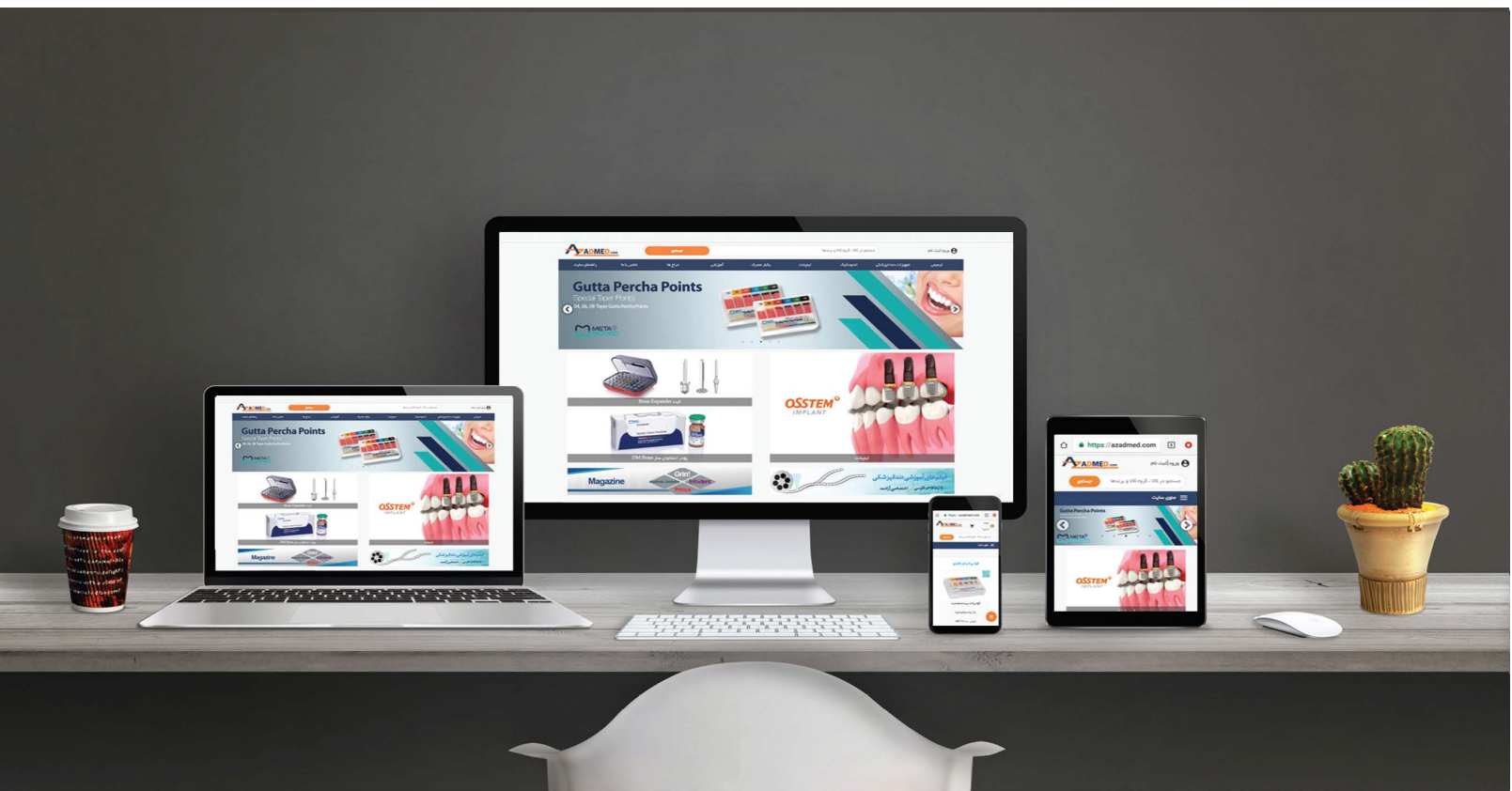




AZADMED.com



www.azadmed.com



 azaadtejaratpars

 @azadmed2

 88 98 80 63 - 6

Aesthetic Dentistry

TECHNOLOGY AND TRENDS IN PRACTICE DEVELOPMENT

ISSUE 1 • WINTER 2019

Balancing Act

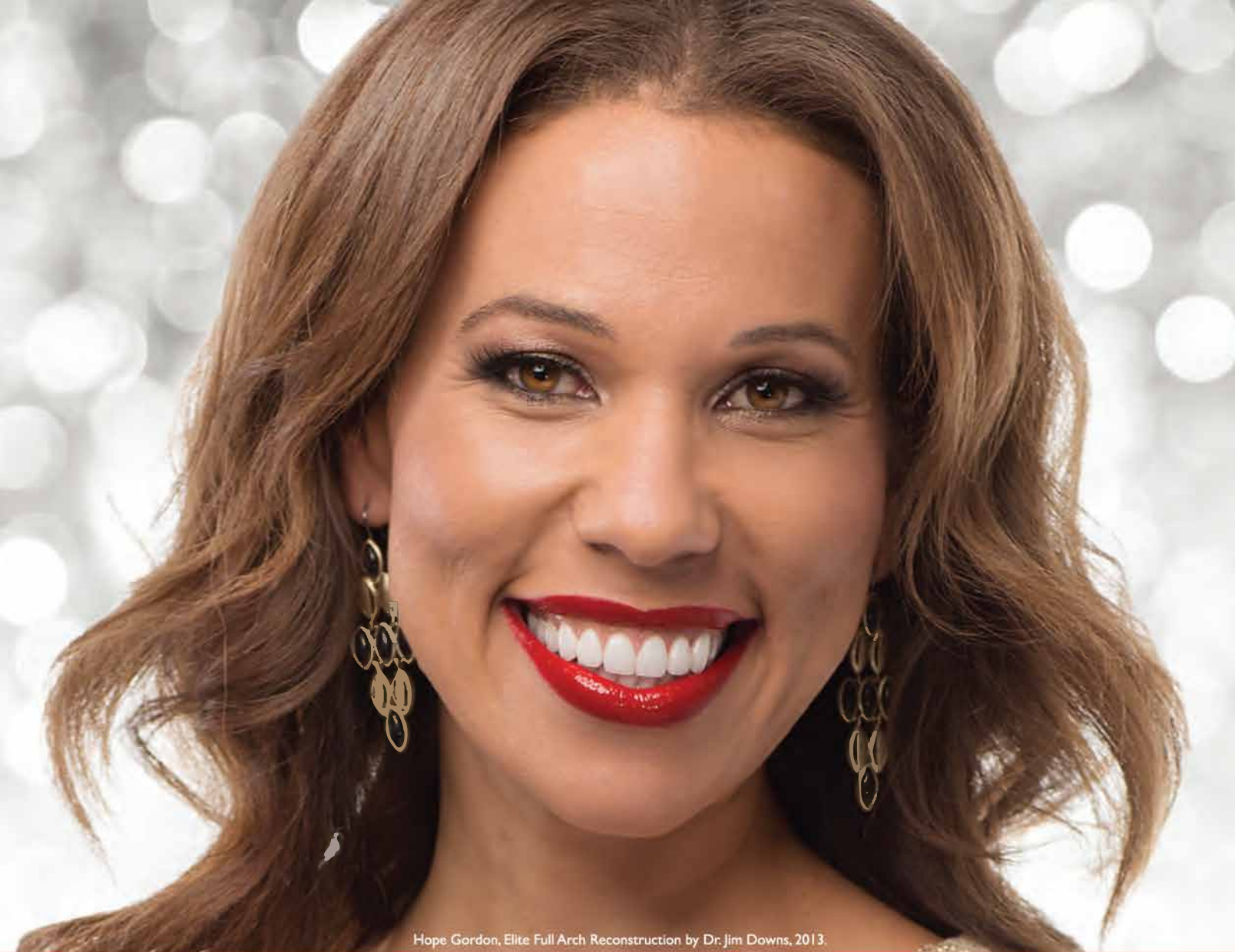
Participate in PPOs without sacrificing patient care.

Safe Harbor

Find the right dental practice to buy.

Finishing Touch

A new smile creates the perfect look.



Hope Gordon, Elite Full Arch Reconstruction by Dr. Jim Downs, 2013.

ELITE

CRAFTED WITHOUT COMPROMISE

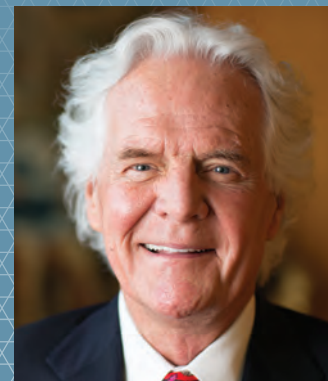
Turn your waiting room into a powerful case presentation tool! Get your free copy of the Elite before-and-after DVD. This looping DVD features cases from *Aesthetic Dentistry* magazine and will show your patients the transformational possibilities of dentistry. Your patients will ask how they can get an Elite smile!

To receive your FREE Elite DVD, call 1-877-502-2443.

ARROWHEAD

www.ArrowheadDental.com

Looking Inward



Ask, "What Kind of Dentist Do I Want to Be?"

A new year is the ideal time to take a moment and examine your life—both personally and professionally. This is not a passive activity—it is a conscious effort to stop what you are doing and examine how you are performing and where you might be missing some opportunities. As dentists, sometimes we have to force ourselves to pause and to recognize those opportunities that habit and tradition may be blinding us to.

Throughout my career, the process of introspection has resulted in some profound insights that allowed me to find a level of success and satisfaction that eludes too many dentists. I humbly submit to you a few of those realizations.

Early in my career, I was having a difficult time making ends meet and finding the level of satisfaction that I had envisioned in dental school. I just couldn't understand why things weren't happening for me. I had graduated from dental school, put in the hard work, and was ready to reap the benefits. I forced myself to stop what I was doing and ask the question, "What kind of dentist do I want to be?" The answer, though it initially seemed simple, was actually more complex.

I had to dig deep and ask myself, "Will I be a dentist that treats the classes or the masses?" For too long, I had been tailoring my case presentations to what I thought my patients could afford, rather than what was the best that dentistry could offer. As dentists, only offering patients the dentistry that

Therefore, I made the determination that I was going to treat all my patients as if they wanted the best dentistry possible. This changed my mindset and consequently changed how I did things. My mission was to share with every patient what was possible in terms of their dental care. I was amazed at how many of my

For too long, I had been tailoring my case presentations to what I thought my patients could afford, rather than what was the best that dentistry could offer.

patients started to see what I was offering as a value proposition rather than focusing on cost. I became a dentist who treated everyone the same, and because of that, I was able to have direct and honest conversations with my patients about what they needed. Plus, I was able to find ways to make it happen.

After taking time to stop and see my world differently, I also realized that I had to change my *(continued on page 42)*

"What kind of dentist do I want to be?" The answer, though it initially seemed simple, was actually more complex.

we think they can afford or what their insurance will cover is a "wait-until-it-breaks" approach. It robs the patient of the opportunity to get the best care and it steals higher levels of satisfaction and productivity from the dentist.



Over the Shoulder™: Full Arch Reconstruction

Only 30 percent of dentists offer this innovative procedure in their practices—it's time you became one of them.

14 CE Credit Hours | \$1,995

May 10–11, 2019 (sold out)
June 7–8, 2019

Salt Lake City, UT

Clinical Hands-On

Prep and seat one of your full arch patients while under the supervision of leading experts.

30 CE Credit Hours | \$4,995

Mar. 22–23, 2019 (prep), April 12–13, 2019 (bond) (sold out)
Oct. 11–12, 2019 (prep), Nov. 15–16, 2019 (bond)

Denver, CO

Everyday Occlusion

Help your patients improve their dental health by applying these specialized techniques.

14 CE Credit Hours | \$1,995

April 5–6, 2019 (sold out)
July 12–13, 2019

Salt Lake City, UT

Total Team Training

Give your entire team the tools they need to help build a more profitable practice.

14 CE Credit Hours | \$550

May 3–4, 2019

Dallas, TX

Know Your Numbers

Master business principles that will give you the competitive edge in dentistry.

14 CE Credit Hours | \$2,695

Sept. 13–14, 2019
Dec. 13–14, 2019

Nashville, TN
Salt Lake City, UT

Implant EZ I

Reduce the number of patients you refer out and keep valuable revenue in your practice.

14 CE Credit Hours | \$1,995

Mar. 8–9, 2019

Salt Lake City, UT

Implant EZ II

Greatly accelerate your level of confidence to implement implants as part of your practice.

14 CE Credit Hours | \$1,995

May 17–18, 2019

Boston, MA

Airway Management and Dentistry

Learn how to integrate sleep dentistry and the treatment of sleep-disordered breathing for your patients.

14 CE Credit Hours | \$1,995

May 17–18, 2019

Salt Lake City, UT

Beyond the Basics

Mastering comprehensive techniques for everyday dentistry.

14 CE Credit Hours | \$1,995

June 21–22, 2019

Salt Lake City, UT

Removables Simplified

Discover the approaches to removables that will enhance your treatment options.

14 CE Credit Hours | \$2,270

July 26–27, 2019

Salt Lake City, UT

CBCT Directed Oral Surgery

Mastering implementation of CBCT scans.

14 CE Credit Hours | \$1,995

May 3–4, 2019

Salt Lake City, UT

TO REGISTER, CALL 1-877-502-2443

Full schedule at www.DrDickBarnesGroup.com

Aesthetic Dentistry

TECHNOLOGY AND TRENDS IN PRACTICE DEVELOPMENT & AESTHETICS • VOLUME 18 ISSUE 1 • WINTER 2019

DR Dick
Barnes
GROUP

NEW SEMINAR!



Presented by
DR. BILL BLACK and DR. BRAD POTTER

CBCT Directed Oral Surgery

TOPICS INCLUDE:

- A–Z of 3D CBCT techniques (basics to diagnosis)
- Mastering interpretation of CBCT scans
- Planning guided implant cases
- Lab fabrication and process/team approach of surgical guides
- Troubleshooting for oral surgery
- Quick tips for oral surgery techniques from the experts

May 3–4, 2019

Salt Lake City, UT | 14 CE Credit Hours | \$1,995

TO REGISTER, CALL 1-877-502-2443

LIMITED SEATING AVAILABLE

www.DrDickBarnesGroup.com

CONTENTS

3 EDITOR'S COMMENTARY

Looking Inward: Ask, "What Kind of Dentist Do I Want to Be?"

Dr. Dick Barnes, D.D.S.

6 COVER STORY

Completing the Look: A Makeup Artist Gets a Full Smile Makeover

Amanda Lee, with Diana M. Thompson

12 CASE ANALYSIS

Overcoming the Unexpected: "Earning a T-shirt" After a Full Mouth Reconstruction

Eric P. Wendelschafer, D.M.D.

18 SCIENCE & TECHNOLOGY

Making Smart Technology Decisions: Avoid the Sales Pitch and Evaluate Technology Effectively

Matthew Cook

22 A CLOSER LOOK

Playing to Win: PPO Strategies to Get the Best Dentistry for Patients

Ben Tuinei

26 SECRETS OF SUCCESS

Seeing Is Believing: Advantages and Implementation of Intraoral Cameras

Jim Downs, D.M.D.

32 TECH TIPS

How To Fabricate a Crown Under a Removable Partial Denture

Aesthetic Dentistry Editors

36 INDUSTRY INSIGHTS

Smooth Sailing: A Simple Guide to Purchasing a New Practice

Hernan Varas, M.B.A.



Use code to subscribe or read this issue online. Go to **AdentMag.com**

Completing the Look

A Makeup Artist Gets a Full Smile Makeover.

Makeup is a lifelong passion for me. My journey into makeup artistry as a career started at home—my mom and sisters are all glamour girls. I loved watching them do their makeup. Later, during high school, I was a cheerleader

For as long as I can remember, I've wanted to have my teeth done, but it became a priority for me when I was becoming more of a public figure on social media.

and I was always doing everybody's makeup for homecoming and prom. It was natural for me to turn to makeup as a profession.

I started building my career when I was about 17 years old—working at retail cosmetic stores and spas. A week after graduating from high school, I enrolled in cosmetology school at the Aveda Institute, and I eventually got my license in Louisiana. I'm licensed to do both hair and makeup in Louisiana, but I've focused my career on makeup.

After working hard to develop professional relationships, my clientele started to grow. Soon I was busy with my own appointments. Today I am a celebrity makeup artist (MUA) and instructor, and I host makeup seminars.

I love what I do because makeup can help women feel good about themselves and give them a sense of





confidence. I've seen the transformation of hundreds of women, and I love being able to help them enhance their beauty.

I started offering makeup seminars early in 2018. During the seminars, I use a live model to teach participants how to do the looks. I invite vendors, offer an open bar with food and drinks, and let everyone mingle and network together. The seminars help with job placement within the industry.

About 15 women attended the first seminar, and it's grown each time! At the last seminar, I invited a social media reality star. During the classes, people can interact with celebrities and learn how I do makeup. It's really fun!

When I am doing a client's makeup, I am only a few inches away from her face, so I want my teeth to look good during those up-close interactions.

I'm very active on social media—that's where the bulk of my business comes from. I post something every day on my social media accounts. I have a website and a YouTube channel, and accounts on Twitter, Instagram, and Facebook. I also film my seminars and post them on YouTube and my Instagram account, "GlamByAmanda."

COSMETIC DENTISTRY

For as long as I can remember, I've wanted to have my teeth done, but it became a priority for me when I was becoming more of a public figure on social media.

At first, I only posted pictures of the makeup work that I had done for clients on my social media pages. However, soon my followers requested photos of me too.

Whenever I posted a picture of myself, I got positive responses, so I didn't worry much about my teeth. But as I became a bigger part of the social media world, I grew increasingly insecure about my smile.

Also, whenever I am doing a client's makeup, I am only >

Aesthetic Dentistry

EDITORIAL DIRECTOR: **Dr. Dick Barnes, D.D.S.**

EXECUTIVE ADVISOR: **John Bauer, D.D.S.**

MANAGING EDITOR: **Michelle Billeter-Maxfield**

ACQUISITIONS EDITOR: **Matthew Cook**

ASSISTANT ACQUISITIONS EDITORS: **Debi Evans
& Peggy Nelson**

COPYWRITERS/EDITORS:

Diana M. Thompson

Gavin Glover

Michelle Billeter-Maxfield

LAYOUT & DESIGN: **mGraphicDesign**

CUSTOM PUBLISHING: **Arrowhead Dental Laboratory,
Salt Lake City, UT**

PRINTING: **Hudson Printing, Salt Lake City, UT**

THESE COMPANIES HELPED MAKE THIS ISSUE
POSSIBLE:

Arrowhead Dental Lab, Ivoclar Vivadent Co.

ADVERTISING SPONSORSHIP OPPORTUNITIES:

Send email to info@AdentMag.com

ISSN 2379-9188 (Print) ISSN 2379-9196 (Digital)

© 2019 Arrowhead Dental Laboratory. All rights reserved. No part of this publication may be reproduced in any form without written permission from the publisher. The views and opinions expressed in the articles in this publication are those of the author(s) and do not necessarily reflect the views or opinions of the editors or the publisher.

Warning: Reading about techniques, procedures, and materials in this publication does not necessarily qualify you to integrate the new techniques and/or procedures into your practice. Exercise caution as you are solely responsible for specific treatments and options for your patients.

a few inches away from her face, so I want my teeth to look good during those up-close interactions.

DENTAL CONCERNS

Growing up, I had problems with my teeth. My teeth grew on top of each other and I had a really bad overbite. I got braces when I was about 12 years old and wore them for four and a half years, which felt like my entire life.

At one point I had an orthotic installed to help with my overbite. The orthodontist placed a bar that almost looked like a hydraulic lift from the top teeth to the bottom teeth. Even though it helped with my overbite, it changed my bite when I got the braces taken off. My bite was kind of like a zigzag when I bit down, and it caused additional issues with my teeth.

I got braces when I was about 12 years old and wore them for four and a half years, which felt like my entire life.

When I my braces were removed, I had calcium spots left on my teeth. No matter what I did, they wouldn't go away. And with the braces off, my teeth shifted into each other again.

I got braces for a second time when I was 18 years old. I had just finished cosmetology school and gotten my first job at a spa so that I could afford to pay for them. But they did not straighten out my teeth as quickly as I wanted. I was told that I would only need to wear them for a few months, but time passed with little improvement.

I eventually asked the orthodontist to take them off for several reasons. I didn't want to be in braces for four years again, I started getting frequently booked at the spa, and I felt self-conscious about being in braces. I felt like I was too old for them. I thought there had to be another (and better) option, so I decided to explore getting veneers instead.

FINDING THE RIGHT DENTIST

I researched everything I could about veneers. Before I even had a dental exam, I knew they were what I wanted. And I knew *when* I wanted to get them done: before my birthday in July. I was having a big party! I had just purchased a house and I wanted my smile to look pretty and perfect.

I started looking for the right dentist. I found Delaune Dental on the Internet. I read the reviews for Dr. Duane P. Delaune, and they were very positive. I booked an appointment for a consultation in June 2018.

At my consultation, I immediately asked for veneers. I thought Dr. Delaune would probably tell me that I'm too young or try to dissuade me from such a big decision. But once I explained about my job and how important it is for me to look a certain way, he was on board with what I wanted to do. I felt comfortable with him and his team immediately.

We decided to do a full smile makeover—eight veneers on the uppers and eight veneers on the lowers. In other words, basically everyone can see.

Initially, I just wanted to do the top two front teeth because they had the calcium deposits on them. But Dr. Delaune explained that



(Above, left to right) Amanda Lee works on a client during one of her makeup artistry (MUA) seminars in New Orleans, LA. The seminar, called Woman2Woman, was held in March 2018.

my smile would look more natural if we put veneers on more teeth. Also, I didn't like the shape of my natural teeth. They were kind of short and I wanted to make them a little longer. So we decided on 16 restorations.

Two weeks later, I returned to the office to start the process. I didn't want to wait any longer than necessary! During the first appointment, the hygienist did a cleaning. I returned to the office three days before my birthday and Dr. Delaune placed my temporaries. My final restorations did not come in before my birthday, but that was fine because the temporaries were gorgeous—and they looked just like the final outcome.

PREPARATIONS AND TEMPORARIES

At the prepping appointment, Dr. Delaune worked on all 16 teeth, one by one. It was a long appointment—I was in the dental chair for nearly seven hours. I didn't complain because I wanted my teeth done so badly.

I remember being hungry during the appointment. And once the process began, I couldn't eat because my lips were so numb. During that first day, the team took a 30-minute lunch break and I was able to drink a smoothie.

Before the appointment, I didn't feel nervous, but when the doctor started drilling, I felt a few butterflies in my stomach. I didn't feel anything painful, but hearing the drill made me a little anxious. If I felt anything at all, I would tell the dental team and they would fix it right away.

I didn't ask the doctor to change anything from the temporaries because they were perfect!

They numbed the area a few times throughout the day because it wears off after a while. The doctor and his excellent team took care of everything before it became a problem.

By the end of the day, I was getting antsy, but it was so worth it! Initially, after they put the temporaries on, I didn't know what

to think because my lips were so numb and it was hard for me to smile. But when I took a good look at them later, I immediately loved them!

As I continued to evaluate my smile over the following days, I could really see what the temps looked like, and I was so happy. I didn't ask the doctor to change anything from the temps because they were perfect! They were exactly what I wanted: longer, whiter teeth that looked natural (not big and thick). Initially, I was afraid that all my teeth would be the same length and that it would be obvious I had had work done. But they're different sizes for a more natural look.

The doctor really made sure that with my new bite, the teeth fit together perfectly—just like a puzzle. My mouth feels better and I can definitely tell a difference.

I listened to everything Dr. Delaune and his team told me to do, and I followed their instructions for good maintenance of the temps. I brushed my temps twice a day with water or mouthwash because regular toothpaste has abrasives in it that can take the shine out of the temps. I also used a Waterpik® with hydrogen peroxide and water along the gumline to keep the gums healthy.

The second restorative appointment—the one to place my permanent restorations—was shorter than the prep appointment. It only took about four hours.

When I saw my new smile, I was so thrilled I was crying! I loved the temporary veneers, but seeing the permanent ones was even better. They looked and felt more natural.

Now that I've had several months to live with them, the veneers feel just like my real teeth, only better. My lower teeth were crooked, but the veneers are so straight and pretty.

My bite is much better too. The doctor really made sure that with my new bite, the teeth fit together perfectly—just like a puzzle. My mouth feels better and I can definitely tell a difference in my bite. ►



The doctor didn't make any adjustments to the permanent teeth after he placed them. He adjusted my bite twice in the temporaries, so by the time we got to the permanent ones we were dialed in. It was the best birthday present ever!

ADVICE TO OTHERS

I did a lot of online research before having my smile makeover. Some of the things I read were scary: I remember one person said that it was extremely painful and they were crying in the chair. But that didn't deter me. And it wasn't nearly as bad as everyone made it sound. I was a little sore and uncomfortable afterward, but that was pretty much it. I didn't need two days off to recover.

I used to edit photos of my teeth, and now I don't have to. I can just smile and have it look perfect.

A lot of people mistakenly think that a smile makeover is a one-day process, and of course it's not. It's important to take the time to get everything right. Having some time in the temporaries gives patients a chance to test the look and feel of the teeth and decide if there is anything they want to change. It's important to take that time for aesthetic reasons as well as practical ones.

SOCIAL MEDIA REVEAL

I live in Louisiana, and when people ask where I got my teeth done, many people are shocked to find out that I had them done locally. People assume that you can only get dental work like this in Los Angeles or New York. But you can get it done in Louisiana and lots of other smaller areas. You just have to do the research.

I considered not saying anything on social media about getting my teeth done. But my mom pointed out that people would notice something different, and not talking about it would cause them to speculate and wonder about my teeth, which might make it into a bigger deal. I didn't want that.

So after I got my teeth done, I posted a little snippet that showed me smiling. My mom was right—everyone noticed very quickly. I immediately started getting messages asking where I had gotten my dental work done. I didn't want to reply to

everybody separately, so a few days later I made a YouTube video and told everyone that I got veneers. I talked about the process and where I went. I answered all the questions in one video. It was fun to get such a big response.

Today I have a whole new confidence because of my smile. It's one thing to be behind the scenes and have a perfect smile, but if you're going to teach a class and post videos for the public to see, a great smile is important.

Now, I hold my head up high and I don't mind if the cameras zoom in on my face. I used to edit photos of my teeth, and now I don't have to. I can just smile and it looks perfect. On a scale of 1 to 10, I would rate my experience a 10. I got everything that I wanted and more. ■



Diana M. Thompson graduated magna cum laude with a bachelor's degree in English from Utah State University in Logan, UT. For more than 10 years, she has worked as a copywriter and editor for the natural products industry. She has written for several newspapers and edited a variety of full-length books and booklets. She specializes in nonfiction literature, particularly for the healthcare industry. Diana can be contacted at dianamaxfield@gmail.com.

COVER STORY CREATIVE TEAM

AESTHETIC DENTISTRY: *Dr. Duane P. Delaune*, Delaune Dental, Metairie, LA

ELITE RESTORATIONS: *Kim Heninger*, Arrowhead Dental Laboratory, Salt Lake City, UT

PHOTOGRAPHY (cover and page 7): *Zack Smith*, Zack Smith Photography, www.zacksmith.com, New Orleans, LA

MAKEUP ARTIST (cover and page 7): *Dana Gomez*, New Orleans, LA

HAIR STYLIST (cover and page 7): *Troy Alexander*, New Orleans, LA

The Dentist Perspective

by Dr. Duane Delaune

I met Amanda when she first visited my dental practice. During our initial consultation, she explained that she had done orthodontics twice and some whitening in the past, but she still wasn't happy with the appearance of her teeth. As a makeup artist, she wanted the perfect smile.

I immediately noticed that her teeth were relatively small for the size of her face, and that she had a fair amount of orthodontic relapse of her lower front teeth.

After discussing her goals for her smile, I recommended a treatment plan that included veneers on eight of her upper teeth and eight of her lower teeth. With Amanda's case, we discussed smile design, including color, size, and tooth shape. Amanda's goals were primarily cosmetic improvements.

FASHION AND FUNCTION

I looked for signs of occlusal wear, stress, and instability, to make sure that we could set her smile up for long-term stability and success. I found only minimal signs of occlusal stress.

The most unique and difficult part of Amanda's case was addressing the orthodontic relapse of her lower front teeth. She did not want to undergo orthodontics again, and she understood that we could straighten her teeth with ceramics, but that I would have to be more aggressive with the tooth preparations. She was okay with that.

Because she didn't need any soft tissue grafting or any other preparatory work, we were able to start her smile makeover almost immediately. Utilizing a smile design wax-up as a guide, I prepped her teeth conservatively and fabricated provisionals chairside with the shrink wrap technique. The occlusion was idealized in the provisionals, and Amanda returned one week later for a post-op visit to verify the function and aesthetics of the provisionals.

I like to think of her beautiful new smile as the ultimate fashion accessory.

Her Elite final restorations were fabricated using the provisionals as a guide and completed without the need for any chairside adjustments. Her case was a straightforward cosmetic one that showed no significant signs of functional disease. Her occlusion was restored with good cuspid protection in centric relation. Therefore, I did not prescribe a nighttime orthotic for Amanda following the reconstruction.

Amanda and I are very happy with the results. I like to think of her beautiful new smile as the ultimate fashion accessory that will be worn for every occasion.

I placed my first set of veneers over 30 years ago, as a senior in dental school, and they are still functioning today. Veneers can be



a viable, long-term, healthy option if it's done at an elite level. That means always using a smile design wax-up, elite materials (the best you can get) for restorations, and state-of-the-art bonding techniques.

Elite work also ensures that function is addressed and not interfered with. It means being conservative, keeping the preparations in enamel, addressing all the functional parameters, and minimizing physical stresses. Done at this high level, the patient will have at least a half a lifetime of benefits from it, which includes not having to worry about teeth darkening and not having to deal with constant whitening. For people who have teeth that are less than ideal, this is a great option. Patients don't regret getting the work done right.

The only thing that may cause the veneers to fail is random breakage or one of them popping off. If one pops off, it's a simple re-cementation. If one breaks, it's a simple re-fabrication. I have never seen it happen where all of the veneers fail simultaneously.

LONG-TERM SUCCESS

The only thing that might warrant replacing all of Amanda's veneers in the future is if for some reason she became unhappy with the appearance. That could occur due to gum recession, which would affect the look of her teeth. Gum recession is independent of the veneer process. It has more to do with a functional problem or disease process. For this reason, maintaining oral health is important for the long-term viability of her veneers.

Amanda can't afford to have any type of disease, because if she ends up with gum recession or dark triangles, it compromises the cosmetics. Such things could happen even without veneers.

Regular professional care is extremely important for the longevity of Amanda's veneers and for her overall dental health. As long as she takes this opportunity to focus on her oral health, she will be better off because of it and enjoy the rewards of her beautiful new smile for many years to come. ■

Overcoming the Unexpected

“Earning a T-shirt” After a Full Mouth Reconstruction.

In 2014, I took the Full Arch Reconstruction course with the Dr. Dick Barnes Group at Arrowhead Dental Laboratory in Salt Lake City, UT. Following the course, I was eager to implement all the things I had learned. I did my first full mouth case on a friend of mine, and wrote about the experience in the November 2015 issue of *Aesthetic Dentistry* magazine. The case was straightforward and went smoothly.

After my second full mouth case, however, I learned that it is during the more complicated cases that dentists have to stretch beyond their comfort zones, and it is where they find opportunities for extra growth.

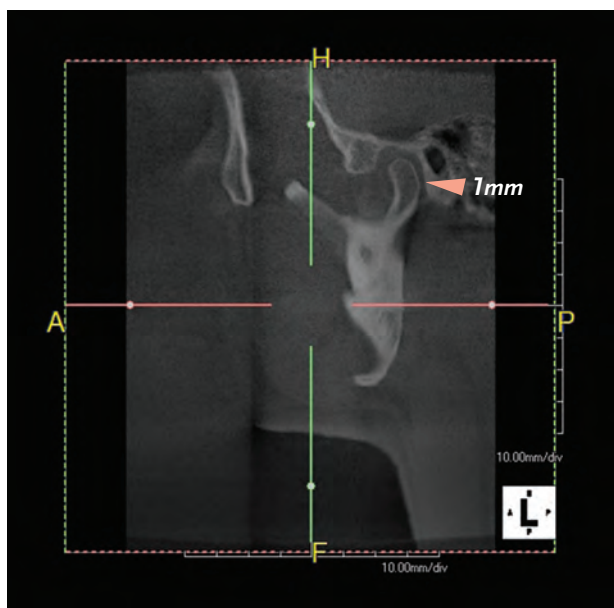
After my second full mouth case, however, I learned that it is during the more complicated cases that dentists have to stretch beyond their comfort zones, and it is where they find opportunities for extra growth.

In his classes, Dr. Jim Downs talks about “getting that T-shirt.” The phrase refers to the difficulties and struggles common to the profession—financial issues, staffing disputes, or challenges incorporating new clinical skills.

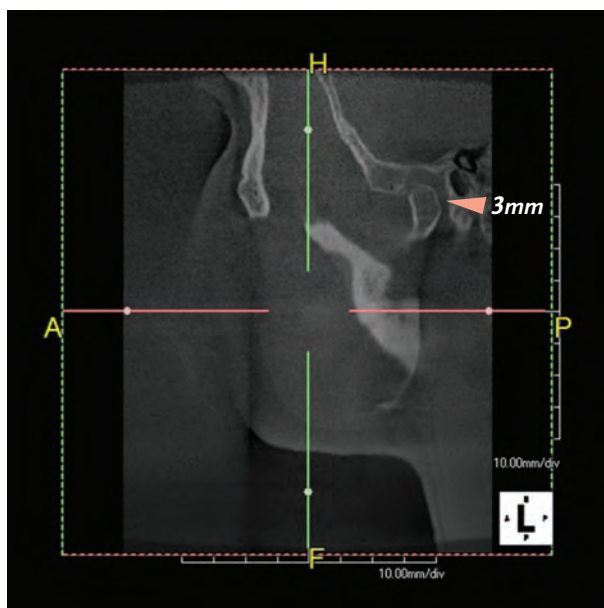
If you’ve “got that T-shirt,” it’s a metaphor that you know what it feels like to experience those struggles and hopefully, you’ve learned to overcome them. I “earned my T-shirt” in troubleshooting problems in full mouth reconstructions with my second full mouth case.



(Above, top) Before view, full face photo, (Above, bottom) Before view, retracted, with old dentistry.



(Above) Pre-op assessment of disc position at MIP.
Shimbashi is 14mm.



(Above) Post-op assessment of disc position at MIP.
Shimbashi is 17mm.

THE PATIENT

A few years ago, a 61-year-old patient came to my office. She and her husband had recently moved to Sun City, Arizona, (on the northwest side of Phoenix) from Juneau, Alaska, for the winter. The patient saw my office sign and decided it was time to get her bridge replaced with implants.

After conducting a comprehensive exam, I learned that she had knocked out tooth numbers 8 and 9 on a playground when she was young. She'd had a bridge done, from tooth numbers 6 to 11, a long time ago. She never really liked it but couldn't explain why.

The patient said that she wanted me to place implants at tooth numbers 8 and 9, and place crowns on tooth numbers 6, 7, 10, and 11. After a comprehensive exam I realized that her bridge was made parallel to her occlusal plane, which was canted to her left, so she unknowingly tipped her head to compensate for the look. At that time, the dentist followed her occlusion and likely did what was the standard of care, and it had lasted more than 40 years.

In addition, the patient's gums had receded and there was some marginal exposure and decay (see image on page 12). She also had several precarious amalgams. I questioned the patient further and found that for many years she had experienced jaw pain, headaches, and neck pain, but she didn't realize that those could be related to her occlusion.

The patient indicated that she felt pain when I palpated her masseter and temporalis muscles, as well as her upper neck muscles. She had mild popping of both temporal mandibular joints (TMJ). Her Shimbashi measurement (9:24 CEJ to CEJ measurement) was 14mm.

The patient explained that all she wanted was a bridge replaced, which for most dentists would be a good day, but I knew there were more layers to her health concerns, and I prepared a more comprehensive option for her.

There are a handful of ways to determine physiologic occlusion, but the goal is always the same: determine the ideal maxilla-mandibular relationship. With her symptoms, I took a cone beam computed tomography (CBCT) to assess disk position at maximum intercuspation (MIP).

I am still learning just how critical TMJ is to occlusal repositioning. With the availability of cone beam imaging, it's imperative to take one. Physiological theory of bite repositioning to eliminate specific symptoms focuses on jaw musculature and neutral TMJ. Therefore, I used a Lucia jig deprogrammer to reduce muscle memory, then a swallow bite to approximate neutral muscle positioning (opening her up about 3mm anteriorly) and took another CBCT. (Since the time of this case, I have also recently purchased a tens unit, which I now use to deprogram TMJ positioning.)

With a full mouth restoration, the patient would get the implants she wanted, plus she could improve her occlusion, eliminate bite-related pain symptoms, and have all new, beautiful teeth.

For this patient, I compared the pre-op joint to the swallow bite joint position. The condyles had rotated forward, giving 2mm more retro-discal space and less tension. Her new Shimbashi was 17mm.

The patient's primary concern was replacing her bridge, but after gathering the data and demonstrating the relationship of her malocclusion to her pain, I was able to present a full mouth rehabilitation, including implants at tooth numbers 8 and 9. I could do the implants that she wanted, but I explained that even >

if we placed those, her bite plane would still be off. Since we were doing work anyway, it was a great opportunity to restore everything at once. With a full mouth restoration, the patient would get the implants she wanted, plus she could improve her occlusion, eliminate bite-related pain symptoms, and have all new, beautiful teeth.

I explained the benefits of doing a complete restoration now, because she was still young and her dentition would only get worse without it. I showed her the Seven Slides, a case presentation tool from Dr. Dick Barnes that showcases the possibilities of comprehensive dentistry, and after the slideshow all she said was, “When can we start?”

I told her it would take four visits to complete the work, judging from the one full mouth reconstruction case I had previously completed.

Ultimately, in my haste to get started, I forgot to take one of the most important records—the stick bite. The treatment plan consisted of 28 crowns, two implants and abutments, and a nocturnal orthotic. I ordered a White Wax-up to the new bite position, which included Sil-Tech® temporary matrix, Wax-up bite registration, and reduction guides.

I explained the benefits of doing a complete restoration now, because she was still young and her dentition would only get worse without it.

After I submitted the case to Arrowhead Dental Laboratory, the lab called to ask how the case would be mounted. They told me it looked crooked and asked if I wanted them to mount it to level, and I responded “yes.” We proceeded to move forward with treatment.

STARTING OUT

There were a few ways I could have approached the staging of her treatment, given the surgical component that required healing time. I could have placed the implants, used a temporary bridge until implant integration, and then prepped the full mouth.

Ultimately, in my haste to get started, I forgot to take one of the most important records—the stick bite.

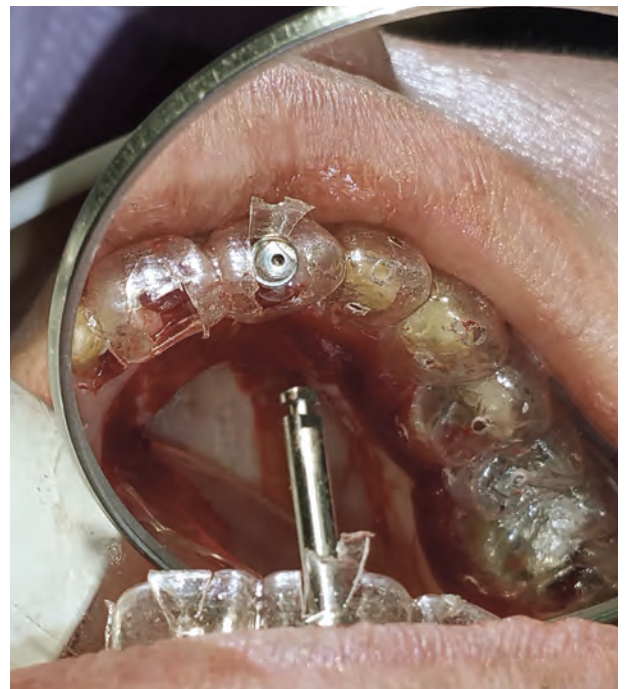
The patient clearly communicated that she wanted to do all prep and surgery work in as few visits as possible due to dental anxiety. I decided to prep and place implants on the same visit, restore all but the anterior maxillary six to allow proper implant integration, and use a temporary bridge.

Prep day was long and exciting. I didn't use a surgical guide for implant placement. Instead, I used the reduction guide and drilled through the guide for the osteotomy (see photo, at right). The paralleling posts were dead on because of the guide that comes with the full mouth kit.

“The Full Arch Reconstruction course was the beginning of my knowledge of comprehensive dentistry. I learned a lot and had to redo things on a few patients because I didn’t know how to troubleshoot.” Dentists should be prepared that things don’t always go perfectly—especially the first few times they do a large case.

I knew where I wanted them, and the reduction guide showed me where the crowns would sit, so I placed the implant with the center through the cingulum, and I didn't have to do any bone grafting, even with her recession. I used a CO2 laser to contour the gums for an ideal shape, both for placing the implants and seating the finals.

When staging treatment for the implant placement, I could have placed temps on the implants and splinted them, or I could have placed the implants months prior to placement to restore all at once. Instead of doing either of these methods, I placed Ankylos® C/X implants, which offer sulcus formers to “groom” the sulcus, lending to a more natural emergence profile of the final restoration. The patient had silver margins while in temps (see photos at the top of page 15), so I told her not to smile too high for the duration of the healing.



(Above) View of the reduction guide from a mirror angle.



(Above) Side view in temporaries, showing the sulcas forming implants on the day of surgery.



(Above) Full face view in temporaries.

After placing the temps, however, I immediately noticed that her entire bite plane was off skeletally; it was obvious that her occlusal plane was canted to the left. I had incorporated so much dentistry into the preparation visit—two implants and 26 crown preps—that I missed doing a proper stick bite, and her bite was off. I couldn't believe I neglected to take a stick bite for the dental lab.

HITTING A SPEED BUMP

With the temporaries, I was able to compensate for the cant by manually building them up chairside with composite. Fortunately, this workaround strategy was fine while the patient was in temps. I was glad we caught the problem before the lab made the permanent restorations.

However, I knew I couldn't offer a solution for the patient if the permanent seatings were off, so I had to send the whole case back to the lab. This time I took a stick bite and took plenty of photos in front of the grid to ensure accuracy (see photo, at right).

I put in the bite registration with Sil-Tech® from the prep guide and added the stick to it. Once that error was addressed and corrected, the case was predictable and proceeded smoothly.

Once that error was addressed and corrected, the case was predictable and proceeded smoothly.

With the adjustments and the healing time for the patient, the case took a bit longer than I had originally estimated. The patient was anxious to have her treatment completed and I explained that her case was more complicated than most, so we needed extra time.

The delay was ultimately a good thing. I had placed implants at tooth numbers 8 and 9, and the more time they had to heal, the better. By the time we did the permanent delivery, I decided

to wait two more months to load the implants, I made a temporary bridge for the front six while seating the rest of the teeth permanently. Ultimately, the case turned out well.

Immediately after seating the finals, the patient showed a little bit of white tissue at the margins due to the gingival sculpting with the laser (see photo on page 16, top left). There was blanching when I seated everything; when I pushed on it, the tissue turned white because of restricted blood flow.

When I got the final case, everything fit perfectly and I didn't need to adjust anything. I put the restorations in and checked the permanents with try-in paste so they would hold in place. I checked the bite with articulating paper, and everything looked ideal so I seated them. >



(Above) View of stick bite, which was eventually taken.



(Above) Retracted view, after treatment.



(Above) Full mouth view, after treatment.

Then I used the T-scan and had to make a minor adjustment: the initial bite was 48 to 52 percent left to right, which is almost dead on. I did a little polish on two teeth, and that brought it to 49.5 to 50.5.

For the terminal teeth, I placed gold restorations. She was a bruxer, but that wasn't the only reason for them—it's just good to give the teeth a "soft stop." The gold is softer and wears nicely, which protects the ceramics. We were able to successfully open up her bite.

The patient was thrilled with the final results. With her dental treatment, we alleviated years of pain that she never thought would go away. Now, every time she comes in, she tells me that she sleeps better and wakes up with more energy. She also feels better about herself from a cosmetic standpoint.

LESSONS LEARNED

A while ago, I went to an Over the Shoulder™ course with the Dr. Dick Barnes Group. The instructor asked me to speak in front of the class of about 15 to 20 people. I said, "This class was the beginning of my knowledge of comprehensive dentistry. I learned a lot and had to redo things on a few patients because I didn't know how to troubleshoot."

The patient was thrilled with the final results. With her dental treatment, we alleviated years of pain that she never thought would go away.

Dentists should be prepared that things don't always go perfectly—especially the first few times they do a large case. I highly recommend that dentists take the Hands-On courses, where they not only observe a case (such as in the Over the Shoulder™ class), but also get to work on a patient. Because of the experiential nature of the Hands-On class, dentists get to troubleshoot their own cases, as well as the cases of those in attendance.

I have taken the Hands-On class twice now, since the patient I brought to the original course initially wanted to do just her uppers and then decided she wanted to return to the class for

her lower restorations. The nature of any clinical work is unpredictable and the more experience that a dentist can get, the better. I've done about 20 full mouth restoration cases now. My advice is to plan and learn everything you can.

For a full arch restoration, dentists may think they're just putting crowns on teeth, but it's a lot more than that: they're creating a system. This system is time- and cost-intensive for dentists and patients, and everyone expects success.

In this case, I had anticipated that the patient's work would be finished in three or four visits, but we had to do a few more than



(Above) Full face view, after treatment.

that. When something unexpected happens, it can snowball. The patient may get upset, which can shake a dentist's confidence.

Even though this was a big and complicated case, I found out how easy it is to sell the treatment rather than present it. I was so excited to apply what I had learned that I found myself over-promising the timeline and mismanaging her expectations.

This case was admittedly more complicated than most, but fortunately the outcome was great. The patient has since told me that the results were even better than she had expected.

*Since today's treatments are so incredible,
all dentists should learn to balance
confidence and excitement with a deep
understanding of the procedures.*

It's easy to over-promise when presenting treatment, especially because dentists must exude confidence to get case acceptance. But once treatment has begun and payment has been made, any mistakes can cause discomfort and diminish the

patient's enthusiasm for and confidence in the quality of the care. Since today's treatments are so incredible, all dentists should learn to balance confidence and excitement with a deep understanding of the procedures, planning for any and all contingencies, and preparing for the unexpected. ■



Eric P. Wendelschafer, D.M.D., is originally from Mesa, AZ. He graduated from the Arizona School of Dentistry & Oral Health (ASDOH), Arizona's first dental school, which is part of A.T. Still University in Mesa, AZ.

Dr. Wendelschafer currently owns Great Smiles Dental Care in Surprise, AZ, a family-oriented practice that specializes in general, cosmetic, and comprehensive dentistry. In his free time, Dr. Wendelschafer enjoys surfing, boating, bow hunting, and snow sports. He also enjoys spending time with his family. To contact Dr. Wendelschafer, please call (623) 933-5749.

ENHANCE *the* BEAUTY *of your next Arrowhead case*

Gold-hued abutments have a reflective property that creates warmth and beauty, and results in a superior aesthetic outcome for your patient. This is especially important in cases where gingival recession is possible.

Make your next implant case the most beautiful and predictable yet. Try Arrowhead's gold-hue service and our dedicated implant support team. **For more information and a free case consultation, call:**

1-877-502-2443

ARROWHEAD



Making Smart Technology Decisions

Avoid the Sales Pitch and Evaluate Technology Effectively.

The 1964 stop-motion version of *Rudolph the Red-Nosed Reindeer* includes a place called the “Island of Misfit Toys.” The island was a place where unwanted or poorly implemented toys would go because no one had a use for them.

Dental practices that understand how to strategically evaluate and implement new technologies have a competitive advantage over those that do not or cannot.

Many dental practices have a similar place—usually a storage room in a forgotten corner of the practice where unused technology purchases gather dust. These “rooms of misfit technology purchases” represent ineffective capital investments. Some of the things I have seen gathering dust include lasers, digital impression systems, intraoral camera systems, and the like. Such tools can

be useful and effective if their acquisition and implementation is properly and strategically executed.

The acquisition of new technologies is an important part of providing the highest level of patient care. Dental practices that understand how to strategically evaluate and implement new technologies have a competitive advantage over those that do not or cannot. How do you know if a dental technology purchase will be worthwhile?

Using dental technology effectively and maximizing your return on investment (ROI) does not need to be a complicated or overly expensive process. It does, however, require that dentists have a process in place to correctly evaluate and introduce new technologies into the workplace. When evaluating new technological investments, I recommend the following:

BUY SOLUTIONS, NOT FEATURES

Most dentists have experienced a slick technology sales presentation where they are shown incredible advancements

that lead to the reaction, "Wow, that's really cool!" Such a phrase is music to the ears of every sales representative.

More than once, I have personally made purchasing decisions based solely on a "wow" factor. Inevitably that feature did not end up being used, or was not used to its full potential. This common mistake happens when approaching technology purchases from a features-based standpoint, rather than a solutions-based standpoint. This problem is one of the main reasons many technology acquisitions end up gathering dust.

Having team members identify areas for technology improvements, and then including them in the consideration process, dramatically increases the ROI for technology purchases.

To avoid this trap, take time to look at the various workflows that constitute the daily operations of your dental practice. Determine where areas of weakness or opportunities for improvement exist. Making this analysis a part of monthly staff meetings is a great way to identify what kinds of technologies you

should be looking at and where you will get the highest return on your investment.

INVOLVE YOUR TEAM MEMBERS

Involving team members in technology purchases is critical because doing so creates buy-in with the team. If your team is left out of this process, they may resist using the new technology. Having team members identify areas for technology improvements and then including them in the consideration process dramatically increases the ROI for technology purchases.

To test this out (without having to acquire a new piece of technology), consider your practice management system. In your next staff meeting, ask team members if they are manually entering data into a spreadsheet for the purpose of generating a report.

Take that manual process, identify what information is being compiled, and then contact your practice management system provider. Give them information about the report and ask if their system can automatically generate a similar one. In most cases, a solution is already available but many dental teams aren't utilizing it.

IDENTIFY AREAS OF IMPROVEMENT

An effective way to approach technology acquisitions is to >



identify inefficiencies in your workflow and evaluate a technology-based solution. If you approach a technology vendor with a specific problem, he or she will have to work for you. Technology vendors typically work with hundreds, if not thousands, of dental practices. When you present them with a problem that their product may solve, they will have to demonstrate how it accomplishes the task.

Consider talking with people in the engineering department rather than the front-line salespeople. When you do this, you've moved beyond the sales pitch into problem-solving. Identifying a problem for the vendor to solve not only ensures that your capital investment adds value to your practice, but it requires vendors to work harder on your behalf.

TAKE IT FOR A TEST DRIVE

Nearly all technology providers offer a free evaluation period for major technology purchases. Typically, vendors will deliver the equipment and give a quick demonstration on a (usually idealized) test case, and then the equipment will sit unused until the evaluation period is almost over—at which time a rush decision will be made.

A better approach is to determine what should be tested before the equipment is delivered and assembled.

A better approach is to determine what should be tested before the equipment is delivered and assembled. This allows dentists and teams to take full advantage of the evaluation period. Do not procrastinate running any tests. On the first day,

An effective way to approach technology acquisitions is to identify inefficiencies in your workflow and evaluate technology-based solutions.

make sure cases are readily available for testing. Doing so will help identify any initial glitches or roadblocks that could hinder your team from implementing the equipment.

A good evaluation plan includes:

1. **A list of expectations.** Prior to the installation of equipment, send the vendor a list of expectations. Include a statement that defines exactly what you are hoping the technology will accomplish and what training you expect to support the technology. This statement helps focus the installation and initial training so you can make a proper evaluation.

2. **A sampling of five to ten cases.** Plan to test five to ten cases on the new technology. The samples should include simple cases as well as more complex ones. Ask the installer/trainer to go through all the cases with you. After that, use the technology daily during the evaluation period.

3. **An idea of what the solution looks like.** If the technology is being considered to save time, make sure that you measure what the time savings actually is and how it compares to your current workflow.



YOU ARE BUYING A FEATURE WHEN:

- *Your primary reaction is “Wow, that’s cool!”*
- *It doesn’t solve a problem or provide a needed enhancement that you have identified.*
- *The only person you interact with is a front-line salesperson.*

YOU ARE BUYING A SOLUTION IF:

- *You identify a problem that needs to be solved.*
- *You communicate to the vendor what you need.*
- *You understand how the new technology will add value to your practice before you purchase it.*

4. An integration plan. Make a plan that integrates the new technology within your existing workflow or outline a strategy for changing the workflow. Be sure to involve the team members who will be using the technology.

5. Contact information for support. Instead of just calling a general support line, ask for the name of a specific person and get their direct contact information so that when you run into issues or have questions, things can be resolved quickly. Let the vendor know that in addition to testing the equipment, you are also evaluating their support.

6. A list of consumables, their expected life span, and their costs. During the evaluation period, track the lifespan of the consumables to make sure their claims match your experience.

Having a patient wait an extra 5 to 10 minutes might not seem like a big deal, but in aggregate, the wait time created by under-provisioned technology can cost thousands of dollars in lost productivity.

7. A test of the equipment in the location where it will be used.

You might be surprised at how something as simple as not having an electrical outlet close by can result in an expensive piece of technology going unused.

BEWARE OF VERSION 1.0

In general, first generation technology tends to have more issues and shortfalls. However, don't assume that you should wait until later generations before adopting technology. Early adopters can experience great advantages. If you adopt new technology early, your input has a greater chance of shaping how the equipment evolves. In some cases, adopting new technology early (especially something with a large patient demand) can provide a competitive advantage over practices that wait.

If you want to be an early adopter, make sure to negotiate special considerations up front.

If you want to be an early adopter, make sure to negotiate special considerations up front. Steep discounting for first generation equipment is common, especially if you are expected to provide input and improvement suggestions. You may also be able to negotiate an agreement that allows a discounted upgrade path for subsequent generations of equipment.

Negotiating an upgrade path is a great way to increase the value of the equipment while at the same time reducing some of the costs and risks of being an early adopter.

SINGLE POINTS OF FAILURE

In situations where the equipment is a key part of your production, and for which there is no easy or efficient fallback, consider purchasing a backup. If the equipment isn't too costly, having more than one piece of equipment is justifiable, especially if not having the equipment dramatically impacts patient care or practice production.

Any time you purchase technology, make sure to keep your eyes open for potential problems created by single points of failure, as well as bottleneck issues.

If having more than one piece of equipment is cost-prohibitive, be sure to negotiate a service level agreement (SLA). For example, if you buy a state-of-the-art cone beam or similar digital X-ray machine, it isn't feasible to purchase two. But having that equipment go down for several days isn't acceptable either.

An SLA spells out terms like what parts, if any, will be inventoried locally so that a repair can be taken care of quickly. An SLA also details expected response times once a repair is needed. Some SLA agreements stipulate three-hour response times with a local service provider. When working with a piece of critical equipment that is too costly to have a spare, an SLA is a great alternative.

(continued on page 42)

Playing to Win

PPO Strategies to Get the Best Dentistry for Patients.

It is no secret that dentists are feeling the financial pain of preferred provider organization (PPO) participation. In some states, dentists must agree to discount their fees up to 80 percent in exchange for being listed as a "Preferred Provider" (in-network).

I recently referred my brother to a local dentist. After having a crown seated on tooth number 30, my brother complained about the lack of quality in the dentist's work. Surprised, I investigated the issue to understand what had happened.

I discovered that the dentist I recommended had an internal policy to only use certain dental laboratories, depending on the reimbursement structure that the patient's PPO offered. As a result, my brother's low-reimbursing PPO led to a low-cost crown that fractured just 10 days after it was seated.

Since most employers look at the total cost of a dental plan, many insurance companies opt only to cover the least expensive dental treatments.

While some people might claim that the dentist was committing fraud by not using the best quality dental lab (and was therefore providing suboptimal care for the patient), the dentist had valid financial reasons for using a discount dental lab.

I learned that this dentist actually lost money with some PPO reimbursements. Using lower-cost labs for the PPOs that required steeper discounts was strictly a business decision, and

not a sneaky strategy to provide low-quality care in hopes that the patient wouldn't notice the difference.

Having known this dentist for several years, I understood his dilemma. He is an honest and trustworthy person who was merely trying to make the numbers work at the end of the day. I believe he was innocently misguided by the perceived rules and regulations of PPO participation.

I place the blame entirely on the insurance industry for driving a so-called "insurance mentality" that causes many dentists to forego quality or conservative dentistry in an effort to sustain a viable dental business.

INSURANCE MANDATES

Even though some insurance plans allow dentists to charge a lab fee to the patient directly, the allowed charges are often at levels that only cover very basic lab work or other materials. A huge disconnect between dental insurance companies and dentists is that insurance companies usually have no idea what it

Dentists can offer higher care for their patients by understanding how non-covered services, material fees, or upgrades can be billed directly to patients.



costs to deliver high-quality dentistry. I once attended a dinner with two executives from a large insurance company who openly confessed that they had no idea how much it costs for a doctor to perform clinical procedures. They said, “Our company simply doesn’t care.”

During this meeting, the executives talked about the rights and options of doctors and patients when it comes to denied claims, and even suggested strategies for patients who seek treatment that is above their coverage standards.

According to both executives, dental insurance (PPO, POS, Indemnity, Capitation, HMO, DHMO, or discount) is only designed to cover the basics. Since most employers look at the total cost of a dental plan, many insurance companies opt only to cover the least expensive dental treatments.

They explained that if a patient chooses to receive a service or procedure that is above and beyond the standard care (referred to by the executives as “added-value” procedures), insurance may only cover the basics. However, covering the basics does not free the patient from the financial obligation to pay for a higher level of care.

In order for a material or service to qualify as one that is an “added value,” dentists must justify that the materials or services they are using/performing are above and beyond the standard scope of service as described in the Code on Dental Procedures and Nomenclatures (CDT).

As an example, D2740 is described as a porcelain all-ceramic crown. A dentist may present an E.max crown to a patient,

but the aesthetic components of E.max are not described in the CDT, even though E.max is a porcelain, all-ceramic crown. Therefore, the justifiable added-value components of E.max are the aesthetic/cosmetic properties of this type of crown.

Here’s an example of what an insurance company can do: a dentist billed insurance for a two-surface composite filling. The insurance company downgraded the code to an amalgam two-surface, according to the policy in a standard employer contract. In the contract, the patient is responsible to pay the difference between the cost of the amalgam benefit and the contracted fee for the two-surface composite that was actually placed.

In some states, dentists must agree to discount their fees up to 80 percent to be listed as a “Preferred Provider.”

According to the executives, a downgrade—referred to as an alternative benefit on an Explanation of Benefits (EOB)—is not a denial of benefit. It’s simply an election by the patient’s employer regarding what the employer is willing to cover/pay.

LETTING PATIENTS CHOOSE

Another example I discussed with the insurance executives involved a dentist placing several crowns. A patient who fractured several anterior teeth needed crowns on all of them. For this particular patient, D2740 was the standard benefit ▶

for anterior teeth. However, the contracted rate between the doctor and the insurance company was 50 percent less than the doctor's standard fees.

If the patient elected or requested high-quality aesthetics (where material and lab costs equal the contracted fee for D2740 per tooth), would the doctor be obligated to pay out of his or her own pocket for the work? According to the insurance executives, the answer was no.

The doctor was not obligated to take a loss if the patient elected to receive added-value care. Keep in mind that insurance likely only covered the D2740 at the contracted rate, but the higher-end aesthetic materials were fees that the patient was responsible for (according to the contract between employer and insurance).

In an effort to protect the patient's choice to obtain higher-quality materials and services, insurance companies are prohibited from interfering with a patient's right to pay.

Here's where it can become complicated. Often when a dentist calls the insurance company's provider relations, the person who answers the call does not take the time to research that particular patient's employer contract. Instead, they give a scripted response that is neither accurate nor truthful and tell the doctor that he or she must stick to the contracted rates only.

Both executives agreed that the problem with provider relations is that they are trained to give the same response for all issues, even though many employers have different contracts and different types of benefit coverage. Provider relations reps steer dental offices in the direction of strictly following the contracted rates for all situations.

The executives explained that their internal systems are designed to benefit the insurance company, not the dentists or the patients. They recommend that, instead of fighting the insurance system, dentists follow any state or federal laws that protect the financial integrity of quality care. They specifically recommended following the federal HITECH Act of 2009 and any state non-covered service laws.

HITECH ACT OF 2009

In 2009, after dental and medical practices began using electronic methods to store patient information, the HITECH Act (a.k.a. the Health Information Technology for Economic and Clinical Health Act) was passed, which mandated that such information be stored securely.

Upon consulting with my attorneys, I learned that HITECH allows patients the right to waive billing insurance for any procedure for any reason. If this right is invoked, the doctor is legally obligated to not bill or disclose the treatment at hand to any party, *including insurance*.

A doctor can suggest (via a signed consent form) that material fees not be billed to insurance, as they are not covered and may interfere with benefit coverage for any covered services that are a part of the treatment plan. If a patient agrees and signs an insurance waiver for material fees, the insurance company cannot interfere with the patient's election, and insurance does not need to know about any material charges.

Both insurance executives I spoke with agreed that in an effort to protect the patient's choice to obtain higher-quality materials and services (which are not covered by the patient's insurance plan), insurance companies are prohibited from interfering with a patient's right to pay for them independent of insurance benefits.

STATE NON-COVERED SERVICE LAWS

Nearly 40 states have passed laws that allow doctors to charge their standard office fees for non-covered services. Both insurance executives agreed that while dental lab work is often included in reimbursements for the procedures that require labs, aesthetics and durable materials are not always included.

For example, E.max and most zirconia have aesthetic components to them, and while the American Dental Association (ADA) has advised billing both crown types as D2740, the cost of either crown can vary depending on the level of aesthetic material applied to each.

The insurance executives agreed that if the crown has any added-value work that is above the standard CDT description, the crown may qualify for an additional material fee that the patient can opt to pay for.

In short, aesthetic or durable material fees should be considered added-value treatments in addition to crown treatment, which places the materials in a billable category of their own.

HOW TO LET PATIENTS CHOOSE HIGHER-QUALITY CARE

- **Contact your insurance providers to obtain copies of their dental resources guides (DRGs).**
- **Study the "non-covered services" section. Look for language that allows you to charge patients directly for non-covered or added-value services.**
- **Meet with a healthcare attorney for advice on consent forms and case presentations.**
- **Offer patients the choice for added-value services and treatments with confidence!**



CONSENT FORMS

To comply with legalities, getting written consent from patients should be mandatory. Attorneys and other insurance carriers suggest that doctors always provide written consent when billing material fees or other non-covered services to the patient. One way to be in compliance with laws and avoid the insurance mentality is to ask patients to sign consent forms if they chose to upgrade their dental materials and/or services.

Many insurance waivers include a clause in their contracts stating that patients "acknowledge that procedures or services listed on this consent form are a non-insurance covered service and will not be billed to insurance." In other words, patients agree (in writing) to pay for non-covered services and procedures on their own.

When a patient signs a release form, it is important for them to understand what it means and that they will not and cannot obtain reimbursement from insurance for those particular procedures or services listed on the form.

It is absolutely possible for dentists to provide high-quality dentistry with high-quality materials independent of PPO provider reimbursement coverage. Dentists can offer higher care for their patients by understanding how non-covered services, material fees, or upgrades can be billed directly to patients.

KNOWLEDGE IS POWER

Each dentist should view this article merely as a suggestion that they consider the strategies I've mentioned and do further

research on their own. I strongly recommend that dentists first understand their insurance contracts and seek advice from attorneys and other professionals before adding material or upgrade charge policies in their practices.

Fortunately, the strategies I've outlined are not new. Thousands of dental practices have already implemented similar ones in their own offices. Since following these strategies can entail some liability (depending on the state in which you practice or the PPOs that you participate with), I recommend that you contact each of your contracted insurance providers to obtain copies of their dental resource guides (DRGs).

Study the "non-covered services" section of these DRGs to make sure there is language that allows you to charge patients for non-covered or added-value services.

Covering the basics does not free the patient from the financial obligation to pay for a higher level of care.

Next, meet with a healthcare attorney or other professional who can give you advice on areas such as consent forms and case presentations. To avoid losing an insurance audit, it is very important for dentists to understand what needs to be included in a consent form and what not to say to patients when presenting material fees.

Finally, once you are fully prepared to legally and ethically start implementing material fees within your practice, proceed with the utmost confidence. When given a choice, consumers often (and proudly) upgrade to first class airfare, premium fuel for their cars, or even more expensive movie packages that cable/satellite companies offer. Why can't patients exercise their same rights when it comes to dental upgrades?

It is my hope that dentists will find ways to implement effective strategies to combat the pervasive insurance-driven mentality that is poisoning the dental industry. I sincerely hope each of you will find legal and ethical ways to protect the financial integrity of quality care. ■



Benjamin Tuinei is president of Veritas Dental Resources, a company serving dentists who seek assistance in improving their insurance reimbursements. He has been recognized by several state dental associations and reputable CE institutions as "the authority" on PPO strategies and fee negotiating. Benjamin has worked with more than 6,000 dentists nationwide and has influenced more than \$2.5 billion in newly negotiated revenue for his clients. He resides in Salt Lake City, UT, with his family. For more information, visit veritasdentalresources.com.

Seeing Is Believing

Advantages and Implementation of Intraoral Cameras.

For a lot of doctors, the most difficult thing to do is to convince a patient to accept treatment. If you show patients an X-ray, they usually do not proceed with treatment because they don't know how to read it. X-rays cause confusion because patients don't see or feel a problem. Therefore, convincing patients they need a crown can be a challenge.

About 30 years ago, Fuji Optical Systems introduced the first intraoral dental camera. It was called the Fuji DentaCam. When I saw it at a dental conference, I was enthralled! I knew immediately that I wanted one. The camera system was on a huge roller stand and had a Sony mavigraph printer (which printed only still shots—no videos), like a glorified Polaroid camera. It had strobe light optics and a large monitor. It was so heavy it had to be on wheels.

If you show patients an X-ray, they usually do not proceed with treatment because they don't know how to read it. X-rays cause confusion.

When I purchased this camera system in 1989, it cost me around \$20,000. At the time, it was the biggest purchase of my life—other than my practice. I was the first dentist in Denver, CO, to have one, and I recouped the cost very quickly. We used the DentaCam for new patients and we called the printed images a “virtual tour of the mouth.” Patients were wowed by it!

The images created a real sense of urgency for the patient. When I showed them the photos, they could see what their teeth looked like, particularly under their old fillings. Patients would often ask, “How many of those old fillings do I still have in my mouth?” They wanted to know what they could do to take better care of their teeth. The early intraoral camera provided a way to document areas of concern in patients' mouths. Their charts quickly filled up with photos.

IMPROVING TECHNOLOGY

I had the Fuji DentaCam for a while, but in retrospect, it was somewhat cumbersome and it eventually became difficult to get replacement parts for it. Also, it was so heavy that my team members disliked bringing it into the exam room.

Eventually, the age of computers took off and more options became available. In 1994 I moved into my current office and I had a lot of wiring installed to accommodate the new intraoral camera systems. Over time we added different types of plug-ins. Initially they used an S-video connection, but now it's a USB or wireless connection.

To use the early models, I had to hold it far away or very close, and if I wanted it to be really close, I could dial in the focal length and it would become a macro lens. I had to hold the camera very still to capture a good image.

Carestream was the first company to develop an intraoral camera with auto-focus features. Auto-focus was a great advancement because I didn't have to worry about the focal distance from the patient.



The most important advancement in intraoral cameras systems was the ability to capture and create videos. That changed everything! While still photos were great, seeing a live video feed of the mouth was even more compelling. With video, dentists could show the patient what their entire mouth and bite looked like. They could ask the patient to bite and show them exactly what was happening.

With today's intraoral videos, patients are glued to the screen. At LêDowns Dentistry, we show our patients a video on a 40-inch television monitor. It's impressive! Only a small minority of patients (about 2 percent) do not want to see the video because it looks too graphic to them. Most patients watch the video and say, "Wow! Your technology is incredible. I've never seen the back of my front teeth."

With the video format, dentists can stop at any time and explain to their patients exactly what they are looking at. Plus, they can still print a photo or a screenshot. All of this helps patients become extremely involved in the process.

The imagery recorded by an intraoral camera is stored digitally. Our practice takes a lot of videos, which takes up a lot of memory. The videos have to be stored somewhere other than the chairside computer so the office computers aren't slowed down. Our camera connects to a main office server as well as a cloud storage site for backup. Videos can be viewed on any computer in the office network at any time.

In our dental practice, we have two intraoral cameras at each location, for a total of four cameras. One camera is used in hygiene, and the other one is used in clinical. An intraoral camera, with its brilliant LED illumination, reduces the need for such things as an SLR camera, a ring flash, and a mirror.

Intraoral cameras are mounted on a small wand that is extremely light. They can travel from room to room with appropriate hook-ups. Make sure to purchase one that has a long cord—they are available as long as 15 feet. Our cameras are about five years old and have been in constant use.

USE IN PRACTICE

When a new patient visits our practice, we take bitewing X-rays and a 3D X-ray, check their periodontal status and dental health, and then take a virtual tour with the intraoral camera.

When a new patient visits our practice, we take bitewing X-rays and a 3D X-ray, check their periodontal status and dental health, and then take a virtual tour with the intraoral camera.

But it's not just for new patients; we take intraoral video on current patients as well. If an existing patient comes in with an emergency, we pull out the camera. We take an X-ray, do a clinical exam, and then take photography with the video camera, all to find what is causing their pain.

Patients who watch a video don't have to create an image of the problem in their minds because they can see it for themselves. Even if a patient isn't yet experiencing pain, he or she can see the problem and take steps to fix it before it becomes painful and more expensive. ➤

Since our practice became accustomed to using the intraoral camera regularly, we've had great success in helping our patients to accept treatment. On top of that, we get referrals. Often, the referrals say that their friends told them about a video we took of their mouths.

We charge a nominal fee for the intraoral images (around \$20), and some insurance companies will pay for the photos. There is even a CDT code for intraoral photography—00220. But it only covers photographs, not video.

BENEFITS

Intraoral cameras offer multiple benefits for clinicians and their teams. If I were to start a new practice today, I would require four things: an intraoral camera, a 3D X-ray, electric handpieces, and a CO2 laser.

Here are some of the main benefits of intraoral cameras:

1. Return on investment (ROI):

The ROI for an intraoral camera is quickly recouped—after maybe two or three patients. If the images help sell a full mouth rehab case, it pays for itself with only one patient.

2. Patient education. The intraoral camera helps us educate our patients so they can make better decisions about the care of their teeth. Also, it helps build trust between the patient and dentist because the patient can see what the dentist sees. The intraoral camera is likely one of the main reasons I have been doing a lot of larger cases.

3. Communication with the dental lab. Intraoral cameras have also been helpful in working with the dental lab. We can send video to the lab, and the technicians can zoom in and out to look at the shading, the translucency, and any other features we might want to include.

4. Insurance claim disputes. Soon after I purchased the Fuji DentaCam I received a call from a dental insurance company



representative asking me how I got the photos of some teeth. He told me it would be great if I could take a “before” photo, and then a photo during treatment. In the treatment photo, he wanted to see what the tooth looked like after we took the filling out.

I realized I could give the insurance company an over-the-shoulder look at why we were doing the work that we did. It became a huge benefit in winning claims for our patients.

For the first time, I realized that I could give the insurance company an over-the-shoulder look at why we were doing the work that we did. It became a huge benefit in winning claims for our patients. If we sent in a photo X-ray narrative along with the claim, we won a high percentage of the cases.

Using the intraoral camera has helped me do more work and more complex cases, and has helped me to accomplish more on the cosmetic side of things rather than just traditional dentistry. Taking videos for insurance is now commonplace in our dental practice. These images help prove that we found fracture or decay, and that way it helps the front office on the insurance appeal process.

POTENTIAL BENEFITS

- 1. Positive return on investment (ROI)**
- 2. Increased patient education**
- 3. Improved communication with the dental lab**
- 4. Support for insurance claim disputes**

TRAINING THE TEAM

1. Practice makes perfect
2. Take it slow
3. Maintain a dry environment
4. Consistency is key
5. Watch and learn
6. Take care of the equipment

TRAINING THE TEAM

Dentists should include intraoral photos as part of every new patient exam. If I walk in to an operatory and I don't see the camera, I ask my team if they did the virtual tour already, and if not, I make sure it gets done.

The doctor should set the expectation for the dental team that the intraoral camera be used on every new patient. I've learned a few ways to have success in implementing intraoral cameras at dental practices. Here are some of my suggestions:

1. Practice makes perfect. For dentists using the camera for the first time, there is a learning curve. It takes some practice to look at the screen and use the camera in the patient's mouth simultaneously. Dentists have to train their brains so they know which direction to move. Hygienists and dental assistants need to practice as well so they get used to the process.

2. Take it slow. Train team members to move the camera slowly, especially during the learning phase. Otherwise, the video will look jittery and jumpy, like *The Blair Witch Project*. If the video

is fast and jerky, there's no way to show the patient anything and have them understand it.

3. Maintain a dry environment. Make sure the patient's teeth are as dry as possible. Use a suction straw to remove any condensation in the patient's mouth so their breath doesn't fog up the camera.

4. Consistency is key. It is helpful to have a replicable system for using the camera. For example, start on the upper right, go all the way to the upper left, then drop down to the lower left and come back to the lower right. On average, the process should take about two minutes, depending on how severe the patient's oral health is.

5. Watch and learn. At our practice, I ask team members to watch the learning videos from the vendor and then practice taking videos of each other. I mentor them and critique their videos so they know what I am looking for. When team members use intraoral cameras regularly, they become proficient quickly. With a solid week of practice, they should be quite skilled.

If I had been able to offer video capture in my practice when I bought my first intraoral camera in 1989, I'd probably be retired by now.

6. Take care of the equipment. Intraoral cameras have a limited lifespan, and it is important to properly care for the equipment to get the most out of your investment. Because team members take the camera from one room to another, the cord may deteriorate due to being bent. Team members should handle the cords carefully so that they last longer. ➤



We put clear sleeves on our cameras—not only for universal precautions, but to make them easier to sterilize. Dentists should review with their team members how to clean the cameras, how to store them, and what precautions to take to avoid bending and crimping the cord (we hang ours up).

MAKE THE LEAP

Whenever you purchase a piece of equipment, the vendor typically offers an evaluation period where you can try it out (see story, “Making Smart Technology Decisions,” on page 18). During this trial period, ensure that the camera you buy is compatible with your computer system. Some of these require at least a 2.0 GHz processor and 1 GB of RAM, so you need to make sure your computers are up to date. Most intraoral cameras are PC-based, but some have Mac compatibility.

The investment is going to pay out, both in terms of paying for the equipment, and in the sense of making you a better dentist.

Once you have made the decision to buy an intraoral camera, just do it! The investment is going to pay off, both in terms of paying for the equipment, and in the sense of making you a better dentist. I'm so happy I was an early adopter of

intraoral cameras. They've been a huge part of my practice ever since the days of the Fuji DentaCam.

The cost of investing in an intraoral camera has dropped considerably since the early cameras. Prices average about \$4,000, which is far less than I paid for my first one. It's worth it! If I had been able to offer video capture in my practice when I bought my first intraoral camera in 1989, I'd probably be retired by now. ■



Dr. Jim Downs received a D.M.D. degree at Tufts University School of Dental Medicine in Boston, MA. He is an expert in comprehensive restorative treatment and has completed numerous full mouth reconstruction cases. He maintains an aesthetic, family-oriented practice in Denver, CO. Dr. Downs is an instructor for several continuing education courses with the Dr. Dick Barnes Group seminars, including Implant EZ, Full Arch Reconstruction, and more.

PUBLISH YOUR CASE!

We are looking for articles to publish in upcoming editions of *Aesthetic Dentistry* magazine! Please send us your case study that features Arrowhead Dental Laboratory's **Elite** dental restorations.

To be considered for publication, we ask that you include step-by-step information, photos, and any products that were used. Your story may help other doctors learn how to provide life-changing dentistry! For more information, please contact:

Email: info@adentmag.com
Phone: 1-801-572-7237
Address: 11170 South State Street
Sandy, UT 84070

White Wax-Up

The Key to Predictable Outcomes

Arrowhead White Wax-Ups can help by providing a stunning 3D physical model that you can use to show patients exactly what their new smile will look like.

A White Wax-Up kit includes:

- a Sil-Tech® temporary matrix
- a clear reduction guide for prepping
- a prep model

Arrowhead White Wax-Ups are the key to patient acceptance and predictable outcomes.

With Arrowhead's dedicated support, doing full arch cases has never been easier.

FOR MORE INFORMATION CALL
1-877-502-2443

www.arrowheaddental.com/whitewax



ARROWHEAD

How To:

Fabricate a Crown Under a Removable Partial Denture

Step-by-Step Procedure So Patients Can Keep Their Partials.

Aesthetic Dentistry recently spoke with Arrowhead's Removables Department about the best practice for fabricating a crown under a partial clasp. Anytime a patient needs a crown on a tooth abutting a partial denture, the dentist can follow this procedure. These steps eliminate the need to make an entirely new partial or send in the existing partial.

This process can be used when placing any type of crown—PFM, E.max, full zirconia, or full gold.

By utilizing materials that mimic the shape of the clasp, there's no need for patients to surrender their partials when getting a crown. Patients with RPDs appreciate keeping their partials during treatment because the function and aesthetics of the bite are maintained.

Here's a step-by-step guide to the recommended sequence:



STEP 1. Simply prep the tooth for a crown as you normally would, with whatever technique and materials that you prefer.



STEP 2. Seat the partial and make sure there is clearance for the crown between the prepped tooth and the clasps and rest.



STEP 3. Remove the partial and inject a light body impression material all around the prep. Build it up higher and wider than the adjacent teeth.



STEP 4. Seat the partial in the patient's mouth. Make sure the partial seats completely and correctly, and that the material is displaced by the clasps and rest. Ask the patient to bite gently on the partial to check if it's seated correctly and to make sure the partial hasn't moved.



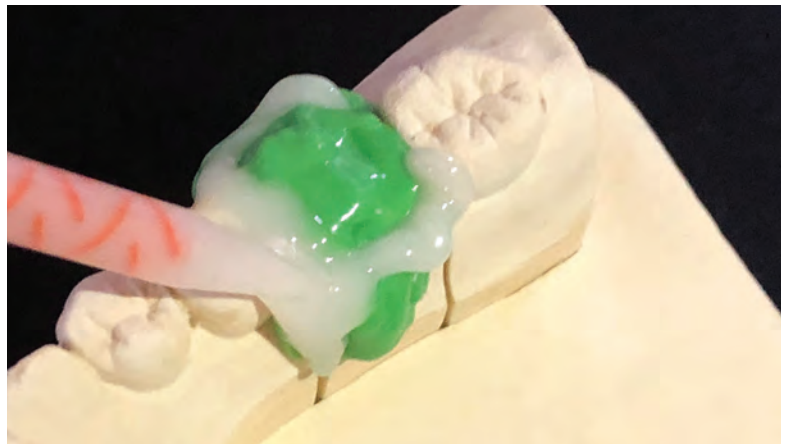
STEP 5. Remove the partial from the patient and separate the impression material from the partial. Check to ensure that you have captured the rest and the clasps. Return this piece with the rest of the case to the lab.



From this angle you can see all the required indentations.



STEP 6. The lab will inject Luxatemp material into the indexes of the clasps and attach it to the die model.



STEP 7. The lab will shape the Luxatemp material to mimic the clasps.



Here is another view of the Luxatemp material.



Patients with removable partial dentures appreciate keeping their partials during treatment because the function and aesthetics of the bite are maintained.

STEP 8. The lab will build the crown. It will be contoured according to the matrix.



STEP 9. When completed, the partial is lifted off the model, and the crown will be retained on the partial. This shows that when the crown is seated or cemented, it will hold the partial in place in the mouth.



Smooth Sailing

A Simple Guide to Purchasing a New Practice.

Buying a dental practice is one of the biggest purchases that a dentist will ever make. A dental practice has the potential to deliver the kind of career and service that the dentist envisions. Many difficulties in transitioning dental practice ownership from one dentist to another can be eased if the incoming dentist knows exactly what he or she is buying before signing on the dotted line.

Sometimes dentists buy a great dental practice and the transition seems easy. However, even in such ideal circumstances, dentists have to learn how to maintain and increase the value of that practice.

When a dentist purchases a practice, he or she buys more than just a building and a team. A dental practice is a complex culture, so it is critical to understand all the intricacies of that culture. Occasionally a dentist buys a great dental practice and the transition seems easy. However, even in such ideal circumstances, dentists have to learn how to maintain and increase the value of that practice.

FOUR QUICK RECOMMENDATIONS

I like to think of it in terms of being a captain of a ship. Even if a captain takes over a well-run ship, he or she needs to know how to inspect and mend the sails, how to navigate in both

storms and calm waters, and have a destination in mind so that the ship keeps sailing on a steady course. Sometimes a captain can catch a favorable wind that takes the ship where it needs to go, and other times the seas can be a little choppy and force anyone off course.

1. When buying a practice, the first thing I recommend is that you do your research. Don't make an impulsive purchase based on something superfluous—such as the location being near your house or your favorite shops, or because it looks fancy and might attract “posh” or high net worth patients.

Understand the management style, the accounting procedures (see *number 3, below*), the finances (see *number 4, page 37*), and the overall state of the practice—both the clinical and the business sides.

2. The second thing I recommend is that every dentist act as his or her own consultant. Spend as much time as possible at the practice. Learn whether they have an effective and efficient recall system, hygiene program, and accelerated hygiene strategy.

Ask the following questions: How are patients treated in recall? How often are they called/contacted? How do they make appointments? What's the median age of the patients? It's important to look at systems and how those systems lead to the financial health of the practice.

3. The third thing I recommend is that every dentist understand the accounting procedures. Make sure that you know the major expenses, minor expenses, discretionary expenses, and owner's compensation expenses.

Ask how funds are allocated and whether they are in compliance with industry standards or not. There are standards that all

Look Toward the Horizon



dentists have to abide by. Dr. Jim Downs, with The Dr. Dick Barnes Group (DDBG), teaches a course called “Know Your Numbers,” which helps dentists forecast what production should be for the forthcoming year.

4. The fourth thing I recommend is that every dentist look at the numbers. Review accounts receivable, accounts payable, cash flow, who owes and who doesn't owe, and what collections are on a regular basis. If collections are not at 98 or 100 percent, there may be a problem. When collections are below 98 percent, it indicates that a fair amount of outstanding monies need to be collected. It's good to know who owes the practice money and how the practice handles collections.

Even if a captain takes over a well-run ship, he or she needs to know how to inspect and mend the sails, and how to navigate in both storms and calm waters.

Smart people surround themselves with smart people. Get advice from accountants, financial advisors, and attorneys. Listen to what they tell you and consider their business analysis of the practice. In addition, consider finding a coach and/or a mentor. Develop relationships with colleagues and other professionals (suppliers, industry influencers, etc.) who are also trying to navigate the same waters.

CASE STUDIES

Example 1: I once helped a dental practice through a new-owner transition and we had a curveball thrown at us. As patients came in for their exams, they told the dentist that the previous doctor had diagnosed treatment and that the work had yet to be done. Plus, the patients claimed they had already paid for the treatments in full. We found no records that payment had been received in advance for treatments.

Sometimes the captain can catch a wind that takes him or her where they need to go, and other times the seas can be a little choppy.

The predicament put the dentist in a “lose-lose” situation—either he had to accept the patients at their word and do their dental work, or risk the likelihood of losing the patients.

Example 2: Sometimes dentists buy a culture that doesn't function. I remember a practice where the previous dentist raised team members' wages across the board before he left. However, the practice wasn't doing well financially, so the new dentist inherited a cash-flow problem.

Eventually, the new dentist had to let several team members go. The team members told the new dentist that patients would not come in if they were not there, which of course was not true. All dentists should do research into accounting and payroll practices to avoid being potentially blindsided. ➤



BE A LEADER

Sometimes the decision to buy a dental practice seems like the easy part of a dental practice transition. After the financial transaction has closed, Monday morning arrives and you are the dentist in charge! Now what do you do? Here are some ways to create and maintain an effective culture:

Opportunities are everywhere. All patients are new patients to you, which is a great business proposition because according to Dr. Dick Barnes, the value of a new patient is somewhere between \$3,000 and \$5,000.

Greet every patient like they are a new patient. Have an “eye-to-eye and knee-to-knee” conversation and spend some time getting to know them. It doesn’t take long—just a couple of minutes.

When you buy a practice from another dentist, there is often a lot of undone dentistry on patients. The previous doctor may not have had the latest technology, or perhaps he or she was retiring and didn’t present as much treatment in the months leading up to retirement. Or, the former dentist may have given up on presenting comprehensive dentistry to patients because they usually rejected the treatments. With fresh ideas and a new approach, you may find numerous production opportunities.

Take your time. As the saying goes, “Sometimes you have to slow down to speed up.” If new dentists are too enthusiastic and try to move too quickly, some patients may be resistant. The first year of a new practice should be focused on getting to know patients and establishing relationships of trust.

Some patients will be ready for comprehensive dentistry immediately, but others may be used to a system of supervised neglect. Certain patients are going to resist treatment until you have become “their” dentist, so give them time.

Look at areas for growth. A new dental practice is a great opportunity to analyze growth potential. Look at your skill sets and levels of competency and identify new technologies and procedures that you could add to the practice. Some examples include orthodontic services, implant placements, and sleep dentistry solutions. Learn new skills and be prepared for modifications to make your ship strong and expansive as you sail along. No company ever “shrank” its way to success.

Work together. Dr. Barnes recommends having the previous dentist introduce the new dentist and help with the transition for a brief period of time. Sometimes this isn’t possible. Regardless, it’s important for the new dentist to have open communication with all patients.

Take an interest in your patients. To maintain a successful new practice, greet every patient like they are a new patient. Have an “eye-to-eye and knee-to-knee” conversation and spend some

CREATING AN EFFECTIVE CULTURE

- Opportunities are everywhere
- Take your time
- Look at areas for growth
- Work together
- Take an interest in your patients
- Help them help you
- Always use diplomatic language
- Confused patients don’t buy

time getting to know them. It doesn't take long—just a couple of minutes.

In that conversation, praise the previous dentist. Never say, "I just bought this practice from doctor so and so." Instead, say, "Dr. Smith was very happy to pass on the practice to me." Patients don't want to feel like they were sold to somebody.

Once you show patients that you have a compulsive interest in them and their good oral health, they will support you.

Keep in mind that six months or a year ago, patients came to "Dr. Smith" and everything was fine. With your training and a new set of eyes, you may find several areas of concern. Start building relationships and having honest conversations with patients to build an environment of trust.

However, keep your expectations realistic. Patients will not sign up for everything that you recommend all at once. Tell patients that the former doctor took notes on their dental history, and that he or she was happy to pass the dental practice on because of your commitment to maintaining the patient's good oral health, or your plans to restore the patient to good oral health.

Help them help you. In an established practice, the front office and clinical teams already have relationships with patients. It is important for them to support the new dentist as an authority and expert. This can be accomplished through leadership and

mentoring. The team should be guided so that they understand your vision and goals for the practice.

Always use diplomatic language. Taking over a new practice is an opportunity to make your patients your biggest fans. Once you show patients that you have a compulsive interest in them and their good oral health, they will support you. They will open up to you and soon you will become "their" dentist.

When transitioning a dental practice from one that has been more drill-and-fill oriented to one that offers comprehensive dentistry, it is critical not to disparage the previous dentist. Phrase suggestions positively without questioning the credibility of your former colleague.

Say, "Dr. Smith was concerned about retiring because he loves his patients and the patients loved him. He was glad to know that I'm bringing new technology and new procedures to his patients, so he was happy to pass the practice along to me. Dr. Smith kept detailed notes of all the work he has done, so I have a good idea of where you are."

After doing a comprehensive exam, you may identify several areas of concern, but remember—the patients aren't "yours" yet. It takes time and patience.

Such statements can lead to a discussion about comprehensive dentistry. Tell the patient that you will do a comprehensive exam, but remember—the patients aren't "yours" yet. It takes time and patience to build that trust. ►



Keep Your Sails Full



Confused patients don't buy. Presenting a lot of dentistry and high treatment costs to your new patients could confuse and alarm them. Confused patients do not accept treatment.

After you have seen patients once or twice and have started to establish relationships with them, then they are “your” patients.

Instead of presenting comprehensive treatment all at once, take your time. For example, say, “The previous doctor mentioned that you are wearing down your teeth. How long have you been noticing that this is happening? At your next appointment, six months from now, we would like to check this again to see how quickly it is progressing.”

Use conditional words so that when the patient returns in six months, he or she is prepared for more comprehensive treatment. Maybe the patient was completely unaware of the problem, but will be motivated to make a change after hearing the diagnosis. Say, “I’m going to keep an eye on certain things that are happening with your teeth. It is important for me to see you in six months because of such areas of concern.”

BELIEVE IN YOURSELF

Dental practice transitions are a process, not a destination. It typically takes about a year and a half for patients and team members to adjust to a new dentist, depending on how many patients are in the practice. Most practices need some time to put new procedures in place and to see improvements.

Purchasing a practice is a big undertaking, but also a rewarding voyage. During the journey you will encounter all kinds of waters, weather, obstacles, and opportunities. Trust your instincts and stay the course! Keep an eye toward the horizon, but adapt to whatever may come. Allow for ingenuity, creative thinking, and risks. Many resources are available to you and your crew. Following these suggestions can help any new dentist weather the storms of transition and begin smooth sailing with a new practice. ■



Hernan Varas is in Clinical and Practice Development with Arrowhead Dental Laboratory in Sandy, UT. Hernan has been with the lab for more than 15 years and has worked in the dental industry for more than 30 years.

Originally from Chile, Hernan attended Westminster College in Salt Lake City, UT, for a bachelor's degree in marketing and communications. Afterward, he continued his studies at Westminster and received a Master of Business Administration degree, with an emphasis in international management.

Since working at Arrowhead, Hernan has been mentored by and visited thousands of dental practices with Dr. Dick Barnes—including every state in the contiguous United States. Hernan specializes in strategies and techniques for increasing productivity and case acceptance in dental practices.



“My practice is
more successful
than I could
have imagined!”

Dr. Valerie Holleman, Broken Arrow, OK

Arrowhead Dental Lab and the Dr. Dick Barnes Group offer a CE plan specifically designed to make new dentists more successful. Dr. Valerie Holleman was in practice for about eight years before starting the New Dentist Program with Arrowhead. Dr. Holleman said, “My advice? Do it now! It’s the best decision I ever made and the courses are life changing.”

Get the skills and support you need for success and keep your patients coming back by providing the latest in dentistry.

Sign up today for Arrowhead’s New Dentist Program by visiting our website at: www.ArrowheadDental.com or by calling 1-877-502-2443.



Arrowhead’s New Dentist Continuing Education (CE) Plan:

All For Only \$4,995

ARROWHEAD

- **Full Arch Reconstruction:** Only 30 percent of dentists offer this innovative procedure in their practices—you can be one of them!
- **Total Team Training:** Give your entire team the tools they need to help build a more profitable practice.
- **Implant EZ I:** Reduce the number of patients you refer out and keep valuable revenue in your practice.
- **Everyday Occlusion:** Help a large number of your patients achieve improved dental health by applying these specialized concepts and techniques.
- **Airway Management and Dentistry:** Learn how to integrate sleep dentistry and the treatment of sleep-disordered breathing for your patients.

Get Started Today! www.ArrowheadDental.com

Making Smart Technology Decisions (continued from page 21)

Aside from a single piece of equipment failing, consider the potential for bottlenecks. I have seen this occur with intraoral camera systems. For example, a dental practice buys one and then passes it around as needed. If patients are waiting in the chair because someone else is using the camera, you have a bottleneck problem.

Being a dentist doesn't just mean doing dentistry—it means making sound business decisions.

Having a patient wait an extra 5 to 10 minutes might not seem like a big deal, but in aggregate, the wait time created by under-provisioned technology can cost thousands of dollars in lost productivity. Any time you purchase technology, make sure to keep your eyes open for potential problems created by single points of failure, as well as bottleneck issues.

CONCLUSION

Technology is part of today's world. Being a dentist doesn't just mean doing dentistry—it means making sound business decisions, including large capital investments in technology.

Don't let your practice's technology purchases go to the "Island of Misfit Dental Purchases." Ensure that you are not making purchasing decisions based upon sales presentations, but instead on an in-depth knowledge of your practice, its workflows, and the needs of your patients and team. Doing so will result in a better return on your technology investments, while at the same time creating a competitive advantage over less-effective adopters of technology. ■



Matthew Cook has been a dental technology consultant for more than 18 years, specializing in the creation of technology-enhanced business processes. In 2004, he joined Arrowhead Dental Laboratory in Salt Lake City, UT, as the head of their IT Department.

Looking Inward (continued from page 3)

approach to large cases. During dental school and the early years of my practice, I focused on how many teeth were in a particular case because that is how cases were billed. For smaller cases (usually below five units), such a pricing structure is perfectly fine.

A Chinese proverb says that the longest journey begins with a single step. I have worked diligently my entire career to help other dentists find the joy in dentistry, like I did.

However, once dentists get above six units and start working on full arches or full mouth reconstruction cases, the price-per-unit strategy is no longer reflective of the skill it takes for such cases and the complexity involved in them. A full arch case is not just incrementally more difficult than a three-unit case. It is exponentially more complex. I continue to advise dentists that for large cosmetic cases, they need to consider the price of heart muscle and stomach lining that they may lose in the process.

Another great insight was the realization that doing large cases needn't be as difficult as I was making it. For a long time, I thought it was only up to me to make these cases work. I was constantly on the telephone with different dental laboratories,

trying to find one that would do things exactly the way I wanted them done.

Eventually, I realized that great achievements are rarely the result of a single person's effort. I knew I had to find a team of people that I could rely upon to help me produce amazing dentistry. I sought out mentors and associations with other like-minded dentists.

I looked to build a team of front-office support people and hygienists that were as passionate about comprehensive dentistry as I was. Because of this, I went from being a dentist with excuses about how my patients couldn't afford a full arch reconstruction, to being a dentist that patients of all income levels would seek out because they wanted outstanding care.

I invite all of my colleagues, regardless of where they are in their careers, to pause for a moment and look at their world differently. If you find that you are not where you want to be, or that there is something more you want out of dentistry, start moving in a different direction.

A Chinese proverb says that the longest journey begins with a single step. I have worked diligently my entire career to help other dentists find the joy in dentistry, like I did. Make it your goal to present the best option to every patient. Surround yourself with people who can help you. If you need a mentor or a new direction, start on that journey today. I wish you all a happy and productive new year. ■

FAST TRACK PROGRAM

Jump start your production potential



FOR MORE
INFORMATION
1-877-502-2443

ARROWHEAD & THE DR. DICK BARNES GROUP are pleased to offer a program designed to get your dental skills on the production fast track. The program is specifically designed to help take any dentist, regardless of experience, through a specific sequence of instructions that will dramatically increase your production potential, starting with the first course. For a fixed price of **\$7,980** you will get access to four of the Dr. Dick Barnes Group's most sought-after courses. This program includes:

- **EVERYDAY OCCLUSION**
- **FULL ARCH RECONSTRUCTION**
- **CLINICAL HANDS-ON**
- **BEYOND THE BASICS**

Call Arrowhead Dental Lab for details.

WWW.ARROWHEADDENTAL.COM

ARROWHEAD



Exceed expectations:

95%¹

Clinical survival over 8 years*

IPS e.max®

All ceramic,
all you need.



Download the complete report at
makeitemax.com/data

*November 2018 Independent Clinicians Report (Volume 11, Issue 11)

For more information, call us at 1-800-533-6825 in the U.S., 1-800-263-8182 in Canada.
© 2019 Ivoclar Vivadent, Inc. Ivoclar Vivadent and IPS e.max are registered trademarks of Ivoclar Vivadent, Inc.
Dentistry by Dr. James Fondriest and Matt Roberts CDT.
¹ 5% cementation failure.


**ivoclar
vivadent®**
passion vision innovation



TS III CA

SUPER HYDROPHILIC SURFACE

Tel: +98 21 88 98 80 63 - 6

Web: www.azadmed.com

This is
the First

OSSTEM[®]
IMPLANT

آزاد تجارت پارس
AZAD TEJARAT PARS.LTD

