my own line of braces and create a system of devices to complement treatment that I feel comfortable and proud to provide for the people who seek our advice and assistance.

In the process, I grew an orthodontic practice by creating relationships built on trust. So, I guess there aren’t too many things I would have done differently.

Do you have any final comments for our readers? Orthodontics is a life-long learning process, and there always appears to be more and more to learn. It’s sometimes overwhelming to consider.

As Alexander Pope wrote: “A little learnin’ is a dangerous thing, Drink deep or taste not the Pierian Spring.”

Or to paraphrase the mathematician Alfred North Whitehead: “How much orthodontics do you need to know? Enough not to be taken in by it.”

I’m fortunate to have found a career that I’ve embraced — pun intended — completely, and I enjoy being involved in so many aspects.

Dr. Bowman is a diplomate of the American Board of Orthodontics, a member of the Edward H. Angle Society of Orthodontists, a fellow of the American College of Dentists, fellow of the Pierre Fauchard Academy International Honor Organization, a charter member of the World Federation of Orthodontists and is a regent of the American Association of Orthodontists Foundation. He developed and teaches the Straightwire course at the University of Michigan, is an adjunct associate professor at Saint Louis University and is a clinical assistant professor at Case Western Reserve University. He received the Angle Research Award in 2000 and the Alumni Merit Award from Saint Louis University in 2005.

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Creating a strong foundation

LeAnn has been visiting all referring offices, including infrequent referral sources. Some orthodontists believe it’s a waste of resources to spend time referring to dentists who hardly ever refer. But often when you pay attention to these offices, they will think of your office when it comes time to refer their patients. For referring to their referral sources in her geographic area, Gonzalez received a referral from a dentist who had stopped referring years ago. This success will continue, as long as the referral marketing program is consistently maintained.

Retooling the schedule

Gonzalez and her team have finished the process of procedural time studies, which is key to constructing an accurate schedule. The schedule serves as the cornerstone for all systemic change in the practice. An inaccurate schedule leads to lost productivity, appointment overruns and increased stress for the team.

“We are trying to create an ideal (optimal) schedule that refocuses our current strengths and services,” Gonzalez said.

The practice has installed computers at each operatory chair, making it easy for the clinical team to schedule patients for adjustments and follow-up appointments.

Benchmarking performance

The practice is now using what Levin Group calls Key Practice Expanders™ — 15 critical indicators that measure practice performance, including:

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- Case acceptance ratio
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- Observations
- New patients
- Total referrals
- Number of referral sources

Conclusion

Gonzalez and her team will be heading to the Levin Advanced Learning Institute in Phoenix for Phase II of their consulting experience. During this two-day session, the team will receive advanced training on case presentation, collections and customer service, setting the course for the second half of the practice’s makeover.

To jumpstart your own Total Success Ortho Practice Makeover, come experience Dr. Roger P. Levin’s next Total Ortho Success Seminar being held Dec. 2-3 in Las Vegas. Ortho Tribune readers are entitled to receive 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.

Orthodontists interested in getting their own Levin Group Total Ortho Success Practice Makeover can now apply online to win one by going to www.levingrouportho.com.

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 the Oral Health

(continued)
The evolution of IPR

By Paul A. Rocke, DDS, MS

Bolton focused orthodontists’ attention on the need to alter the mesial-distal dimensions of teeth for optimal occlusion. Peck and Peck offered another rationale for interproximal enamel reduction (IPR) during a time when orthodontists were still banding teeth. Their protocol relied upon the need to reduce the mesio-distal dimensions of the mandibular incisors to coincide with their facial-lingual dimensions. Clinicians needed to make such reductions before banding the teeth, and those reductions were ordinarily miniscule. Not until orthodontists began to bond teeth did they consider removing larger amounts of enamel for therapeutic purposes. Sheridan first suggested the possibility of reducing the mesial and distal surfaces of teeth with rotary instruments, e.g., the air turbine with thin diamond or carbide burs. The rationale was to mimic by fast, deliberate removal of enamel the natural attrition of enamel that Begg had discovered occurring with Australian aborigines.

Instrumentation

Most early recommendations for reducing the mesio-distal dimensions relied on abrasive strips, which require a maximum of labor for minimal results. Cavitron developed a thin-bladed instrument that combined with an aluminum-oxide slurry to reduce enamel ultrasonically, but the ADA removed its approval, and the company stopped making it.

Dome Corporation developed a rechargeable reciprocating electric motor based on a General Electric toothbrush. The thin abrasive tips were made of diamond-encrusted films or aluminum-oxide films. The Dome Corporation stopped production of the Dome Stripper several years ago. This left primarily two effective mechanized instruments for quick enamel reduction: thin rotary discs, which can cut in one plane only and carry a high level of danger, and the air rotor instruments, which often remove more enamel than necessary.

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The Ortho Slenderizer is the clinician’s best tool for the task, i.e., reducing the drudgery of IPR.

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**Edge Animations**
Edge Animations is a powerful tool for enhancing patient education, compliance and case presentation. Edge includes a set of patient-compliance animations at no charge and an optional extended set of treatment-based animations. According to Ortho2, the cutting-edge rendering techniques used produce videos of such quality they must be seen to fully appreciate their educational power. These animations allow the patient and parent to experience and quickly understand many aspects of treatment and compliance in ways that still images and verbal descriptions can’t match.

**Edge Reminders**
Edge Reminders allows you to easily send messages via phone, e-mail and/or text as desired for each patient. Send appointment reminders or messages from a customized subgroup of folders to remind patients about a variety of important events such as birthdays. Define up-to-the-minute start and end times as well as retries for your reminders. In addition, patient responses are integrated into the Edge Scheduler to easily see which patients have confirmed for the day.

**Comprehensive features**
Edge also includes Workflows Standardized Tasks, HR Manager, Dynamic Dashboard and Widget Library, Edge Reports, Goal Tracker, Smart Scheduler, Collections Assistant and more. Edge is compatible with PCs, Macs or a mixed environment and can support multiple monitors for a power user.

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Improve your production, profitability, quality of life

By Paul Zuelke

In many practices, less than 60 percent of exams with orthodontic treatment diagnosed ever start. That is a much lower rate of case acceptance than what the profession had 30 years ago, yet too many orthodontists have accepted today’s rate as “the norm” and therefore believe that their only path to growth is more exams.

A never-ending search for more new patients is rarely the solution to greater production or to greater profitability. Instead, the answer is to improve your production, profitability, quality of life to increase the percentage of your new exams that start.

The responsibility of the orthodontist is to make it easy for his/her customers (patients) to buy the product (braces) that he/she sells (diagnoses). However, far too many doctors have forgotten, or perhaps never understood, that 80 percent of patients/parents cannot afford to write a check for $5,000 to $7,000 in treatment.

These practices’ financial policies, the insistence on large down payments and short-term contracts and the efforts to push patients into outside financing have done more to drive potential patients away from the practice than any other single factor.

Our advice to our clients since 1980 has been to be negotiable and flexible with respect to financial arrangements. If a $0 down payment and 24-month — even 30-month — financing is necessary in order to get a patient started, and if the responsible party is credit worthy, then grant that type of in-office credit to your patients.

Are you really willing to lose a $5,000-plus case start because your patient/parent cannot afford an $800 down payment or cannot afford the payments because you have limited your contract to 18 months?

Notice the key phrase above is, “if the patient is credit worthy.” There is nothing worse for the quality of life within the practice than to get into a negative financial relationship with a financially weak patient. Missed appointments, poor clinical cooperation, over-treatment time, etc., are always the result.

So, while it makes sense to be financially liberal with quality patients, it is a major mistake to do so with patients/parents who are immature, unstable and unwilling to or incapable of keeping their financial agreements.

Fortunately, with modern electronics and communications, in less than 60 seconds a practice can make a high-quality credit decision identifying the potential financial risk of any given patient.

What is it worth to you to know that the patient/parent has, for his entire life, paid all of their bills perfectly? What is it worth to you to know that this person has never paid a bill and has been sued by every credit grantor in town?

Seventy-five percent of most practices’ new patients are in the low-to-zero financial risk category — what we call “A” patients. Twenty-five percent are in the moderate-to high-risk category — “B” and “C” patients.

Take the time to find out which of your patients are which, grant credit proportional to that risk, and you will improve production, profitability and your quality of life within the practice.

Various products are available to help you assess risk as. Consider the Zuelke Automated Credit Coach (ZACC), which returns a letter grade and a payment-plan recommendation in seconds. This web-based tool, which was specifically designed for orthodontists, evaluates stability, maturity and credit integrity in exactly the same fashion as a bank loan officer but does not affect your patient’s credit score.

To learn more about ZACC, take a look at www.getzacc.com.

Paul Zuelke is president and founder of Zuelke & Associates, a management consulting firm specializing exclusively in teaching credit management and accounts receivable control techniques to health-care practices. Zuelke’s extensive, professional background in lending and corporate finance, combined with 30 years of experience with more than 1,000 client practices located throughout the United States, Canada, and Australia, position him as a leading authority in using effective credit management to build a quality health-care practice.
Align Technology announces the launch of Invisalign® G3, the most significant collection of new features and innovations in the company’s history.

Invisalign G3 is engineered to deliver even better clinical results, with new aligner and software features that make it easier to use Invisalign with Class II and Class III patients. New SmartForce™ features are designed for increased predictability of certain tooth movements and simpler, more intuitive software to streamline treatment planning and review.

Invisalign G3 builds on a new and improved feature set introduced to the Invisalign product line last fall.

Easier Class II and Class III treatment
The treatment of Class II/III malocclusion often requires the use of inter-arch elastics to provide anchorage control. Previously, clinicians had to manually cut the aligners to accommodate the use of elastics.

Invisalign G3 addresses this barrier with new precision cuts, which are doctor-prescribed pre-cuts in the aligners that accommodate the use of elastics. Using a new drag-and-drop interface in ClinCheck 3.0 software, clinicians have the flexibility to specify the placement and the type of precision cuts on the aligners.

SmartForce features
SmartForce features, such as the optimized attachments introduced last fall, are attachments and aligner features that are engineered to deliver the forces needed to achieve predictable tooth movements. Based on biomechanical principles, SmartForce features are customized to each tooth using advanced virtual modeling and are positioned precisely to deliver the proper forces.

New SmartForce features in Invisalign G3 include an optimized rotation attachment for bicuspids (previously available only for cuspid), a new Power Ridge™ feature for lower anterior teeth (previously available only for the upper arch) and a lingual power ridge feature for upper anteriors.

A new variation of the optimized rotation attachment is also being introduced to address clinical situations where placement of the attachment may have previously been difficult.

ClinCheck 3.0 and the Invisalign Doctor Site
In addition to clinical tools and enhancements, Invisalign G3 streamlines the overall treatment-planning process. Specifically, a significant evolution of the ClinCheck software makes it easier and more intuitive for clinicians to create and modify Invisalign treatment plans.

New innovations represent leap forward in clear aligner therapy
One of the improvements is the addition of drag-and-drop interfaces for ordering precision cuts and attachments, providing clinicians with new tools designed to make it easier and more efficient to develop and review treatment plans.

The Invisalign Doctor Site (formerly Virtual Invisalign Practice or “VIP”) is a secure website where clinicians access Invisalign patient records, review and approve ClinCheck treatment plans, view patient account status, order treatment supplies and more.

A significant redesign of the site not only makes it simpler and more intuitive to use but also consolidates all of a patient’s Invisalign records and treatment tasks together in one location for easy access. The Invisalign Doctor Site also introduces a new online prescription form that is integrated with the clinician’s clinical preferences.

Available soon
The improvements and innovations in Invisalign G3 also include new clinical preferences, improved staging for interproximal reduction (IPR) and the addition of compliance indicators to Invisalign Assist.

Invisalign G3 features will be available at no additional cost to Invisalign-trained clinicians in North America in October, with international availability in 2011.
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**Extrusion and Rotation Attachments**
New attachments are designed to improve anterior teeth extrusions and canine rotations.

Watch video demos at www.invisalign.com/tribune