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WINTER 2011

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Treat Bell's Palsy?**



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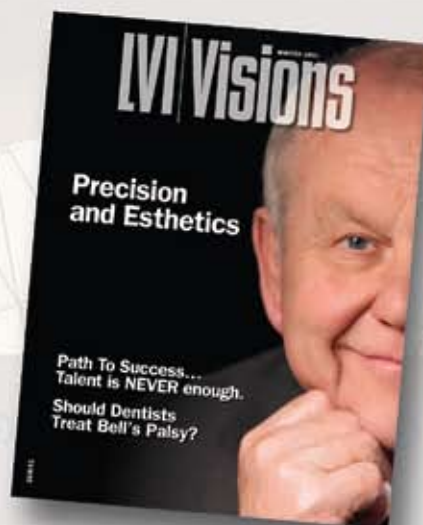
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WINTER 2011

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The Las Vegas Institute for Advanced Dental Studies (LVI) publishes LVI Visions. Please send any comments or suggestions to 1401 Hillshire Drive, Suite 200, Las Vegas, NV 89134. Telephone (888) 584-3237 or (702) 341-7978. Web address • [www.lviglobal.com](http://www.lviglobal.com).

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*CHANGING DENTISTRY. CHANGING LIVES.*

E D I T O R I A L

**WILLIAM G. DICKERSON, DDS, FAACD, LVIM**

Like many doctors, Dr. William Dickerson was unhappy with the progress of his chosen profession. Twenty-two years ago he made the decision to change that. His practice success and personal metamorphosis led to his passion to help others in dentistry so that they too could enjoy the profession they have chosen. Since that time he has educated thousands of dentists all around the world inspiring them to make the necessary changes for their own practices and lives. Because of his dedication and passion to help other dentists, he is considered by many to be one of the most influential dentists in North America, affecting the practices and lives of thousands of dentists around the world. He is the Founder and CEO of the Las Vegas Institute for Advanced Dental Studies (LVI Global).



*Are You Preventing  
Your Success?*

*Talent is NEVER enough*



*The underlying premise of this article is that*  
**EVERYONE OF YOU CAN BE SUCCESSFUL!**

**A**re you as successful as you want to be? Is there something that is preventing you from your desired success? Have you come to the conclusion that success is not in your cards? Do you believe you can have the life you want to have, or do you think that it belongs to that “other” group of people?

*The underlying premise of this article is that* **EVERYONE OF YOU CAN BE SUCCESSFUL!**

One of the most important messages that every person, including young people, need to know to be able to succeed in ANY business, is that talent is never enough! If talent was enough, how come I know so many dentists who are very talented, yet are not highly successful? How come I know so many talented people outside of dentists who are not suc-

cessful? You all are talented or you would not have made it through dental school, hygiene school or laboratory technician programs. But perhaps your talent lies in another area of your profession. What is your passion? Have you lost that passion you once had? Remember, talent may be given, but success has to be earned!

*“There is no level of skill so high that it cannot be overcome by significantly poor judgment.”* - Bruce Lansberg

We should go to work every day with enthusiasm, passionate about what we do. I’m not saying we don’t have to work hard, or there are not going to be some frustrating days, and some people with whom we’d rather not be around. That’s all part of life. Ultimately, we should enjoy what we’re doing. When you get home at night, you should feel that you’ve accom-

plished something and you’ve helped to make the world a better place. I believe that when you discover your destiny, and start working in some realm associated with it, you will thrive.

You are not meant to live a miserable and unfulfilled life. Make sure you are in a field that is part of your destiny. Or find that fulfillment and passion in the field you’re in. Don’t give up on the dream you once had. Don’t spend your entire life in an unfulfilling existence, doing something you don’t like doing, staying there simply because you feel trapped and don’t have the energy to “change”.

**Are you smart enough?**

Some of you may think you are not smart enough to be successful. Peter Drucker, the father of modern management said, *“There seems to be*

*little correlation between a man's effectiveness and his intelligence, his imagination, or his knowledge."*

More than 50% of all CEO's of Fortune 500 companies had a C or C- average in college.

65% of all US Senators were in the bottom half of their class.

75% of all Presidents were in the bottom half of their class.

More than 50% of Millionaire entrepreneurs never finished college.

So why are they more successful than you?

**1. Everyone has a talent.**

**2. Develop the talent you have, not the one you want. Don't spend time strengthening your weaknesses.**

**3. Anyone can make choices that will add value to talent.**

### **Believe in your potential**

Many people have asked me how I created LVI and turned it into the most prolific, successful post graduate dental education center in the world with over 60,000 sq ft of campus on 6 acres. My answer was and is... I expected it!

So the question is, can you be successful? Are you capable of achieving great success? The answer is absolutely... YES!

Thomas Edison – *"If we did all the things we are capable of doing, we would literally astonish ourselves."*

Mohandas Gandhi – *"The difference between what we do and what we are capable of doing would suffice to solve most of the words problems."*

Sharon Wood, the first North American woman to climb Mount Everest, said, *"I discovered it wasn't a matter of physical strength, but a matter of psychological strength. The conquest lay within my own mind to penetrate those barriers of self-imposed limitations and get through to that good stuff – the stuff called potential, 90% of which we rarely use."*

Charles Schultz – *"Life is a ten-speed bike. Most of us have gears we never use."*

Point is... most of the time your lack of success is due to a self-imposed limitation.

Joel Olsteen – *"I heard someone say that the wealthiest place on earth is not Fort Knox or the oil fields of the Middle East. Nor is it the gold and diamond mines in South Africa. Ironically, the wealthiest places on earth are the cemeteries, because lying in those graves are all kinds of dreams and desires that will never be fulfilled. Buried beneath the ground are books that will never be written, business that will never be started, and relationships that will never be formed. Sadly, the incredible power of potential is lying in those graves."*

Your potential is up to you. It doesn't matter what others might think. It doesn't matter where you came from. It doesn't even matter what you might have believed about yourself at a previous time in your life. It's about what lies within you and whether you can bring it out. Talent may give you a head start, but it's only a short lived advantage.

Stephen King – *"Talent is cheaper than table salt. What separates the talented individual from the successful one is a lot of hard work."*

Harvey Mackay – *"Hard work often leads to success. No work seldom does."*

As May V. Smith said: *"The only place you will find success before work is in the dictionary."*

William Jennings Bryan – *"Destiny is not a matter of chance, it is a matter of choice; it is not a thing to be waited for, it is a thing to be achieved."*

And remember that teamwork multiplies your talent. Getting the team on board your mission will dramatically enhance your chance for success.

### **Defining Success**

People define success in different ways, but I think most people would agree that true success is mainly feeling that you have been fulfilled in life. It's that deep satisfaction that you have

*"Hard work often leads to success.  
No work seldom does."*

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Dentistry courtesy of Scott Wagner, DMD, Jacksonville, FL



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## *“Always remember that the greatest enemy of learning is knowing it all.”*

---

served a purpose and have made the world a better place. Yes, providing a good life for you and your family is also important and a result of serving a purpose. The end result is a sense of happiness and peace of mind.

The best definition I have ever read about success came from Bessie Anderson Stanley, 1904.

*“Those have achieved success who have lived well, laughed often and loved much;  
Who have enjoyed the trust of pure women, the respect of intelligent men and the love of little children;  
Who have filled their niche and accomplished their task;  
Who have left the world better than they found it, whether by an improved poppy, a perfect poem or a rescued soul;  
Who have never lacked appreciation of earth’s beauty or failed to express it;  
Who has always looked for the best in others and given them the best they had;  
Who’s lives were all inspiration;  
Who’s memories a benediction.”*

You notice there is nothing in there about money? Money is not a bad thing, in fact, just the opposite. Money allows people to do good. It’s your moral obligation to provide for your family. I know it seems in today’s society they want to demonize the wealthy, but the wealthy are those that are philanthropic and provide jobs for others. Money is not evil... perhaps the pursuit of money may be a problem, but not money.

*“We are prone to judge success by the index of our salaries or the size of our automobiles rather than by the quality of our service and relationship to mankind.”* Martin Luther King, Jr.

Truth is, in reality, it’s just a scorecard of how you are doing. Our salaries or the quality of our automobiles IMPROVE if our focus is on the quality of our service and relationship to mankind. As Earl Nightingale said:

*“Success is the progressive realization of a worthy goal or ideal.”*

*“Efforts and courage are not enough without purpose and direction.”* JFK

### **What are YOUR excuses?**

We all have a tendency to make excuses on why someone else can succeed and we can’t. It’s easy to make excuses on why you are not as successful as you would like to be. I’ve heard them all. And as the saying goes, excuses are like anal sphincters, we all have them and they all stink.

*“Ninety-nine percent of failures come from people who have the habit of making excuses.”* George Washington Carver

Many people want success. Few people work at it. Results come from action! Most people usually just hope for success. Good results come from good actions. All the positive attitude in the world will not create success unless you take action towards

achieving your goals.

Sophia Loren – *“Getting ahead in a difficult profession requires avid faith in yourself. That is why some people with mediocre talent, but with the inner drive, go much farther than people with vastly superior talent.”*

### **The successful have an open mind and a desire to learn**

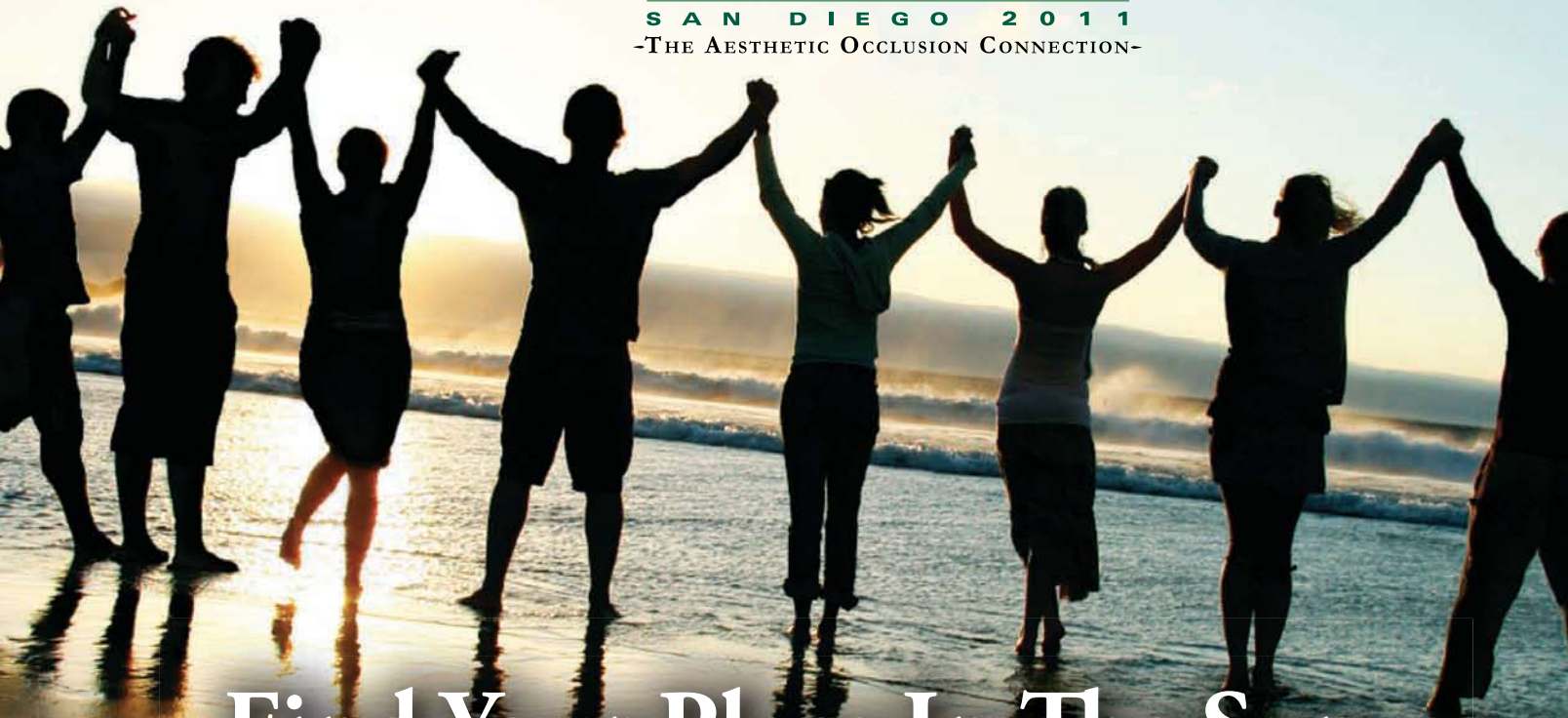
Always have an open mind. The other reason I believe LVI is successful is because we never stop learning. Talented people are usually the toughest to teach. Don’t let your talent get in the way of your success. Be teachable. One of the things I’m most proud of about LVI is that we are constantly evolving and changing the curriculum in our effort to constantly improve and grow. Our alumni that audit programs they took in the past would attest to this fact.

Proverb – *“Do you see a man who is wise in his own eyes? There is more hope for a fool than for him.”*

Always remember that the greatest enemy of learning is knowing it all.

One last note. Perhaps your talent lies in another area or one that you think is silly... Or just not prudent. Perhaps you are afraid to change, not sure about the unknown. Richard Edler said: *“Safe living generally makes for regrets later on. Don’t let yourself be pressured into thinking that your dreams or your talents are prudent. They were never meant to be prudent. They were meant to bring joy and fulfillment into your life.”*





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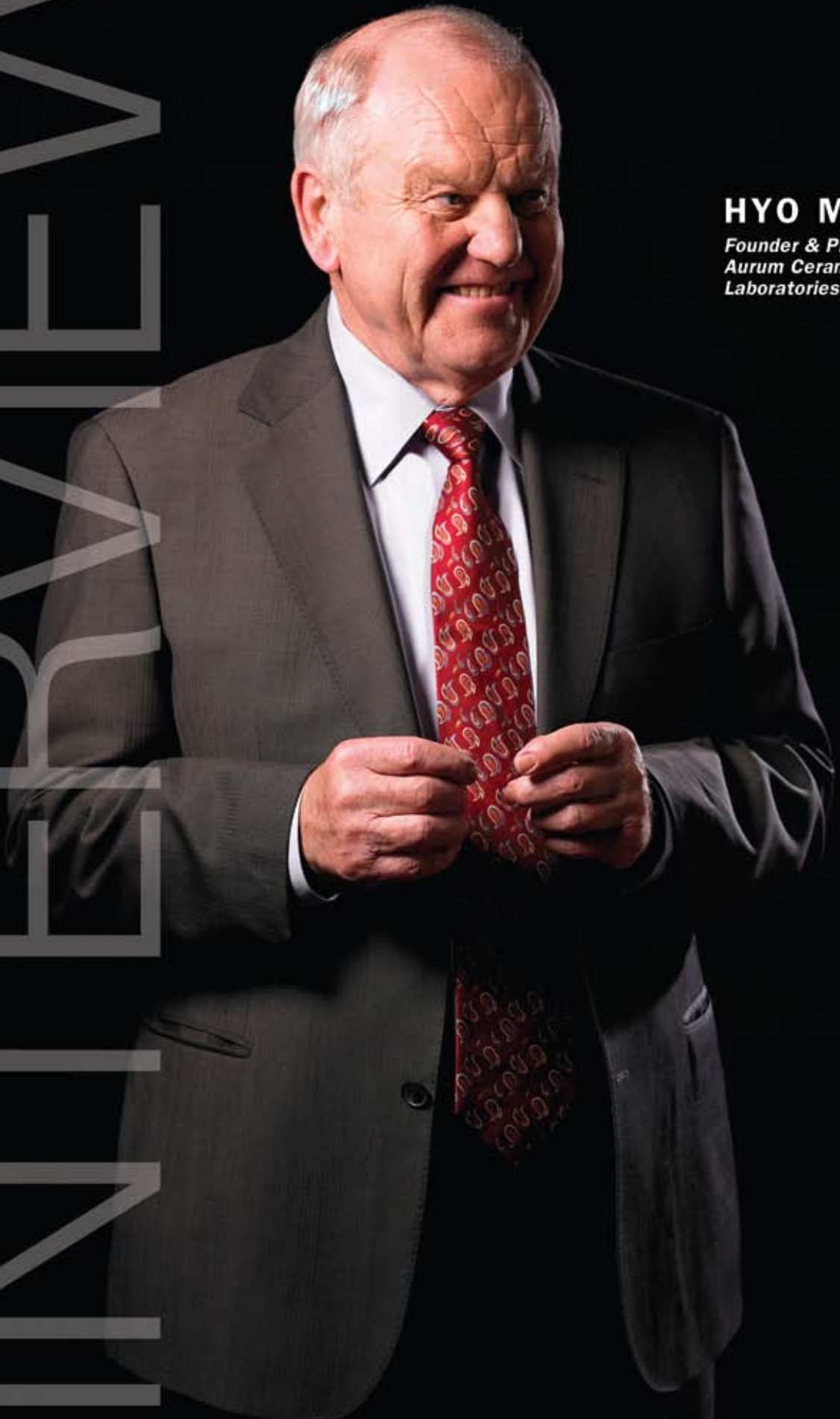
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INTERVIEW



**HYO MAIER**

*Founder & President of  
Aurum Ceramic Dental  
Laboratories*

Founder and President of Aurum Ceramic Dental Laboratories, Mr. Hyo Maier began his dental career as an apprentice dental technician at the University of Tubingen Dental Hospital in Germany. Immigrating to Canada in 1962, he joined a dental laboratory in Calgary. In 1971, he founded Aurum Ceramic and has overseen his growth from a single location to an integrated group of 12 laboratory locations across North America along with separate fixed orthodontic product and dental consumables supply companies and a number of removable orthodontic laboratory locations.

Mr. Maier has been active in a number of trade, professional and educational organizations. He is currently a member of the Board of Counselors for the University of British Columbia and has served as R&D Chairman of Terec North America and as a director of The Dental Laboratory Conference. His long-term support of the dental industry was recognized when he was presented with the Special Friend of Canadian Dentistry award by the Canadian Dental Association and an Honorary Membership by the Alberta Dental Association in 2001.

*Can you tell us about your background, how you created and developed Aurum Ceramics, what is arguably one of the most successful dental labs in North America?*

I arrived in Calgary, Alberta as a dental technician from Tubingen, Germany in 1962 and joined a small local dental laboratory. Strangely enough, Calgary was only supposed to be a stopover in the grand plan for my life – I was on my way to sunny California eventually, like everyone else in those days – or so I thought. Yet, here I am some “few” years later, happily headquartered in Calgary.

At any rate, I was made a partner in 1968 and ended up purchasing that laboratory in September 1971, renaming it Aurum Ceramic Dental Laboratories. We had 12 employees at the start. Over the next few years, we branched out slowly, setting up full-service laboratories throughout Canada and into the US. Today, we have over 500 employees and 12 laboratory locations across North America, including Aurum Ceramic @ LVI of course, along with separate fixed orthodontic product and dental consumables supply companies and a number of removable orthodontic laboratory locations.

I would like to think that our growth and success over the years has been due to three major factors: our willingness to embrace new technologies, materials and techniques as they emerged; our commitment to personal service; and, perhaps most importantly, our ability to identify, grow and retain excellent talent both on the bench and in support positions that embraced our philosophies and made them work for our clients.

*Please share some of your fondest memories over the past 50 years.*

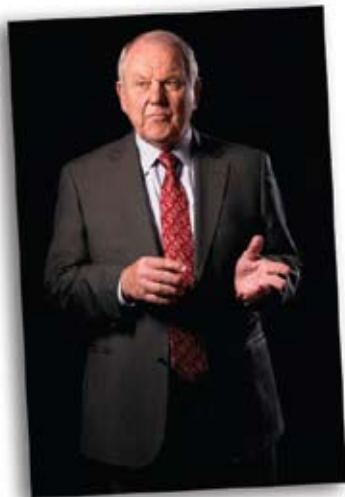
It’s hard to separate out any events particularly, but I would certainly have to say that I have enjoyed watching the industry itself explore, test and grow in terms of what we offer to the patient today. Compared to 50 years ago, we all have so much more we can do for the patient.

*You have been involved with LVI for around 15 years. Can you explain to everyone why you decided to join the LVI mission as one of its major sponsors?*



*You've had such a fulfilling life, what would you consider the greatest achievement of your life?*

*Which professional accomplishment(s) do you value most?*



Both in terms of my own interests personally, and as an organization, Aurum Ceramic has always been committed to supporting dentistry in terms of research, education and program assistance.

As part of this effort, we knew Bill Dickerson well before the Las Vegas Institute came into being. We sponsored some of his Continuing Education programs in our local markets and grew to know Bill and his vision very well. When it came time for Bill to launch that vision in the form of the Las Vegas Institute, it was a very easy decision for us to jump on board as I think we shared many of the same passions for advancing dentistry.

One of the things that excited us, in the early days and today, was the chance to have our technicians participate in the leading edge education on a regular basis. I think that we have now sent more technicians for LVI training to date than any other dental laboratory and we will continue to do so. In dentistry, I think it is the dialogue between dentist and laboratory technician that is one of the most important aspects of all of our success and LVI has always fostered and reinforced that dialogue.

Really, I would have to say that my greatest achievement is my family – my wife Diana, three children, their spouses and seven grandchildren. Maybe best of all, it's having my three children - Mark, Grant and Tatyana - actively involved and successful in the business.

Over the years, I have been fortunate to be involved with some great organizations. I am currently a member of the Board of Counselors for the University of British Columbia and have served as R&D Chairman of Terec North America and as a director of The Dental Laboratory Conference, both at exciting times in the dental industry. Perhaps my most memorable accomplishments were unexpected honors given to me by the dentist community. I was fortunate enough to be presented with the Special Friend of Canadian Dentistry Award by the Canadian Dental Association, and an Honorary Membership by the Alberta Dental Association in 2001. Both of these are seldom given to dental technicians and I was truly honored to receive them from my friends in the dental community. The one that might top them all was an honor presented to Aurum Ceramic/Classic as a corporate entity by the CDA - the Outstanding Philanthropy Award for Dentistry. That award really summed everything we have tried to do over the last four plus decades.

*Who do you view as a leading visionary in dentistry today?*

I'm going to say Bill Dickerson. I touched on it in an earlier response but I really admire how Bill says what he thinks and stands up for what he believes. Having known him since his early days, I can say without reservation that Bill is a true pioneer. Like any pioneer, he has faced some tough challenges and yet built a great institution in LVI, despite some very difficult resistance – I might even say a hostile climate at times - from others out there. Yet, he continues to fight on for what he believes in, and for the right of dentists to debate and test “accepted norms”.

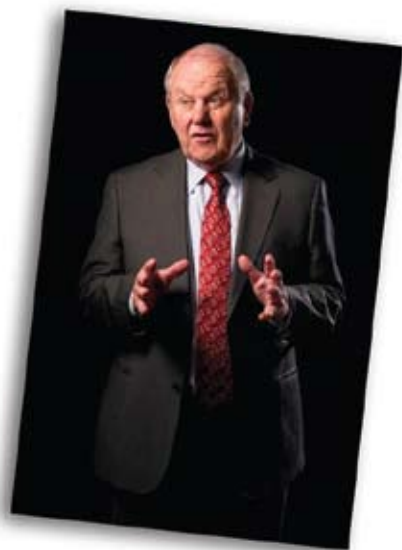
*What are some of the advances that you see happening in the laboratory aspect of our profession in coming years?*

I can sum that up in three words “computer-based digital technologies”. We are seeing its impact today in the dentistry we are doing every day and its impact is accelerating throughout the industry.

The whole digital concept just makes so much sense in a dental laboratory and clinical restorative environments. You remove imprecision at each stage in the process, from initial impression and model right through to the final restoration. The artistry is still there but when the product is produced by CAD/CAM, for example, the industry is just removing some of the human error in creating the final result. The benefits are enormous for both doctor and technician. We can cut chairtime, speed up turnaround times and dramatically reduce costly remakes that have plagued technician and clinician alike.

Aurum Ceramic has always been ready, willing and able to embrace new technologies. We have invested in these technologies to the point where, through our sister technology company, Core 3d Centres, I think we now offer the most comprehensive suite of CAD/CAM capabilities on the market. Today, dental labs are milling everything from acrylic to wax, ceramics, titanium and chrome-cobalt. Utilizing both open-architecture automated 5-axis industrial milling systems and closed proprietary systems such as Zeno® Tec and LAVA™, we now have the flexibility in-house to choose the best “manufacturing system” to meet an individual case situation and preferred material for the restoration as prescribed by the dentist, combined with complete control over scan, design, manufacturing scheduling and quality. We can import digital impressions from systems like Cadent iTero™ directly into our work-order processing system (minimizing possibility for entry error) and into our milling systems for simultaneous model and restoration fabrication on a wide variety of different technology platforms.

I'm asked frequently, “why all the different milling systems”? Well, there are many options in terms of material, technology and technique. Physical properties vary, milling systems vary. So by having choices, we can best match material and systems, particularly when there is that special challenge. For example, the combination of iTero combined with Brightsquid Dental Link and



*What advancement do you find the most exciting for the future of dentistry?*

Ivoclar Validated IPS e.max milling technology from Core 3d Centres, provides us with a transparent real-time digital work-flow to complete a flawless digital full-mouth reconstruction in as little time as a week! What's more, we can mill customized titanium or zirconia abutments for the case at the same time. The digital workflow has truly revolutionized the way we do business and the level of service we can provide our dentists.

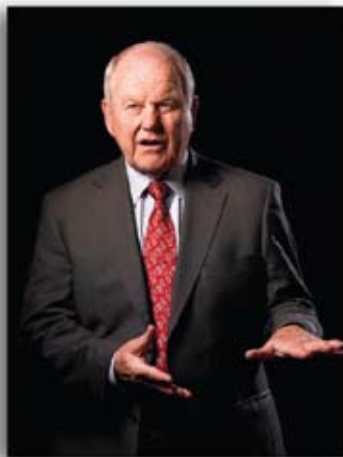
I think there are many advancements in the digital area. You can now offer your patients tremendous strength, precision, fit and esthetics anywhere in the mouth! The dentist can create predictable, accurate impressions using optical scans from digital impression systems like Cadent iTero™. But, I think what is most exciting is that the available materials physical and esthetic properties are now catching up with the capabilities of the systems that mill them. It really is a race where all of equipment, both in-lab and in-operator, technique and materials are evolving at breakneck speed. We've gone from milling metals to all-zirconia and glass-ceramics but there are new and exciting materials on the brink of introduction daily. It truly is an exciting time to be in dentistry!

*You have an interesting perspective about TMD because you are a laboratory that has many neuromuscular-based clients. What is your take on dentists treating TMD today?*

As a dental laboratory serving dentist clients across North America for more than 40 years, we have been involved with literally thousands of cases involving TMD. Over the past 10 years, an increasing percentage of these have involved dentists employing neuromuscular principles, along with those practitioners who choose to follow more traditional approaches.

I don't feel it is my place as a dental technician or as a dental laboratory to debate the "science" of these approaches one way or the other, I will leave that to those involved in scientific studies and research. I will state, however, that we believe strongly that the discussion must be allowed to continue unhindered. I can say that our experience with neuromuscular cases over the years has been universally good and successful based on long-term feedback from dentists and patients. A number of these cases have even involved technicians and staff from our laboratories along with their family members. We have seen, and continue to see, a wide variety of severe problems related to TMD resolved successfully long-term by neuromuscular-based restorative treatment (after other modalities failed to provide the patient with relief).

To sum it up, it has been our experience that neuromuscular modalities do work in the hands of those trained to apply them. We would suggest that the opportunity to discuss, research and debate this subject must continue to be afforded to all clinicians with an interest and background in the topic.



*What is the biggest challenge in dentistry today? What bothers you the most?*

The challenge for all of us is to keep abreast with the incredible speed of change. To sort it all out in our minds, select what systems, materials and techniques offer the best solution for the patient today and then obtain the training to be able to apply those solutions properly.

That is where an institution like LVI is invaluable. By being able to offer a concentrated and impartial review of what is available and provide the hands on training to the clinician and technician necessary to apply the developments appropriately, we all benefit from the experience. I don't believe any individual in private practice or in the laboratory today can stay up to date by themselves, no matter how well read or well-intentioned.

*If you could give a piece of advice to all the dentists out there what would it be?*

Invest in your practice, invest in yourself. Embrace the new technologies and techniques and seek out the educational opportunities available. I know we are all finding the pace of change a bit daunting today but the potential benefits of applying that change are enormous. There are just so many opportunities. I can list off a few right off the top for implants alone: In2Guide and Co diagnostic systems for implant solutions, Nobelguide from Nobel Biocare, NIS system, Basic System, Suck down surgical guides – there are far more than that. Look at digital impression systems like Cadent iTero – everyone benefits with that type of system... patient, dentist and technician.

*What do you think the future of dentistry is and why?*

From a laboratory point of view, I believe that 50% of all restorations will be designed with CAD systems and milled on CAM technology. The implications of that type of shift are incredible in how we “do business” in dentistry. However, at the same time, I also believe that these systems will actually enhance our efforts in esthetics and function, not hinder them as some seem to fear when they talk about “production” versus “craftsmanship”. The patients demand esthetics, the clinicians demand esthetics, we as laboratories demand esthetics and I see no reason those developing the materials and equipment won't respond magnificently.



*With the proper training for both the laboratory technician and the dentist... the future of dentistry is brighter than ever!*

# Should Dentists Treat Bell's Palsy?

DR. HEIDI DICKERSON

**Bell's Palsy is a form of temporary facial paralysis. It can occur from damage or even trauma to the facial nerve. It is the most common cause of facial paralysis. It usually occurs on one side of the face; however, in rare cases it occurs on both sides. Symptoms begin suddenly and reach their peak generally within 48 hours. Symptoms range in severity from mild weakness to total paralysis and may include weakness, twitching, paralysis, drooping eyelid, mouth droop, drooling, dry eye or mouth, excessive tearing, impairment of taste, and more. Most often it causes significant facial distortion that lasts an average of 4-6 months.**



*I hope my personal experience will make you realize that as a dentist you can be highly effective in treating these patients.*

As a dentist I have seen patients with this disorder and understand its relationship to the facial nerve and associated muscles. It took a personal incident; however, for me to realize our potential to help patients in this situation. I hope my personal experience will make you realize that as a dentist you can be highly effective in treating these patients.

It started with the worst sinus infection of my life. Four days of a low grade temperature, facial discomfort, congestion, sinus pressure, and fatigue.

My husband, Bill, and I were on a family vacation and I could not lift my head off the pillow. We did everything you'd normally do to treat a sinus infection: nasal irrigation twice a day, taking decongestants, and taking an antibiotic. Nothing seemed to help. My twin sister, Wendi, commented, "She hasn't been this sick, since she had pneumonia as a kid."

By day four, my niece and nephew started to call this vacation..."Uncle Bill's Family Vacation"...as I could only come down and enjoy the on goings for an hour at a time! Poor Bill, he is likened to the cruise director, Julie McCoy, from the love boat!!

By the evening of day four, as we sat down for dinner...I noticed my lip felt strange as I sipped my drink. I excused myself and went to the rest room to take a look in the mirror. What I saw was scary! My lips were really pulling to the right side and I could not make a pucker on the left. I noticed that my philtrum was off center as well. I

came back to the table and showed everyone and the consensus was that my face was just "swollen from the sinus infection". Internally I'm nervous, I knew something was not right. To my horror, within an hour things started to go bad. My face was really starting to look paralyzed on the left side! We noticed my eye and cheek were now involved.

Bill immediately drove to one of our nearby LVI Doctor's offices and borrowed a T.E.N.S. unit. I called my internist and told him I had developed Bell's Palsy. Knowing the importance of early treatment, he prescribed the necessary medications, if I promised to go to the emergency room in the morning for confirmation of diagnosis. I agreed, and by midnight I'm on Prednisone (to decrease inflammation), Levaquin (in case the cause is bacterial), and Acyclovir (in case the cause is viral: HSV or Varicella Zoster).

You see, no one knows what causes Bell's Palsy. The incidence in the United States is 25 cases per 100,000 persons or 1 person in 65 per a lifetime. So why me? What has caused this? The answer: no one knows! So we need to treat it for all possibilities.

I'll describe the night as "restless", to say the least. I remember my mom had Bell's Palsy at the same age I am now, 42. She had it for 3 months. My imagination started getting the best of me now...is it genetic? No one knows. Will I have it as long or longer? The average length is anywhere from 4-6 months...with a 7% chance of recur-

rence. My good friend, Bill Wade, an instructor in our LVI laboratory programs, is also suffering from Bell's Palsy. He has had it for 4.5 months now...with no resolve at all. Will I be the same? No doubt I'm scared and emotional.

By 6:00 a.m. I was on my way to the emergency room. The result, a positive diagnosis for Bell's Palsy.

Immediately my husband, Bill, jumped on the internet. He did all the research to find what has helped others. Our LVI alumni were instrumental as well. They were emailing and sharing personal experiences with treating Bell's Palsy patients in their offices and what treatments have seemed to help.

We decide to immediately treat this thing as aggressively as possible. So here it goes:

- Antibiotic (Levaquin)
- Antiviral (Acyclovir)
- Steroid (Prednisone)
- Daily B12 shots (IM)
- Supplements: B6, B1, Zinc, and daily vitamins
- T.E.N.S. (as much as I can tolerate... up to 18 hours a day)
- Acupuncture (which helped to relieve my sinus congestion)
- Cupping (which immediately rid me of the metallic taste from the antibiotic)
- Nasal irrigation (2x/day)
- Facial exercise (biofeedback)
- Facial massage (ala Bill)
- Heat packs
- Eye lubrication
- Rest
- Laser treatment (photobiomodulation): this was not started until day 12
- CT Scan (to rule out other possible causes)
- Positive attitude/Positive reinforcement/Prayer/Meditation

*No one knows what causes Bell's Palsy.  
The incidence is 25 cases per 100,000 persons.*

## WEEK 1:

The sinus drained after acupuncture and the horrible metallic taste that I had, resided after the acupuncturist applied Cupping (stimulates blood flow and releases toxins). I was T.E.N.S.ing so frequently I actually lightly burned my cheeks at the myotrode side and decided that I needed to change them more frequently. My eye was droopy, dry, light sensitive, and uncomfortable with any breeze. The right eye was blinking 3x more than the left eye and it would not close all the way. It is very important for an ophthalmologist to see a Bell's Palsy patient and to test for eye dryness, blink reflex, eye closability, and any corneal involvement. I needed drops during the day and a lubricating gel at bedtime. It was suggested to stop wearing an eye patch, as I was possibly causing corneal irritation.

The T.E.N.S. is a lifesaver as it stimulates the facial nerve (CN 7) and

the trigeminal nerve (CN 5) and all the muscles they innervate. T.E.N.S. is helping with the facial pain I am experiencing. Also, one night I woke up with excruciating shoulder muscle pain (a side effect from the prednisone). We placed the T.E.N.S. on my shoulders and it was the ONLY way I could sleep.

The only change seen in week one was a decrease in facial swelling in the parotid area. Paralysis neither increased or decreased.

## WEEK 2:

My sinus infection is better. I am tired all the time. I learn quickly not to get up every morning and look in the mirror expecting a miracle. That just does not happen!

Something to note: this condition really plays on your emotions. Its sudden onset and disfiguration can be depressing. Even though I consider myself strong natured...I certainly had my breakdowns.



**Day 6: Smiling wide to show effects of palsy.**



**Day 9: Tensing as much as possible. I am not trying to smile in this picture, at rest this is how much face is going to the side.**

## DAY 12:

We add laser therapy to our regimen. After talking to our "laser guy" at LVI, we decide to try biostimulation Using Hoya's DioDent Micro 980 Soft-Tissue Laser.

At a setting of .7, using an uninitiated fiber, an inch above the skin...we used small circular movements from behind the ear, tracing the jaw bone, and on the entire left side of my face. I wore laser glasses and we stayed well away from the eye. Bill lased me every morning and every evening before bed time.

What does a low level laser do in this situation?

**REDUCES PAIN:** by stimulating endorphin production

**DECREASES SWELLING:** stimulates lymphatic drainage

**REDUCES INFLAMMATION:** by as much as 75%

**PROMOTES FAST HEALING ON A CELLULAR LEVEL:** by increasing the production of healing enzymes

**ENHANCES THE IMMUNE SYSTEM:** by increasing the number of "killer" cells by up to 900%

**CELL MEMBRANE RE-ENERGIZING:** allows the transport of needed nutrients across the cell walls which allows new cell growth

## DAY 13:

Upon waking, I am very nervous. Today I lecture for the first time since the "Palsy"...and am not particularly excited about being in front of a classroom of doctors and team when I look this way. As I share my concerns with Bill that morning, he has a huge smile on his face and tells me to go look into the mirror. It was amazing...my lip has a little movement (I'd describe it as being a smirk), and I can slightly flare my left nostril ever so slightly.



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I know...can you believe a nose flair has us this excited?! I proudly showed this off all day!

Are all these treatments finally paying off? Or is it the laser? Who knows...but I am not stopping any of it!

That night we use the laser again.

### DAY 14-16:

Each day we see small improvements: some movement in the forehead and cheek, the eye is blinking more frequently and is closing at 80% now.

I still continue T.E.N.S.ing, B12, B6, B1, Zinc, vitamins, nasal irrigation, facial massage and biofeedback, heat packs, eye lubrication and laser therapy. I will do all of these until I am completely healed.

### DAY 17-24:

Every day improvement is seen. It all started with the lip area, then the nose, cheek, forehead, and lastly the eye. As healing occurred I woke up several nights with facial pain and a generalized achy feeling. I attribute this to the healing process.

I cannot stress the importance of rest and relaxation during this time as well. My body just felt completely fatigued.

### DAY 25:

I consider myself 98% healed in less than a month! I still feel the area directly in front of my left ear is missing sensation...but everything else is normal!

I discontinue all treatment except for supplementation and laser treatments.

### DAY 30:

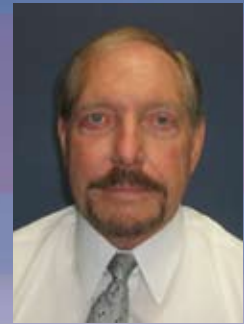
**COMPLETELY RECOVERED!**



Before Bell's Palsy



2 Months



8 Months

### AND WHAT ABOUT MY FRIEND?

Bill Wade did not take as aggressive an approach as I did during his onset of Bell's Palsy. In seeing my quick recovery, and with my constant nagging of him, he began laser therapy. After the first treatment, he noticed a slight movement in the corner of his mouth the next morning! Since that time he has regained more muscle tone in his cheek and lip. He is still undergoing treatment.

After reading all of this you are probably wondering what was the most effective part of this therapy? This question I will scientifically never be able to answer. Unfortunately, I was not willing to be a test subject and only try one therapy! Call me

selfish, but the aggressive approach was to cover any possible causes.

It is possible that we caught the Bell's Palsy within the first 24 hours and the early treatment helped the early resolve. It is also possible that a combination of the treatments were the answer. We really do not know.

What does my gut say? It says that the use of the laser was the single most important part of my recovery. I saw more improvement on a daily basis when we started utilizing the laser.

Physicians are uncertain of the etiology of Bell's Palsy. They treat it with medications and tell you to "wait it out" and "be patient". There is so much uncertainty...that is what scares you the most as a patient. You have no idea how long it will last and if you will be completely healed when it is gone or if you will suffer some residual paralysis. I will share that my physicians were all open to alternative treatments and encouraged everything I was doing. I will also share that none of them are currently using T.E.N.S.ing or Laser therapy in their treatments. That is where we as dentists come in. We have an armamentarium of things that can help these patients. We can supply our patients with a portable T.E.N.S. unit from Myotronics ([www.myotronics.com](http://www.myotronics.com)). We can use our Hoya ([www.conbio.com](http://www.conbio.com)) soft tissue laser for daily in-office laser therapy. We have the tools,



Day 30: Total resolution

*What does my gut say? It says that the use of the laser was the single most important part of my recovery.*

skills, and knowledge to take a role in the active treatment and resolve of this facial paralysis.

Since I have gone through this terrible ordeal I have learned many things: I have learned that Bell's Palsy's onset is fast and must be dealt with quickly and aggressively. I have learned that I am not invincible and I don't know what tomorrow brings. I have learned that my loving husband is the absolute best advocate, partner, and nurse that I could possibly ask for. I have learned that the love and support of family and friends is what emotionally gets you through. And most importantly, I have learned that as a dentist I need to be treating these patients! You do too.

**Dr. Heidi S. Dickerson, DDS, LVIM**  
*VP of North American/Australian Operations, LVI Global*

Dr. Heidi S. Dickerson is a 1994 graduate of the University of Illinois, School of Dentistry. She had a private, neuromuscular-based, restorative practice in Philadelphia, PA. Because of her commitment to excellence, spending countless hours mastering aesthetic, restorative and neuromuscular dentistry, Dr. Dickerson was determined to teach others what is possible to integrate into their practices! From Neuromuscular Occlusion to Full Mouth Reconstruction, Dr. Dickerson teaches a hands-on approach to learning. She holds a prestigious LVIM (Mastership) title at the Las Vegas Institute for Advanced Dental Studies. As an international lecturer she has helped share the NM philosophy to dentists around the world. As an administrator, she facilitates the operations of the Las Vegas campus, the Australian campus and the US and Canadian Regional Events. Her passion helps to motivate doctors and their teams through the LVI Curriculum. She is a featured writer in the Visions Magazine with her regular column called "Ask Heidi...Clinical Questions and Answers". In 2010 she was named one of the Top 25 Women in Dentistry. Her goal is that every dentist be the best that they can be...by being perpetual students throughout their careers.

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## DENTAL LASERS BENEFITS

### Welcome to Laser Pointer!

Welcome to Laser Pointer! This new quarterly segment will educate and outline new ways to obtain better clinical results for your patients, reduce stress and increase profitability through the use of lasers. There have been many new advancements with lasers and techniques and this regular segment will update you on some of them. Did you know that lasers can be used on well over 60 different ADA codes?

Many times we hear "My dentistry is great, I do not need a laser". Laser dentistry does offer many benefits over cold steel/bur and electro-surgery. Here are a few things Lasers can help you with.

#### Soft Tissue Diode Laser Technology

- These lasers work on soft tissue only and interact with Melanin & Hemoglobin
- Most states allow hygienists to use a laser for perio therapy. Offices that implement a diode with adequate training are finding approximately 85% patient acceptance with a production increase of 50% in the hygiene department by implementing a laser. If you have a diode in your hygiene department and you are not getting these types of results, it may be time for some training to get you there.
- You can remove venous varix lesions from the lip with just topical.

- **More conservative.**

If you have extensive dark charring, your laser is set too high. Use the least amount of power to attain your clinical objective and you will get much better healing. Like LASIK, it is truly micro-dentistry.

- **Create a secondary wound, not a primary wound.**

This results in much less post operative pain for your patients and doing much more with just topical.

- **Seal the lymphatic & nerve endings.**

This allows for more comfortable healing.

- **Have great coagulation properties.**

This will give you a nice dry field to work with.

- **Reduce bacteria & cross contamination.**

There will be less need for prescription drugs because of bacterial reduction.

- **Have bio-modulation properties.**

This initiates wound healing at a cellular level dramatically expediting healing.

#### All-Tissue Erbium Laser Technology

- These laser work on soft tissue and hard tissue and interact with water molecules.
- Erbium comparisons on soft tissue
  - Soft tissue contouring with a Erbium is much faster than a diode
  - When ablating soft tissue with an Erbium, you can limit edema to 2-5 cell layers. Compare this to a diode at approximately 150 microns and an electrosurge at 300 microns.
- Erbium on Hard (Osseous & Tooth Structure) Tissue
  - No Smear Layer      – No anesthesia
  - No Micro-fracturing required on a majority of cavity preps

## LASER CLINICAL SPOTLIGHT

By Dr. Peter Pang, LVI Laser Certification Instructor

### Speeding Up Pontics

This is a very typical case—replacing missing teeth and now you want to create the perfect emergence



Before



After



Final

profile for an implant or pontic. Using a laser to modify the tissue is common place in a restorative practice. Many times this tissue is quite fibrotic and can seem rather slow using a diode. This is why I use my Erbium laser to do this procedure. Both pontic sites took less than 1 minute total laser time. Not only is it quicker than a diode, but it will heal faster and be more predictable because I used much less energy than if I had used my diode laser.

## LASER FACTS

### Laser Speed

Did you know based on scientific absorption qualities in soft tissue, an Erbium all-tissue laser is 200,000 times more absorbed in soft tissue than a diode. That is why the Erbium Laser at its lowest power output is still way faster and much more conservative than a diode on soft tissue! That's like traveling at Mach 9.6 compared to a snail!

Predictable and Simple | Positive Patient Response | Increase Referrals and Income

## VALUE OF LASERS STRAIGHT FROM THE DOCTOR'S MOUTH

"The VersaWave enables me to do a variety of procedures for my patients. It pays for itself. I would not practice dentistry in the 21st century without it. What a WOW factor to give my patients and a great way to provide the best quality dental care."

– Ed Reeves, DDS, LVI Fellow & Erbium user for 1 year

"I can say today that the Erbium Laser has been the best equipment investment I have made in my 20 years of practicing dentistry. Not only has the laser allowed me to distinguish my practice from the other dental practices in my area, but it has allowed me to expand my services with less referrals. Plus the laser allows me to achieve superior results with more conservative treatments"

– F. Jay Ohmes, DDS, LVI Fellow & Erbium user for 5 years

## UPCOMING LASER TRAINING AT LVI

### January, 2011

12-14, Core 2 "Dental Laser Overview, it is more than diodes"

12-14, Core 5 "Laser Technique Training"

19-21, Core 7 "Advanced Laser Procedures & How to Increase Revenue with your Laser"

### February, 2011

9-11, Core 2 "Lasers in Hygiene"

9-11, Core 5 "Lasers in Hygiene"

16, Bone Grafting "Lasers in Grafting & Implants"

23-25, Core 7 "Hands-on Laser Workshop"

24-25, HOYA ConBio Introductory All-Tissue Laser Training

### February, continued

25, HOYA ConBio Advanced Diode Clinical Training

25-26, HOYA ConBio Comprehensive Diode Training for the Hygienist

26, HOYA ConBio Advanced All-Tissue Laser Training

### March, 2011

9-11, Core 2 "Dental Laser Overview, it is more than diodes"

9-11, Core 5 "Laser Technique Training"

April 1-2 & Nov 18-19, Laser Standard Proficiency Course



# Precision and Esthetics

*with*

**Aurum Ceramic Dental Labs**

**Core 3D Centers**

**IPS e.max**

John Krasowski, DDS

Grant Maier, BBA, CDT, RDT





## Developed with the patient in mind, restorations created in the dental laboratory of today provide the best in function, esthetics, and comprehensive care.

### Introduction

Through recent advancements in CAD/CAM technologies and material sciences, dentists and laboratories now have the ability to create precise restorations that offer the best in fit and function. Collaborating with laboratories utilizing advanced techniques, dentists can now expect restorations to demonstrate improved function and the durability required to resist masticatory forces. Developed with the patient in mind, restorations created in the dental laboratory of today provide the best in function, esthetics, and comprehensive care.

### Aurum Ceramic Dental Laboratories

A leader in providing the latest in digital technology, Aurum Ceramic Dental Laboratories ([aurumgroup.com](http://aurumgroup.com)) is committed to supporting dentistry with the most technologically advanced materials and techniques. Through research and education, Aurum Ceramic provides the platinum standard in laboratory services and outstanding results. Aurum Ceramic is also a Preferred Lab Partner at LVI Global (Las Vegas Institute), a Corporate Gold Member of the AACD, a supporter of Oral Health America, and works closely with Common Sense Dentistry and PTC.

### Core 3D Centers

Applying high-technology five-axis precision industrial milling technology to restorative dental cases and recently partnering with Aurum Ceramic Dental

Laboratories, Core 3D Centers ([core3d-centers.com](http://core3d-centers.com)) offer a unique global service through collaboration with leading dental companies on three continents. Through dynamic, precision, and intelligent laboratory development, a constantly evolving and wide range of restorative solutions are offered to customers with improved precision, fit, and the ultimate in quality care for patients. Core 3D is also officially validated with Ivoclar Vivadent.

### Lithium Disilicate

Whether using a 3D intraoral scanner or traditional impressions, monolithic lithium disilicate restorations milled by Core 3D Centers offer highly esthetic and durable all-ceramic restorations, with superior fit, for a variety of indications. In cases requiring single or full-mouth restorations, monolithic lithium disilicate restorations milled by Core 3D Centers also allow dentists the choice of adhesively bonding or conventionally cementing intraorally. By providing the best in technology and material sciences, dentists who have partnered with Aurum, along with their strategic partner Core 3D Centers, can offer their patients the best in esthetics, function, and care.

The case below demonstrates how a successful restoration of a patient's dentition was completed through the collaboration and communication of the dentist and dental laboratories utilizing advanced techniques.

### Case Presentation

Karen, a female patient in her mid-

40s, presented to the office with chronic pain that she had been suffering from for over 20 years. The patient displayed multiple signs and symptoms typically associated with airway and neuromuscular occlusal disease. Prior to coming to the author's practice, Karen had been treated for many years with splints and other treatment modalities that had been unsuccessful.

### Treatment Planning

Of the patient's conditions, the anterior teeth were also flared due to a tongue thrust and canting from left to right was present. The patient also demonstrated bicuspid drop-off, incisal wear, and lingually inclined posterior teeth. Therefore, the treatment plan would include a neuromuscular orthotic.

Since the patient was a professional in the public-eye, it was necessary to provide her with an esthetic result that also allowed her to function on a day-to-day basis, without compromising her ability to speak. After discussing various treatment options with the patient, it was decided that initial treatment with a fixed orthotic would correct for the canting and level the occlusal plane to the cranial base or hamular notch to incisive papilla plane (HIP). This also allows for the mandible and associated muscles to function within the "Zone of Comfort" and continued healing within the stomatognathic system. By restoring the upper teeth at this time with lithium disilicate, a better, more stable foundation was created.

## Laboratory Protocol

1. After receiving the necessary case information from the dentist, the laboratory technician created a waxed-up model of the restorations (Figure 1).
2. The monolithic lithium disilicate restorations were then created (IPS e.max CAD, Ivoclar Vivadent, Amherst, NY) utilizing CAD/CAM technology and placed on the model in their blue state (Figures 2 and 3).
3. The restorations were then cut-back to form the anatomical and structural characteristics required of the case (Figure 4).
4. The lithium disilicate then underwent bisque baking to complete the restorations, which were then sent to the dentist for final seating (Figures 5 through 7).

## Clinical Protocol

1. After removal of the transitional restorations, the monolithic lithium disilicate restorations (IPS e.max CAD) were inserted (Figure 8). The restorations displayed excellent incisal translucency and texture, while the supragingival margins were indistinguishable from natural tissue profiles. The anatomy and tooth shapes were successfully developed and the tissue was healing well (Figures 9 and 10).
2. With the lower orthotic in place, the completed monolithic IPS e.max CAD lithium disilicate restorations underwent final cementation (Figure 11). The margins were then cleaned of any excess material and displayed excellent marginal adaptation (Figure 12).
3. An initial coronoplasty was completed to the patient's fixed lower orthotic and good contacts were formed on the lingual cusps (Figures 13 and 14).



**Figure 1.**

The case was waxed-up case on the model.



**Figure 2.**

A frontal image of the monolithic lithium disilicate restorations was taken while in their blue state on the model.



**Figure 3.**

A blue state occlusal view of the restorations on the model.



**Figure 4.**

The restorations were initially cut-back on the model, while still in their blue state.



**Figure 5.**

A frontal view of the upper monolithic lithium disilicate restorations after undergoing bisque bake.



**Figure 6.**

Another bisque bake was completed, with the restorations on the table.



**Figure 7.**

The lower monolithic lithium disilicate restorations on the model.



**Figure 8.**

Tissue irritation was corrected postoperatively with the fixed orthotic in place.



**Figure 9.**

The restorations demonstrated excellent translucency and texture, while the supragingival margins were indistinguishable.



**Figure 10.**

A close-up view of the properly formed anatomy and well-healing tissue.



**Figure 11.**

The monolithic IPS e.max CAD restorations underwent final cementation and demonstrated proper marginal adaptation.



**Figure 12.**

With the orthotic in place, final seating was completed.



**Figure 13.**

A photograph of the monolithic IPS e.max CAD restorations inserted in the oral cavity was taken 24 hours after the first coronoplasty appointment.



**Figure 14.**

The gingival tissue was healing well postoperatively, and the lithium disilicate restorations displayed good contacts on the lingual cusps.



**Figure 15.**

The monolithic lithium disilicate restorations, prior to a second coronoplasty.



**Figure 16.**

A full arch photograph was taken, showing beautiful incisal translucency, and excellent arch form, tissue response, and interproximal contact.



**Figure 17.**

A lingual view of the incisal characteristics, translucency, and margins on supragingival preparations.



**Figure 18.**

The incisal translucency and characteristics of the restorations mimicked those of natural dentition.

4. A second coronoplasty was then completed (Figure 15). After 24 hours, the dentition demonstrated beautiful incisal translucency and excellent arch form, tissue response, and interproximal contact (Figures 16 and 17).
5. Since the patient had an extensive history of plaque and calculous build-up, recall intervals of 8-12 weeks were needed prior to restorative treatment. Due to the bacteriostatic effect, however, this was no longer necessary. The plaque build-up was stopped and the gingival tissue was healing beautifully. Therefore, the patient could return to a normal recall schedule of 3 – 6 months. At this point in treatment, the incisal translucency and characteristics also demonstrated a very natural appearance (Figure 18).

## Conclusion

Through the use of advanced techniques and collaboration with the dentist, the laboratory was able to develop durable and proper fitting restorations that could be placed easily intraorally. Demonstrating excellent fit and function, and displaying esthetics that mimicked the surrounding dentition, the patient was very pleased with the results in this case. By utilizing CAD/CAM technologies, like those employed by Core 3D Centers and Aurum Ceramic/Classic Dental Laboratories, the dentist provided the patient with restorations that demonstrated the fit, function, and esthetics required of the case, as well as the best in comprehensive dental care.



Dr. Krasowski is a Clinical Instructor and Regional Director at the Las Vegas Institute for Advanced Dental Studies. He has attained LVI Fellowship status. Dr Krasowski is a regular contributor to many Dental Journals, and his work has been featured in numerous dental product advertisements and publications. He is a personal mentor to hundreds of dentists regarding conservative Neuromuscular treatment. Dr Krasowski maintains a private practice in Wausau WI.



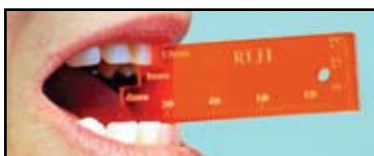
Grant Maier is the Laboratory Manager of Aurum Ceramic @ LVI (specializing in Neuromuscular Dentistry), and VP of Core 3D Centers, USA (comprehensive dental restorative and implant superstructure manufacturing). Upon graduating from Schiller International University in 1995 with a Bachelor of Business Administration in International business, he completed his apprenticeship in dental technology and achieved his RDT and CDT accreditation. At LVI, Grant has been directly involved with the Advanced Anterior (Core 2) and Comprehensive restorative (Core 5) programs since 1998, and the Full Mouth restorative program (Core 7) since 1999 (when it was founded). In June 2003 Aurum developed a truly unique dental laboratory, for which Grant moved from Aurum Ceramic's head office to open Aurum Ceramic @ LVI – a laboratory which provides fixed restorative, all-ceramic restorative solutions, that caters primarily to the Full Mouth Graduate of LVI. Grant continues to oversee operations in Las Vegas as well as being involved with LVI's restorative and implant programs.

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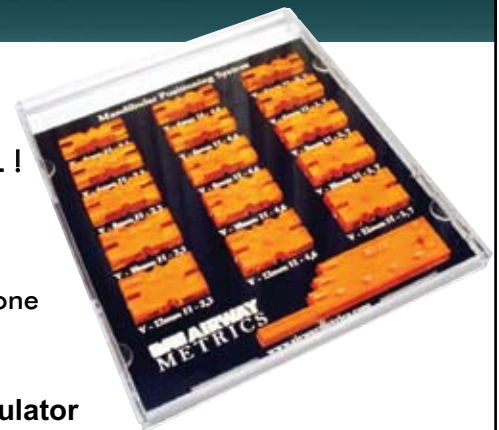
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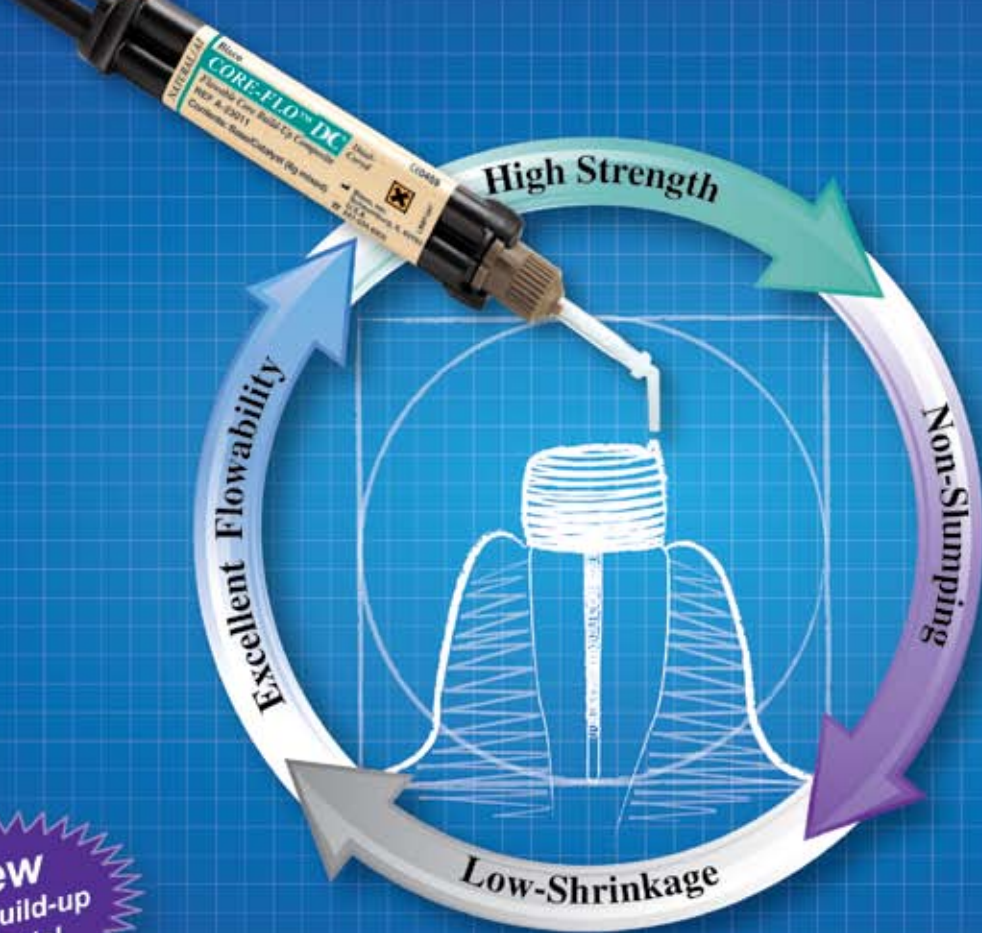


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# A TIMELINE OF

Avi Kopelman

*Cadent Inc., Executive Vice President and Chief Technology Officer*

**C**an dentists be convinced that a digital impression can do everything that a traditional impression can do? That was the challenge Cadent faced when we launched iTero technology in 2007.

We would soon have our answer. While the first iteration of iTero offered as clinical indications only single crowns and three-unit bridges, the early adopters were so pleased with the quality of its results and ease of use, they quickly began using iTero for more challenging indications on their own.

The immediate enthusiasm of our user base spurred us to accelerate our R&D efforts. Soon iTero would be upgraded to handle a wider array of restorations, such as those with four or more preparations, inlays and veneers. This in turn spurred users to

further expand their case volume. Doctors scanning 8 to 10 iTero cases per month were soon up to 20 per month, and counting.

Today, the clinical indications of iTero include virtually every type of restoration in dentistry. Doctors routinely use iTero for their most complex and challenging cases, including those with up to 28 preparations.

## Taking a powder?

Until Cadent entered the scene, digital impression-taking required careful application of powder to the teeth. Powder makes it easier for the technology – reducing the challenges of scanning translucent surfaces in the mouth – but creates difficulties for the doctor. Developing a system that could take an accurate scan without

powder was the greatest technological hurdle we faced.

Our breakthrough solution: parallel confocal imaging, which uses both laser and optical scanning to directly capture the surface and contours of the tooth and gingival structures. iTero today remains the only powder-free digital scanning technology on the market.

## Putting all the pieces in place

Of course, capturing a scan is only the first step in providing an accurate, high-quality restoration for your patient. Recognizing this, Cadent was the first company to provide a truly complete digital impression solution.

We not only offer a capturing device (scanner), but also a way to route the case from office to lab, tools for

# DIGITAL INNOVATION

the dental technician to use to interpret (ditch) the virtual model, and a robust model and die indexing system to build the physical model. Cadent's tools mimic how technicians are accustomed to working on plaster models – we didn't ask the industry to change to conform to our technology; we conformed to you!

## An even more open future

Cadent's timeline of innovation doesn't stop with today. In the coming months, we will launch fixture level impressions for implants – the only clinical indication that iTero currently does not officially support.

We will also continue to expand our open architecture philosophy. That means more options for interfacing with other CAD/CAM systems, a more flexible case routing system,

greater integration with dental office management systems, and more.

Educating the next generation of clinicians about the benefits of digital dentistry will also be a growing priority. We will continue to expand our program of partnering with leading teaching institutes, such as our recent agreement that iTero will be the exclusive digital impression technology taught at the Las Vegas Institute for Advanced Dental Studies.

Ultimately, Cadent's goal is for iTero to meet 100% of the impression-taking needs of the dental office, and for our digital orthodontic scanner, the Cadent iOC™ powered by iTero™, to do the same for the orthodontic office. A future without the gooey mess, wasted time and imprecision of impression material will be a bright one indeed for both dental patients and practices!



Avi Kopelman attended Farleigh Dickinson University where he earned a Bsc. in Mechanical Engineering. He has over 10 years experience in CAD/CAM applications and CNC, and was a product line manager in the field of robotic programming and simulation. He is currently the Co-Founder, EVP and CTO of Cadent, Inc.

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# The Keys to Understanding NM, OSA and PPM Philosophy

## Part III

**Norman R Thomas, BDS; M.B.BSc (Hons Anat/Physiol); PhD; FRCD;  
Certs OMFPath.O.Med;MICCMO.**

**Director of Neuromuscular Research,  
Las Vegas Inst. Adv. Dent. Studies**

## **Introduction:**

In the condition known as upper airway resistance syndrome (UARS), the patient experiences daytime sleepiness and craniomandibulo cervical muscle fatigue due to their role as accessory muscles of respiration as they attempt to open the collapsing airway to maintain airflow to and from the lungs. From this we understand that the clinician must bear in mind that TMD can arise from central nervous system phenomenon. Indeed nocturnal clenching of the craniomandibular musculature may be evident as they take part in maintaining respiration. Indeed Lavigne et al has proposed as part of this central mechanism that clenching promotes salivary flow to act as surfactant to assist in opening the airway. Thus we understand yet another key for developing TMD is the role of masticatory muscles in maintaining airway which is intimately related to the posture of the craniomandibulocervical structures as in CPR in which the neck is flexed ventrally while the cranium is extended dorsally as in the FHP posture.

In 1953 Guzay formulated the Quadrant Theorem (Fig 1) in which he postulated that a physiological occlusion was arranged on a Curve of Spee formed around a center located at the point of intersection between the horizontal plane of occlusion X and a perpendicular plane Y normal to the gravitational field and parallel to the long axis of the teeth. He further hypothesized that when the occlusion was corrupted as in the pathological condition of TMD then the X and Y axes would not be concentric as indicated in Fig 2. This interesting postulate has not been proven.

We tested this hypothesis at LVI by comparing I Cat images of the head, neck, and jaws of twenty TMD pa-

## Quadrant Theorem

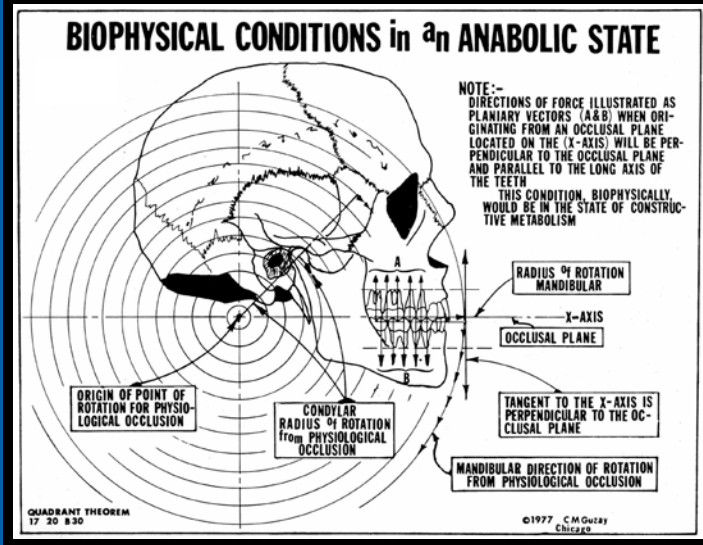


Figure 1

## Pathological Occlusion

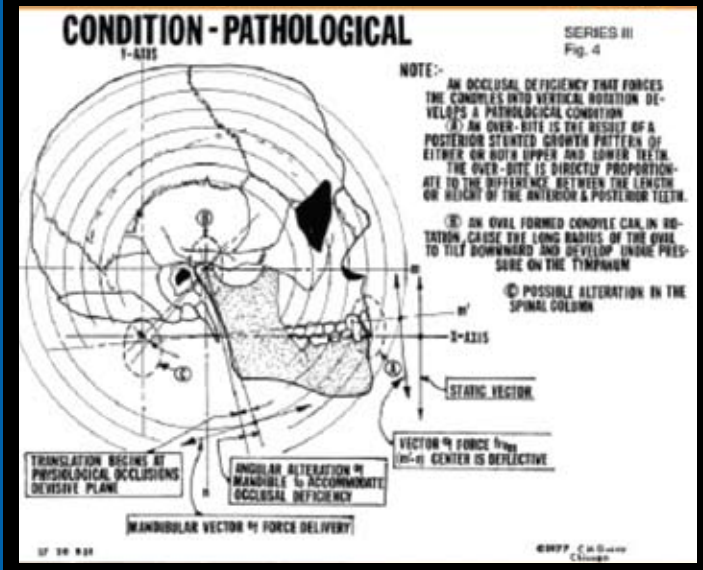


Figure 2

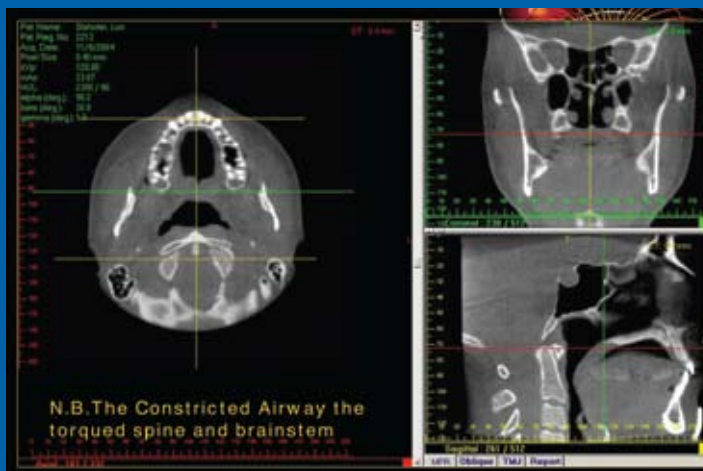


Figure 3

tients prior to and following T.E.N.S. of cranial nerves V, VII and XI (Figs 3 and 4). T.E.N.S. is known to cause craniomandibulocervical muscle relaxation resulting in an improved maxillo mandibular relationship as well as improving body posture and airway. The I cats images through the cranium are seen to be aligned to the HIP plane in view of Cooperman's observation that in pre industrial skulls the occlusion is parallel to this plane, which in turn parallels the base of the skull formed by the sphenoid bone. In the pre T.E.N.S. condition of Fig 3, we note that in a patient suffering from TMD signs and symptoms there is a deep overbite due to vertical overclosure resulting from tongue impedance of tooth eruption and alveolar bone formation correlated with the narrowed and torqued airway. As predicted by Guzey's theorem the subluxation of the upper cervical complex is indicated by the deviated dens (C 1) and the asymmetry of the atlanto occipital joints. The brainstem also appears to be compressed on the left side. In Figs 4 and 5 we also confirm that in cross section the dens is not centered. It will be noted that the A/O dens interspaces are 3.5mm on the right and 4.0mm on the left corresponding to the retrodisical space dimensions of the respective TMJ condyles.

In Fig 4 the lines drawn through the zygohypophyseal joints of the A/O and A/A joints are not concentric as proposed by Guzey for the pathological TMD cases. Following T.E.N.S. V, VII and XI however it can be seen in Fig 6 that the upper cervical joints are concentric. The corresponding status of the temporomandibular joints in the natural bite compared against the T.E.N.S. myobite are seen in Figs 7 and 8.

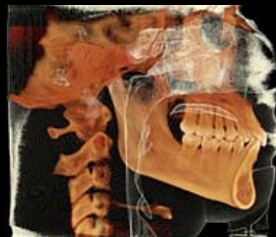
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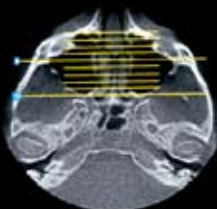
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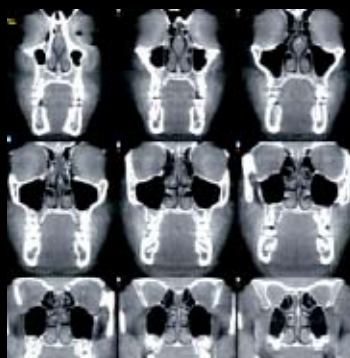
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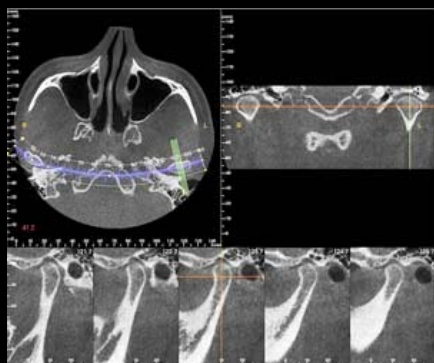
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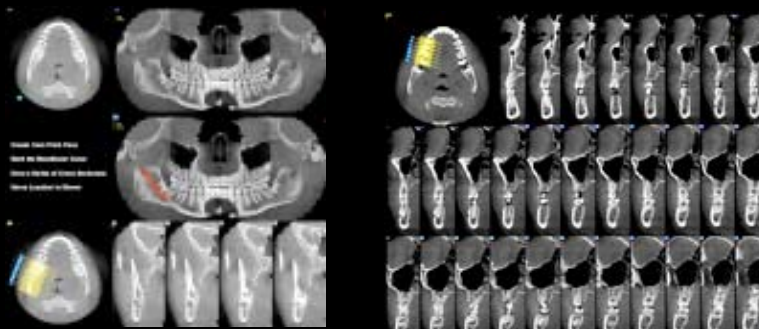
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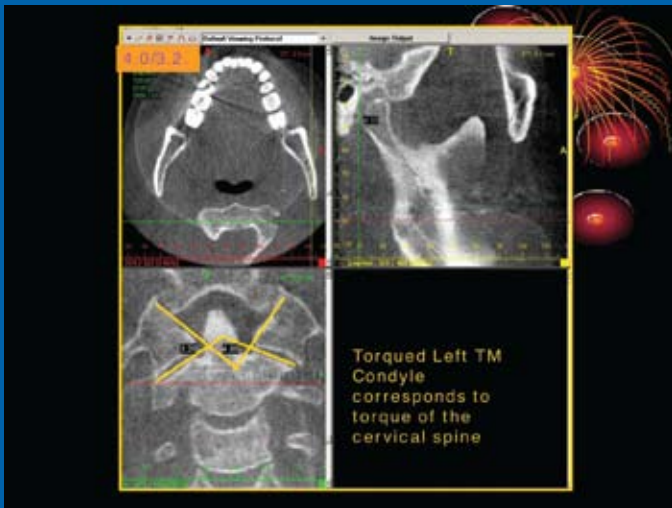


Figure 4



Figure 7

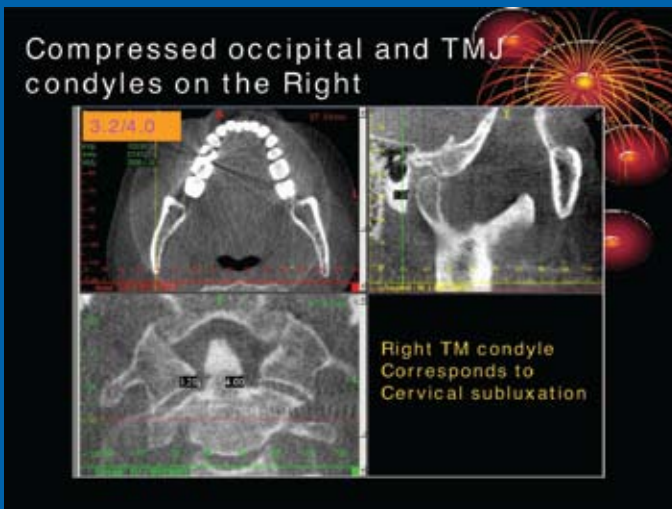


Figure 5

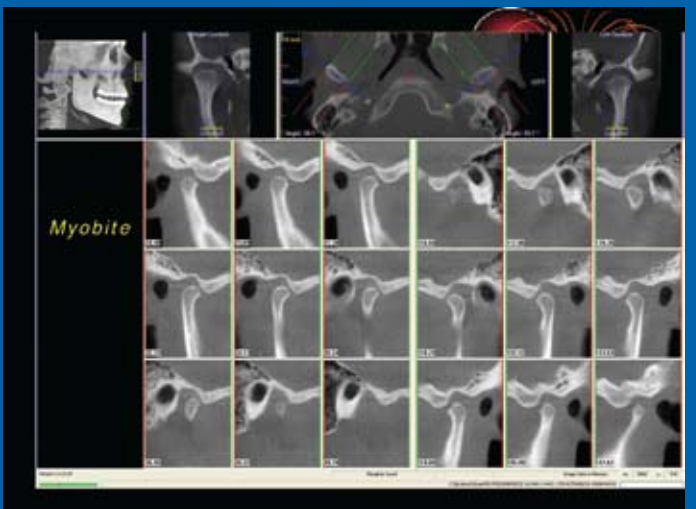


Figure 8-Myobite Post T.E.N.S.

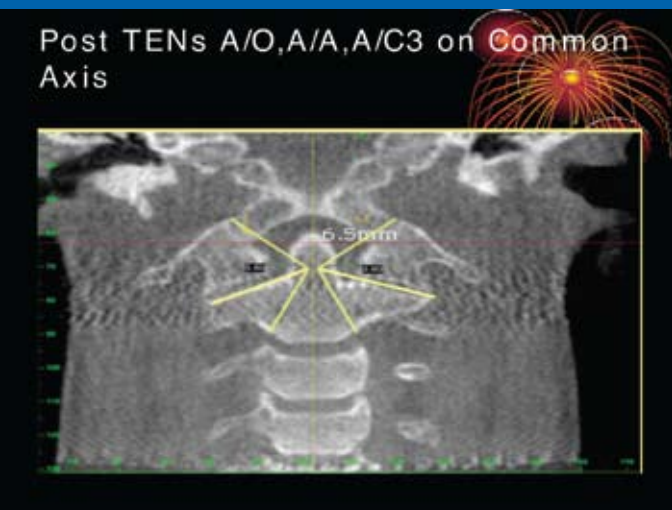


Figure 6

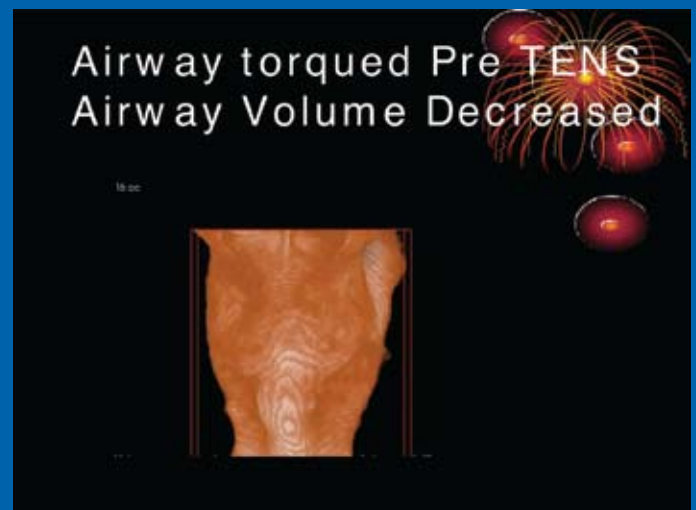


Figure 9

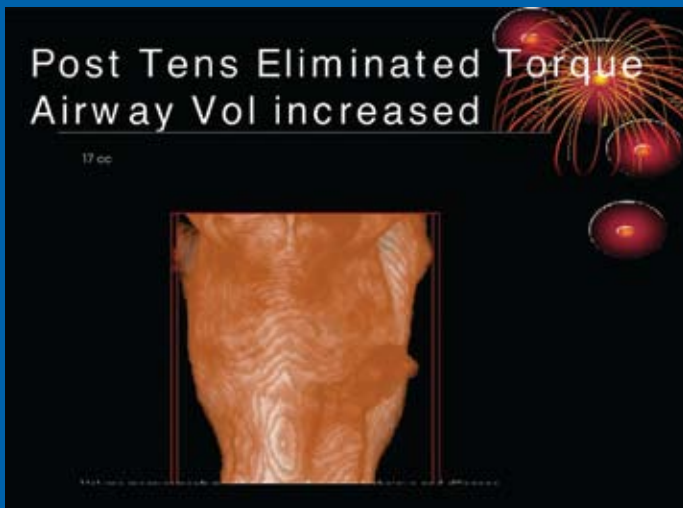


Figure 10

The corresponding changes in the volume of the airway pre and post T.E.N.S. are 16 and 17cc as observed in Figs 9 and 10.

**Conclusion:**

It is evident from the above that Gu-zay’s hypothesis is proven and demonstrates that the keys to understanding NM, OSA and PPM should include concentricity of the upper cervical vertebrae, the posture of the temporo-mandibular joints and improvement of the airway dimensions.



Norman Thomas graduated as a Doctor of Dental Surgery with honors and double Gold Medals in 1957. Dr. Thomas was awarded a Nuffield Fellowship (Oxford) to complete an honors degree in medical sciences in 1960. Between 1960 and 1974, he pursued residency and research programs at the Bristol Royal Infirmary, The Royal College of Surgeons of England, the Medical College of Virginia, and the University of Alberta, where he is now Professor Emeritus. From 1970 to 2002, Dr. Thomas served on the Medical Research Council of Canada, the National Institute of Health, USA, and the Canadian Dental Association, gaining a Certificate of Merit from the latter and several Fellowships in medical sciences and dentistry. He is a Life Member of the Alberta Dental Association and retired from dental practice in 2002. In 1998, he was appointed Chancellor of the International College of Head and Neck Orthopedics and, in that capacity, has lectured in the U.S., Europe, Australia, and Asia. He was awarded a Ph.D. degree in Oral Medicine for research on the process and mechanism of tooth eruption. Dr. Thomas is currently the Director of Research at LVI.



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# STRAIGHT

## In this installment we will cover how to determine the cephalometric position of the Upper Incisors.

It is important to understand that these anterior-posterior (AP) and vertical incisor relations have been derived as a result of extensive EMG and ROM patient samples using the Myotronics K7 at the Center for Occlusal Studies. The original Sassouni Plus analysis was the brainchild of Dr. Richard Beistle. In 1994 Tom Magill and Jay Gerber added the measurements discussed below; additional neuromuscular adjustments have been made to the analysis by this author who is the originator of the Neuromuscular Functional Orthodontic Analysis (NFO).

### Upper Incisors

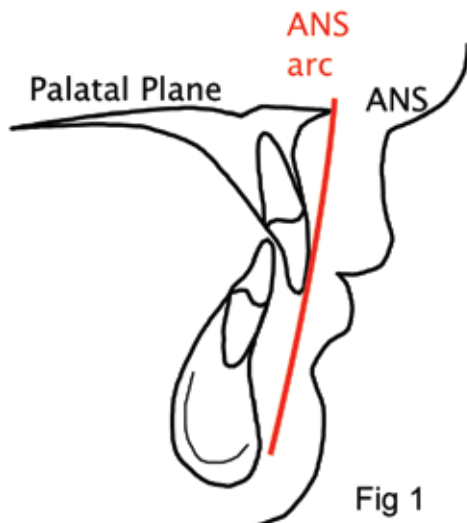
This horizontal measurement of the upper incisors is an indication of the position of the upper incisor tip relative to the arc from anterior nasal spine (ANS). For this to be accurately assessed, the effective length of the Premaxilla must be measured and, if short or long, adjusted using the Palatal Division (PD) compensation (Fig 2). The position of the incisor tip will be influenced by labial torque of the incisor and by its dentoalveolar compensation (eruption). This labial torque should measure in the range of 108° to 115° with an

optimum angle of 110°-112° as it relates to NM trajectory.

In an ideal case, the anterior arc from Nasion will fall on the arc from anterior nasal spine (Fig 1). The tip of the incisor should lie on the arc to three millimeters forward of the arc formed from ANS. The most desirable facial profiles have a +2 or +3 measurement anterior to the arc. This also corresponds to normal NM trajectory. The clinician should take and trace two cephalometric images, one in habitual occlusion and a second one with the Myobite or phase 1 treatment Orthosis in the mouth. That way trajectory can be confirmed and coordinated with the incisor position.

### Dentoalveolar Compensation

DAC is measured from the point where the long axis of the maxillary incisor crosses palatal plane Palatal Division, continuing down the long axis to the central incisor tip. In an ideal case, the average length is 32.5mm. (Fig 2) The incisor length allows you to better understand if intrusive or extrusive mechanics are indicated, and whether retruded or protruded teeth require a change in torque. As a rule: the more extrusion the more the tooth moves labial, and



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the more the tooth is moved labial it goes up from the occlusal plane.

## The Palatal Division

The Palatal Division provides a logical separation of the Premaxilla from the Maxilla. The horizontal distance connecting the Palatal Division and ANS is measured as the Effective Length of the Premaxilla (ELP). This is the measurement that assists us in determining the length of the anterior maxilla.

We measure the Dental Alveolar Compensation (DAC) to give us the relative length of the upper incisor.

## Conclusion

The NFO cephalometric analysis provides an invaluable tool for determining the horizontal and vertical position of the upper incisor as it relates to the Facial profile. It also gives us additional insight to the length of the incisors and thus the anterior face. All of which is important to NM function/trajectory and considerations for anterior facial aesthetics. NFO Cephalometrics provides the clinician with another tool to coordinate measurements of trajectory and tooth position with a desired Golden Proportion and/or Shimbashi.

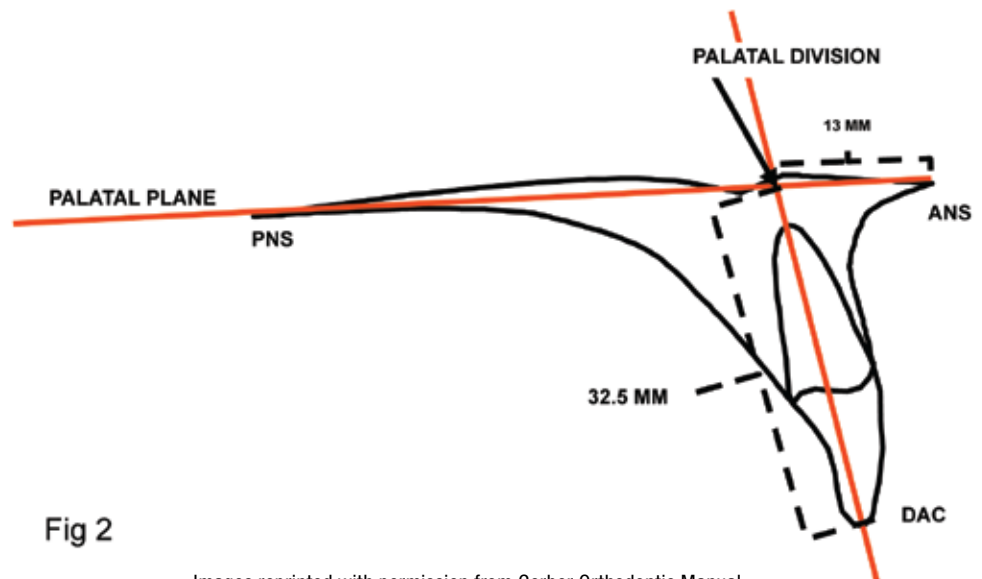


Fig 2

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Dr. Gerber is the Director of Neuromuscular Orthodontics at LVI Global and serves as the Clinical and Educational Director of the Center for Occlusal Studies. Dr. Jay has clinically treated 1,000's of patients since the early 1980's using the principles of Neuromuscular Dentistry. Dr. Gerber is recognized as one of early innovators of neuromuscular functional orthodontics and for the applications of the 'EMG Guided' bite registrations.

Dr. Gerber has made a commitment to stable, pain free neuromuscular correction and long-term occlusal stability. He currently maintains a private practice in Parkersburg, West Virginia.

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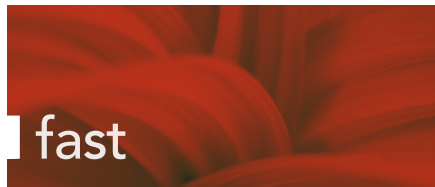
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# Advances in Digital Dentistry:

## *The Introduction of Industry Standards and Collaboration.*

Dr. Deepak Kaura and Rohit Joshi

**Dentistry is at the beginning of an exciting journey into the world of digital healthcare. Digital technologies are rapidly changing traditional dental practices, streamlining workflows and revolutionizing the industry. As the dental world moves to digital, new opportunities and challenges arise, including the evolution of standards and the importance of collaboration.**

### STANDARDS

In the early 80's the medical imaging industry was faced with real challenges in device and data interoperability. Each of the major system manufacturers had created their own proprietary file formats, networks and workstations to enable viewing of images acquired on their systems. None of the systems were able to share their proprietary information with any of the others. Over the past 30 years, many key developments have occurred in the healthcare industry that solves issues of interoperability. Without these developments, advances in digital diagnostic and therapeutic technologies would have been significantly hampered. The efforts to standardize the imaging and communication data have averted potentially catastrophic issues of economics, technology development, and most importantly, enhancing patient care by adopting digital technologies. Fortunately, the dental industry has an opportunity to learn from medical imaging, thereby avoiding the obstacles

and delays faced in the medical arena.

The first of the many challenges faced in digital medical imaging was the existence of manufacturer specific systems. The operator's terminal was connected directly to the network of information which was intimately tied to the data storage units (Figure 1). Although there were ways to export the information from the manufacturer computer systems, the exports were sub-standard and would selectively export information, making interoperability impossible. As a result, data was intimately connected to a manufacturer, making the entire chain of manufacturer specific systems only as good as the weakest link. Worse, hospitals and radiology clinics which purchased the medical imaging systems were locked in to a manufacturer without the ability to easily change. Between 1980 and 2005, multiple standards were created that included a communication standard (HL7) and an imaging standard

(DICOM). These standards enabled Medical images from various devices to converge on a single workstation, enabling systems to share data and simplifying life for the end user (Figure 2). These standards continue to evolve to meet new industry requirements and benefit from wide adoption by the healthcare industry.

The specific nature of the medical standards is less important than the direction that they provide to the Dental industry. Fortunately in Dentistry, there are already a few organizations which have started to create and publish standards relevant for this sector. A subgroup of the American Dental Association (ADA) known as the ADA Standards Committee on Dental Informatics (SCDI) develops and maintains multiple technical reports and specifications that act as guidelines for the dental professional who is making investments in various technologies for their practice. A second group, known as the Open

Exchange Dental Interoperability Group (OXDIG) is in discussions with the ADA and is developing a file format with rapid input from a coalition of industry partners that are solving real world problems of data interchange. The standard, known as the Universal Dental Exchange (UDX) offers great promise in propelling Dentistry toward manufacturer independence and open information systems. With dentists speaking loudly on this issue, manufacturers will have no option but to open their systems to enable interoperability.

Recently, even the President's Council of Advisors on Science and Technology has recommended a universal language for the communication of health information. Given the progress with the ADA and OXDIG, Dentistry appears to be on track to play a major role in the dialogue.

## COLLABORATION

Recently there have been developments in collaborative technologies which enable dentists to communicate with other professionals as a necessary part of successful patient treatment. The rise in collaborative tools follows the adoption of various internet technologies that enable easier sharing across organizations. For clarity, we often use the term 'Treatment Team' to define each of the individuals that handle patient information, including the dentist, specialist, hygienist, receptionist and the lab professional. Each member of the Treatment Team would benefit from having relevant information about the patient provided by the other Team member. Although each Treatment Team member has information that the others would benefit from; this information is often inaccessible by other Treatment Team members who may work in a different organization. Furthermore, electronic and analog systems in use by respective

team members have little or no inter-communication. For example, all of the information in the practice management system is unavailable to the intraoral scanner system, which has no access to the lab management system, and so on. Although standards will help open the information silos, unless there is a clear collaboration system to capture the information and make it available in a privacy compliant manner to everyone involved in the treatment plan – significant information gaps will continue to exist.

The value of collaboration is, at the very least, the ability to create context around the patient's dental health. Treatment Teams need access to restorative information, hygiene information, specialist treatments, prescription information, imaging, lab instructions, lab comments and as much as possible previous dental health history. Providing contextual data in an accessible, elegantly organized manner translates to better patient outcomes and greater involvement amongst the Treatment Team and the patient. For example, enabling a lab technologist to view relevant annotated images provided by the dentist, or having a specialist share a common patient file with the referring dentist gives everyone on the Treatment Team better access to the important relevant patient information (Figure 3).

Collaboration is becoming an integral part of daily practice and will continue to become a focal point, as patients become more involved in their dental health. Dialogue around a patient's health becomes more meaningful when information is aggregated, available and organized.

It's conceivable that a short decade from now, as we look back at the progression of technology in dentistry, we will find it difficult to imagine how work got done without data standards and without collaboration tools that involve the entire Treatment Team.

Figure 1



Figure 2

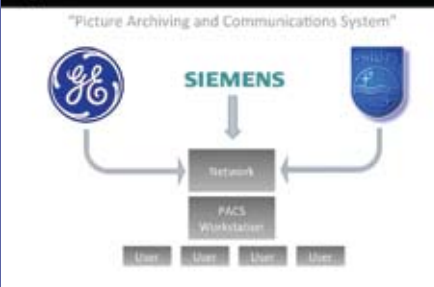
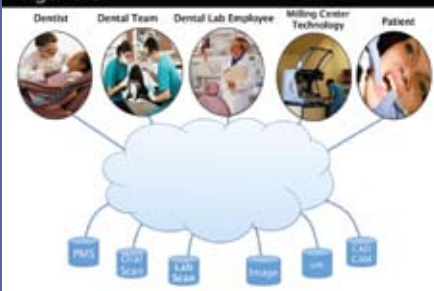


Figure 3



**Dr. Deepak Kaura MD FRCP C DABR**  
*Founder and Chief Executive Officer*

Dr. Deepak Kaura, MD., FRCP C., DABR., is the founder and CEO of Brightsquad Dental Ltd. He is the current Chief of Radiology at the Alberta Children's Hospital and a Clinical Assistant Professor at the University of Calgary School of Medicine. Dr. Kaura is also a successful entrepreneur, having helped start multiple healthcare initiatives including four healthcare related software companies, and an innovation company that has developed an MRI patient positioning accessory for Open MRI.

**Rohit Joshi, MSc., LLB.**  
*Chief Operating Officer*

Rohit Joshi, MSc., LLB., is the Chief Operating Officer of Brightsquad Dental Ltd. For the past 20 years, Joshi has held senior executive positions with life science and technology companies in the USA and Canada. Joshi's career has focused on using technology for effective communication and has led technology teams that excel in web site creation, knowledge management, and on-line commerce. He is passionate about product design and fostering cultures of innovation and excellence. Rohit has earned a Bachelor's degree in Molecular Biology, a Masters Degree in Medical Science (Surgery/Orthopaedics), and Bachelor's degree in Law, all from the University of Calgary.

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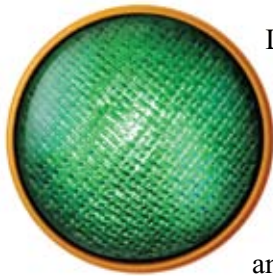
Is Insurance a  
**Bad Thing**

or a

**Good Thing**  
for your Practice?

## Is Insurance Right For You?

Shahin Safarian, DMD



Let's talk some math. If a dentist charges \$1000 for a particular service, but is offered only \$700 to do it then the dentist comes out holding the short end of the stick, right? Such is the case when it comes to accepting insurance. There are standards within our industry and even though price tables may vary from dentist to dentist; we all have fees we charge, based on our respective levels of experience and expertise and those should be met.

With insurance, though, that may not always be the case. In a perfect world, every patient would be an out-of-network patient and dentists would receive the full amount for their services. The reality is, with this economy more and more patients are choosing to stick with their insurance plans – not out of desire but out of necessity. When the economy is hurting, everyone hurts. It doesn't matter if you're a dentist or a patient. The problem is that dentists are looking for an income free of contracts and insurance regulations while patients are looking for a deal, something's got to give.

I accept insurance. Let me be the first to say that I don't enjoy taking a 20 – 30% cut on my work to meet a patient's in-network stipulations and I don't enjoy the hassles and paperwork that come with it but I do so because LVI taught me how to use insurance to my advantage. Allow me to expand on that...

At LVI I didn't simply learn to better my career – I learned to optimize it. My continued education affords me the luxury of offering a plethora of services that many general dentists cannot: TMJ, Cosmetics, Implants, Orthodontics and the list goes on and on. Aside from the clinical and procedural advantages learned at LVI, I also widened my breadth of knowledge for the business side of dentistry and that's a key component for everyone to realize: dentistry is a business.

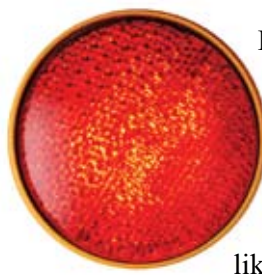
You maximize your income by offering services that your competitors cannot, by marketing effectively and by generating enough of a buzz about your work so that patients readily supply you with referrals. LVI taught me to be the absolute best at what I do and I'd like to believe that that shows in not only the wide range of procedural options I offer, but also in the peace of mind my patients enjoy due to their confidence in what I do. That being said, is there a way to take your knowledge, apply it and still come out ahead while accepting insurance?

While attending the IACA in Boston a while back, I took part in a panel discussion about insurance. It seems like it's

Continued on Page 52

## The Game I Chose Not to Play.

Amy Norman, DDS



Dentists today are either taking insurance, want to stop taking insurance, or are insurance independent. Lately, I've been getting a lot of calls and e-mails from the middle group. The questions usually go something like, "How did you get off insurance?"

How can I do it? What were your struggles? Will you go back?" The frequency of these conversations and the sense of urgency from the doctors have both increased.

As a dentist I was always uncomfortable with my management of the insurance system. I wasn't naturally good at it and every time I took training, the rules changed and the tricks I learned became obsolete. Then I realized that the system is designed to keep the dental providers and their employees from becoming comfortable. Insurance is a game. The problem for us is that the other player is making up all the rules, they always get to play on offense, and just like casinos, they always win. If you want to be good at the game, you need to practice and invest time and money into staying current on the latest plays. I would rather invest my time and money in perfecting the dentistry I deliver.

When I bought my dental practice, I was elated because I was able to step into an office that already met my 10-year goals. It was nearly perfect. The enthusiastic and professional team planned on staying (and 2 of 3 are still with me), there were no evening or weekend patient hours, we took 10 weeks of vacation a year, emergencies were rare, and it was a 'cosmetic practice' with a good base of clientele that either didn't have insurance or they did, but didn't make their decisions based on it. But the practice did have a signed contract with one insurance company, Delta. The practice is in a blue-ish collared area, right near Boeing. Boeing contracts with Delta. Boeing patients were at least 50% of the practice. That was in 1995. The office was well-run and the team well-versed. All I had to do was keep the systems going. And I did for three years. Those who attended the IACA in Boston will have heard the story of why I decided to rock the boat and drop Delta.

Sending in my fee schedule to Delta and asking them for permission to raise my fees always made me feel like Oliver Twist with an empty bowl in my hand. In my third year of practice, after resubmitting my fee request multiple times and having it rejected for no specified reason,

Continued on Page 46

## *Sending in my fee schedule to Delta and asking them for permission to raise my fees always made me feel like Oliver Twist with an empty bowl in my hand.*

I started slashing fees for services which I chose not to provide. I lowered them to ridiculous prices in order to lower my composite score. A complete denture was \$250 because I didn't do them. Then I realized that the \$250 fee that I listed was going into the complete denture UCR for my area. I referred my dentures to the general doctor downstairs who did mostly removable prosthodontics and was probably doing the same thing for his crown fees. Once I realized the scam that the insurance company was perpetrating on us, I couldn't do it another day. I dropped Delta that month, on impulse, and with no marketing plan or strategy whatsoever.

I don't want to ask permission to make an adjustment to something so critical to my business as my fee. Should read: Since I assume all the responsibility, liability and stress of owning my own practice, I want to have all the control over the direction of the practice. If I want to paint the office purple in the morning, by golly, it shall be purple. And similarly, if this weekend I learn a new procedure, buy a new piece of equipment or my overhead goes up, well I want to be able to adjust my fee accordingly on Monday morning.

Quoting from two different fee schedules always felt awkward and uncomfortable to me. When I was on Delta dental and a patient asked me, "How much will the crown you are recommending cost?" I would have to check their chart to see if they were a Delta patient because we had two fee schedules. Quoting fees should be done confidently and with a conviction that the fee is fair and the quality of care is of high value.

Speaking of fees, I don't like the way fees are itemized and coded. I think it is archaic and that the only reason for the traditional fee schedule is because of insurance billing. When you go to the Plastic Surgeon for a nose job he doesn't bill you based on which surfaces he is going to shave off. There are so many other ways to determine an appropriate fee. Truly, for many procedures it makes more sense for us to bill by the hour in the

*I don't like the way fees are itemized and coded.*

*I think it is archaic and that the only reason for the traditional fee schedule is because of insurance billing.*

same manner as an attorney. Take your daily production goal divide by 8 hours and boom there's your hourly rate. Why don't we do that? There is no other reason I can think of other than that little voice saying, "Yeah but how would we bill it to insurance?" I want as few billable codes as possible and to calculate them based on the time it takes and the raw costs I incur. I have only three restorative codes: a simple filling, a complex filling and indirect restoration fee. That's it.

As long as I'm comparing us to other professions like attorneys and plastic surgeons, let's talk about vet-

erinarians. Do you know how much it costs for me to take my two cats in and have a "check up and a cleaning"? It is between \$300 and \$600 for the cleaning (with sedation) and \$65 for the check up, each cat. Over the last 10 years, in addition to a check up and cleaning, we have added to our hygiene appointment the following services: oral cancer screening exam, neuromuscular signs and symptoms screening, sleep and breathing disorders screening, and a full series of digital photos. Should not the fee be at least the same as the one for a comparable service for my cats? The dental insurance companies don't think so.

I was listening to the radio recently and heard an interview so outrageous and nonsensical that it can and should simply be dismissed. It tried to link irrationality of humans to interaction with one's dentist. It stated that every visit to a dentist office is an episode in Stockholm syndrome. The entire interview made no sense and painted dentists in a very poor light. The part that is relevant is when the expert states that the probability of two dentists finding cavities on an x-ray and on the same tooth is only 50%. In this example dentists were painted as unethical and incompetent and the source for the statistics quoted was none other than Delta Dental! What this example reminds us is that dental insurance companies don't like dentists and they don't care about their success.

There is so much talk about how dentists are generally not good business people. And that may be true. But dentists are almost universally analytical, they are generally pretty bright and they are committed to con-



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tinuing education. There is hope for us. When I hear arguments for contracting with insurance companies and agreeing to lowered fees, I often hear, “well that’s just the cost of marketing, it brings a lot of patients in and then I can convert them to other procedures that are not covered by insurance and I can make it up there”. OK, so break that down. To sign back up with insurance my fees would need to be lowered 20-30%. And for that, I get to work harder and see more patients, hire another team member to push insurance claims in, out and around the office, and give up the autonomy and flexibility that I worked all these years to create? That doesn’t seem like a good business decision does it? And for all that I have also invited and made a contractual agreement to allow the insurance company access into my practice. I have heard of insurance companies that send letters to your patients telling them that you are providing care that is not within the standard of care. I’ve heard of insurance companies showing up in offices and demanding to audit the charts of your patients. I don’t want anyone to have access to my practice or its daily operation unless their only purpose and motivation is to see the increasing success and profitability of my business.

I think that some dentists might be tempted to re-sign with insurance as the economy puts new pressures on our practices. I know the topic is coming up, I’ve received e-mails about it and my own accountant has asked if I would consider it. Honestly, I’d quit first. An insurance dependant practice is so counter to the practice vision that I don’t think I could switch back. Furthermore, I have such an amazing team; small, highly-skilled and committed that if I ever were tempted to

re-sign with insurance, they would probably stage an intervention. They would remind me that we would need to hire another person just to handle the billing, which would change our team dynamic as well as raise overhead. They would also rebel over the decreased fees, decreased level of service, decreased time per patient, and increased pace and stress.

Rather than lowering my fees 20-30%, I have a comprehensive marketing plan which includes internal and external marketing of my own brand. I budget 4-6% for marketing and what I get in return are patients who are coming to me because of me.

*They aren’t coming because*

*they found me on a list and*

*I am the closest office, they are*

*coming because someone they*

*trust or something they heard*

*about me resonated and*

*motivated them to call.*

They aren’t coming because they found me on a list and I am the closest office, they are coming because someone they trust or something they heard about me resonated and motivated them to call. When my practice is exactly as busy as I want it to be I see between 8 and 14 new patients a month. When I was on insurance, I would see more than double that number and we would do more single tooth dentistry. Though we appeared much busier, we weren’t more produc-

tive than we are now. As an independent office we see less patients and we do more comprehensive dentistry than when we were on insurance.

The quality of my patients and the quality of my practice are both better now than when I accepted insurance. Since my patients are coming to me because of the type of dentistry I do instead of the fact that I am in their book, I find that acceptance of comprehensive treatment is higher. The critical factor (amount of treatment diagnosed/accepted divided by the number of new patients) is higher. I take more time off, have more time with my family, and do more of the fun dentistry- the dentistry that gets me the tears, hugs, and gifts that make me want to come back and do it all again the next day. My job feels like a hobby.

Another reason that the quality of my practice is higher is that I have carried a negative accounts receivable ever since I dropped insurance. We simply do not send statements. Prior to dropping insurance my AR’s at times would equal three months production. I laugh at my former self and the fact that I thought this outstanding balance was a good thing, like a bank account. Of course I now realize that the value of each dollar that went into receivables was potentially .50¢ or less.

The quality of my care is higher too. Back in the insurance practice days, there was a lot of time spent talking about different materials, what insurance would cover, what they won’t, the difference in price and a ton of time was spent pre-authorizing the options. Now, the conversations are very brief. Without shortcutting informed consent, we simply discuss what I would recommend for the patient if they were my brother or sis-





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ter. Insurance rarely comes up in the treatment planning discussion.

My best advice to those still on insurance is to be very knowledgeable about your numbers. Specifically, look at how much income stream is coming from insurance. Looking back on those three years that I took insurance, I am stunned by the fact that over 50% of my income was coming from Delta. I think that some dentists would actually see this as a good thing. I don't. I think that made me an employee of Delta. I am ashamed that I allowed myself to become so dependant. Even if you have

*My biggest advice to those still on insurance is to be very knowledgeable about your numbers.*

no plan to drop insurance, you should understand your level of dependency.

I built a new office and moved in July of 2007, then in December of 2007 the recession started. Thankfully in 2000 I took my first LVI course and the benefits of my LVI

education go beyond the advanced clinical skills I learned. I have also learned that if someone else is doing "it" then "it" can be done. I have the confidence to continue to pursue my own ideal insurance-independent practice. If I hit bumps in the road, I have a network of like-minded professionals willing to guide me. It takes hard work to maintain the success of my practice while adapting to this new economy and I am so happy that whatever decisions I make, whatever changes I choose, I don't have to go to the insurance companies and ask, "Please sir, may I have some more?"

### Amy Norman, DDS, PS

Since the 4th grade, Amy Norman had dental ambitions. She began dental assisting at the age of 16 and worked her way through college as an assistant in various dental specialties. To date, Dr. Norman has worked in the dentistry field for 23 years.

Amy was granted early acceptance to dental school at the University of Washington and received her DDS degree in 1995. Dr. Norman currently owns and runs a solo dental practice in Everett Washington and is a proud member of IACA, AGD, and DOCS.

The last 10 years of Dr. Norman's work has been focused exclusively on cosmetic and adult dentistry. She is a Fellow of, and an instructor at, the prestigious Las Vegas Institute for Advanced Dental Studies with an emphasis on Cosmetic and Neuromuscular Dentistry.

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## *Let's talk math again. Which is worse: taking a 30% cut to your income or taking a 100% cut? No calculator needed on this one.*

always a hot topic amongst dentists, doesn't it? The overwhelming majority of people are against it and rightfully so. As I proposed earlier, the math works itself out. Why should any of us take a pay cut just because an insurance company asks us to? I urge anyone reading this to walk into a McDonald's and attempt to negotiate prices and see what happens. As dentists, we are highly educated professionals, our work is top notch and the price tag needs to correlate. But insurance isn't going to disappear. In-network patients are going to have to go somewhere for their dental work and this gets interesting if every dentist chooses not to accept it.

Let's talk math again. Which is worse: taking a 30% cut to your income or taking a 100% cut? No calculator needed on this one. Dentists lose out on 100% of every patient they turn down because they don't want to accept insurance. Now don't think that the fringe consequences haven't been considered. Overhead is a killer, it truly is. If your practice runs at a 70% overhead – which isn't crazy by any stretch of the imagination, then taking a 30% cut means that you're essentially doing the work for no gain. If you gain nothing, why do the work?

So, if you're not making any money off the service then insurance can be a real deal breaker. I look at insurance as a variable cost, much the same way that advertising is a variable cost. In-network general dentistry may be a wash in monetary terms but it's the specialized services that make you your money. Think of it like going to the movies using a gift card: sure, they get in for free, but the theater still

cashes in on the popcorn. If you effectively market yourself and your business you can use in-network patients as target for direct marketing, but your success in that area depends solely on your ability to convert patients. The reality of insurance is that you absolutely need to be able to sell your profitable services not covered by insurance in order to come out on top. If every one of your clients is in-network and nobody ever requests any services above the general dentistry level; you're in trouble.

*Thanks to LVI, I can perform additional services and I have the ability to convert cases that are not readily covered by insurance.*

The ideal business philosophy for any dentist is to maintain a low volume free of insurance, relying on higher end services. However, in tough economic times, in some practices, this may not be realistic viewpoint. I can count on two hands the number of dentists I know that can see two patients per day and boast that they have a two million dollar business. That is to say that it is completely doable but most dentists fall short of that level of income. I offer high-end, money making services and have had more success in marketing them by getting people in my chair, building a rapport

and selling them, out-of-network. I accept insurance because I'd rather take 70% of my fee from insurance as a lost leader and risk marketing my specialized skills to gather more income than gain nothing.

Thanks to LVI, I can perform additional services and I have the ability to convert cases that are not readily covered by insurance. Not every in-network plan covers TMJ, Implants, Orthodontics, Sleep Apnea and other services and that is where you make up the difference. This allows me to charge my fees for quality services while still covering the more general items and is the most advantageous part of accepting insurance, in my opinion. This approach has granted my practice the opportunity to survive in this economy. Lets also not forget that many insurance companies do allow you to negotiate your fees. You don't want to do the job for 70% of your fee because the overhead is just too high? Fine. Offer to do it for 80% and see what they say. The worst-case scenario would be that they say "no" and if they do, you can always cut that company loose and hold out for an insurance company that will work with you.

Aside from the monetary and clientele-building benefits of accepting insurance, your business will also benefit peripherally. Consider what happens to the morale of your staff when few patients are coming in. Idle time is very seldom constructive time. Team bonuses may disappear as a result of lowered volume and that directly affects families.

A consistent business is a happy business and insurance can help this happen. When an in-network patient

is looking for a dentist, the process is pretty simple. They take a gander at the list of available dentists given to them by their provider (insurance indirectly markets you) and then they do a little research to find a dentist they feel comfortable with. If you already have a solid marketing plan in place, this can be a gold-mine for you. A good website full of patient testimonials, a clear explanation of services offered and an emphasis on hygiene and qualifications brings patients in and it's up to you to sell your money makers. None of that would matter unless insurance brought potential patients to your site.

Staying versatile and maintaining the ability to adapt to changing economies will not only ensure the survival of your practice but is guaranteed to grow it. When cash flow isn't what it used to be, you'll find out exactly what kind of management, personal and clinical skills you have when you have to. You'll find that it's the intangible assets you possess that turn into material gain. Building relationships, value and trust directly leads to more referrals, more patients and if you know what you're doing, more money.

Accepting insurance now isn't a declaration of defeat. Just because you don't have an entirely cash paying clientele, doesn't mean you've done something wrong. You can use insurance as a tool to market yourself. Yes, this means dealing with more paperwork and having to work with insur-

ance companies but this can be an easy way to build your list of clients. It's all about converting patients and getting to the point where you can eventually cut out insurance entirely and be part of that elite bracket of dentists.

*Just because you  
don't have an entirely  
cash paying clientele,  
doesn't mean you've  
done something wrong.*

We need to stop thinking as dentists and start thinking as business owners. The further you climb in your career, the more attention you need to pay to your net worth and insurance can allow you to maintain a flow of people coming through your door even in tough economic times. If you don't take these patients, someone else will. Insurance may not be right for you but it can keep the heart of your business beating if you find yourself in a tough spot, regardless of how many years you are out of school. Covering your fixed and variable overhead is the name of game and with proper business savvy, insurance can help you do this, even if it is just a temporary thing.

Keep your options open. Don't instantly nix insurance because "that's not what good dentists do", but without continued education at LVI you will never win at the insurance game and your business is likely to plateau or fail. Expand your horizons; learn to optimize your career using the tools that LVI can provide to you. Those high-end services that every dentist aspires to build their business on will make you money; it just might not be today. When the economy goes back up – and it will, the demand for high-end services will increase but when that happens, how many of those patients will be yours?

At the end of the day, insurance does come with some hassles. If you're a dentist who is struggling to make a name for yourself or struggling to stay alive in this economy then it may be time to take on that hassle to keep yourself in business. Insurance isn't a guarantee, but rather a source of potential. LVI can provide you with the tools to make money even while accepting insurance so that you can gain more clients and eventually drop insurance altogether (but you've got to start somewhere). Ultimately, it comes down to you and what's best for you. Evaluate where you are as a dentist, an individual, a business or even a family and make an informed decision. Insurance has its pros and cons and only you can decide whether or not the pros take up the heaviest end of the scale.

## Shahin Safarian, DMD

Dr. Shahin Safarian attended U.S. International University on a soccer scholarship, where he attained his MBA in 1993. From 1992 to 1995 Dr. Safarian played professional soccer for the San Diego Sockers and Puebla F.C., but by 1997, Dr. Safarian recognized the need to pursue a more stable future and he opted to attend dental school.

Dr. Safarian graduated from Tufts School Of Dental Medicine in 2001. Three years into his profession, he felt the need to better himself as a dentist and began attending Las Vegas Institute for Advanced Dental Studies where he received his Fellowship in 2009. He started a private practice in San Diego, CA from scratch in 2006. He is currently a member of ADA, CDA, SDCDS, AGD, ICCMO and IACA. He also currently serves as the Secretary of AGD in the San Diego branch.



**WHERE DID I GO WRONG?**

# **MISTAKES LEADERS MAKE.**

Sherry Blair, CDA

## Doctors, how much training did you get on leadership in dental school? Did you fall into leadership more by accident than design?

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Leadership can be dangerous. Look at work history and the lives of great and terrible leaders and what they have accomplished through others. Leaders on one hand can move men, women and mountains for tremendous good. On the other hand, they hold the power to do irreparable damage to their followers by the mistakes they make.

Doctors, how much training did you get on leadership in dental school? Did you fall into leadership more by accident than design? You went to dental school because you wanted to be a dentist. It's graduation day. You walk out of the dental school's front door with your mouth mirror in one hand and your explorer in the other, ready to conquer decay. You walk through another door and poof - you are the CEO of a company and now hold leadership responsibilities.

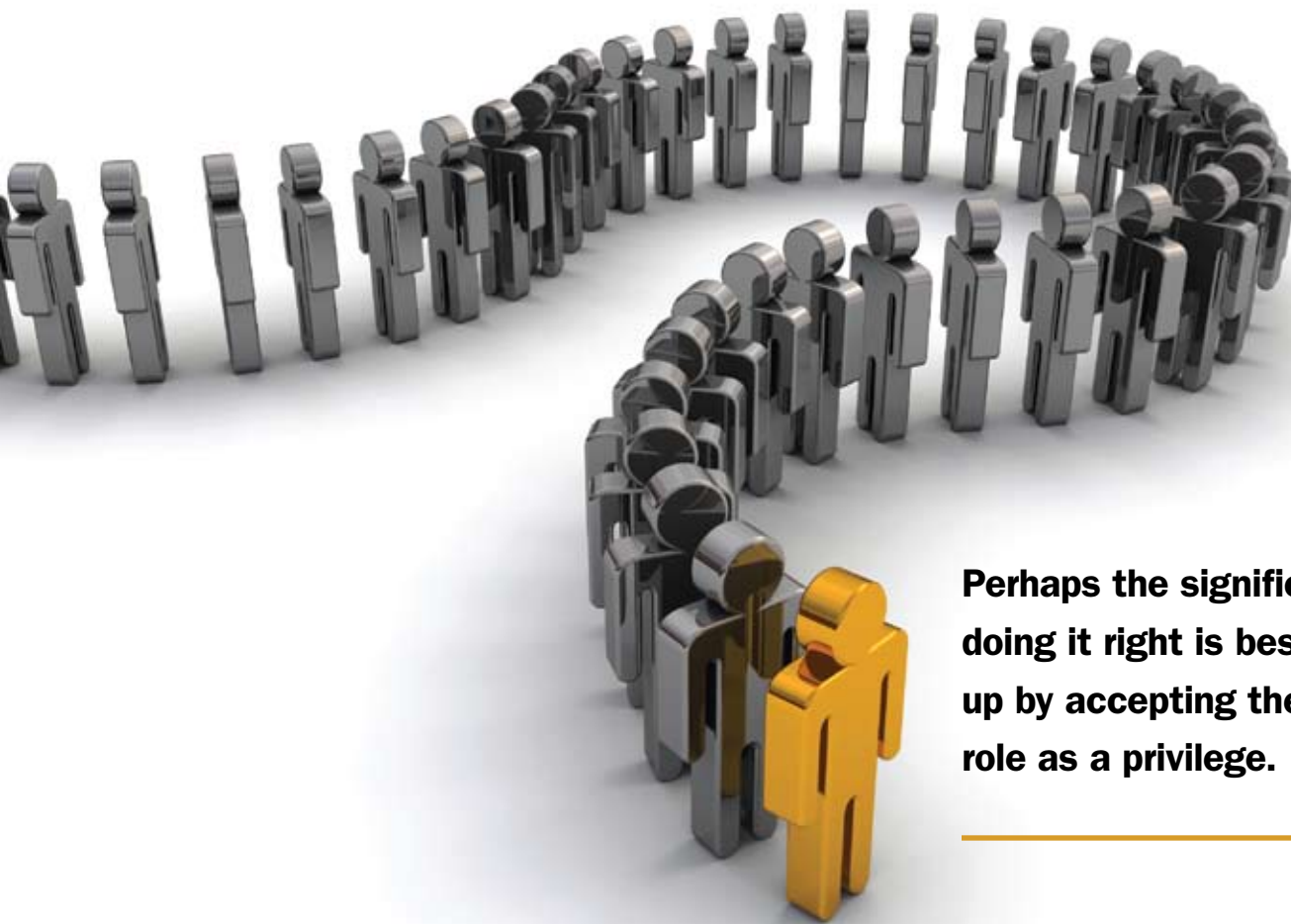
Without training we typically default to what comes natural; the top-down leadership style. You would think that we would have learned by now, yet it still keeps cropping up; that age-old problem of domineering, military based, barking orders to weak underlings style. It sounds something like this: "I'm in charge here, and the sooner you figure that out the better!" Undoubtedly this is the biggest mistake that leaders make. In 1960 Douglas McGregor, whose research was way ahead of his time, outlined a Theory X versus Theory Y leadership style, with Theory X being the top-down leadership style.

Basically, McGregor believed in his Theory Y leadership style, that people really did want to do their best work in organizations and if properly integrated into ownership of the goals of the organization, they would do their best. Respect for individual workers gave them much more participation in their direction. Theory Y was more of an inverted pyramid where the leader carries the organization on his or her shoulders and makes it a goal to make everyone else a winner.

Putting dental-work before people-work is another mistake. The greater the leadership role, the less time there seems to be for team. After all, probably 80-90% of your day is spent with your hands in someone's mouth. However, the greater the leadership role, the more important people-work is. Your team is an opportunity, not an interruption and only through association is there transformation. Why would we ignore people work: usually because observed results take priority over unseen relationships. The material world dominates the immaterial world. We feel judged by what we do, not by who we are. Leadership is essentially a people business. Experts confirm that the most effective leaders spend most of their time being with people and solving people's problems. We can't change people, if we don't spend time with them. People who don't change their minds can't change anything and it takes face time with people to see such transformation.

The absence of affirmation; what could be better than a pay raise? Yet another mistake we make. Organizational researchers have been telling us for years that affirmation motivates people more than financial incentives, but we still don't get it. Poor leaders demand a great deal from people and never give them a pat on the back for a job well done. A huge leadership mistake is to neglect this emotional support that our followers so desperately need. It is the source of high turnover in many organizations and companies, as people leave to find more empowering leadership cultures. Try the "ten dime" technique. Before you start the work day put 10 dimes in one pocket. Each time you recognize and compliment good behavior from a team member move one dime to the other pocket. Your goal is to have all the dimes moved from the first pocket to the second.

Dictatorship in decision making denies the value in individuals. It deflates human spirits when decisions are made behind closed doors, and they had nothing to do with it and can do nothing about it. Dictators hoard decisions. They view truth and wisdom as primarily their decision and they restrict decisions to an elite group. Rather than dictating decisions, good leaders will try as often as possible to let those he or she is leading to make decisions. Creating more of a facilitator leadership style will allow the involvement of others with decision making. Facilitators



**Perhaps the significance of doing it right is best summed up by accepting the leadership role as a privilege.**

---

delegate decisions and see people as their greatest resources for ideas that will bring success. They allow the one who does the job to decide how it is done.

Over managing is one of the great cardinal sins of poor leadership. Dirty delegation follows right on the heels of dictatorship in decision making.

It is all about refusing to let go of control. A person who delegates will give people a job to do and the responsibility and freedom to see it through. Dirty delegators will constantly watch workers over their shoulders and can't relax and let go.

So when you signed up to be a Doctor you probably weren't seek-

ing out a leadership role. But now that you are a leader, are you willing to be the best leader you can? Perhaps the significance of doing it right is best summed up by accepting the leadership role as a privilege. This privilege is to influence people to go where they would never go on their own.



As Director of the Dynamic Team Program at the Las Vegas Institute, Sherry shares her more than 37 years of experience managing each and every system within the dental practice. Sherry has combined her acquired knowledge and personal experience to create an inspired, effective and motivated curriculum that refines the systems surrounding the patient's total experience in a dental practice. Sherry's extensive exposure to most forms of practice management and dental systems, as well as her strong focus on patient satisfaction, make her uniquely qualified to enhance the effects of any dental practice.

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Sherry Blair is featured in LVI's Dynamic Team Concepts Series - a set of courses for dental team members designed to complement the CORE curriculum for doctors. Sherry is also an In-Office Consultant. You can contact her by email at [sblair@lviglobal.com](mailto:sblair@lviglobal.com).




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*"We always welcome new patients!"*

*"The extra card is for a friend or co-worker who might need us."*

# Creating an Outstanding Experience

*"We are expecting you and are happy that you have chosen our office."*

*"Our goal is to take care of you."*

Dr. Terence Yacovitch B.Sc. (Chem.) D.D.S.

How can we become just a little better at all that we do? The economy is still struggling; attracting new patients and keeping existing ones happy can be a challenge, but it doesn't have to be insurmountable.

The ideas to be put forward here apply not only to the dental profession, but any service oriented, individualized care situation. This may include specialty offices, dental laboratories, dental supply industries, medical offices, etc. We can extend the same principles to family or friends in technical or personal service fields as well. Please share this article with those you think might appreciate the ideas discussed here.

Practice growth/business growth through patient referrals is more successful than any external marketing vehicles. The consultants we talk to and confer with agree wholeheartedly.

Word of mouth wins hands down absolutely every time. Good people refer their family and friends to you and your office. Why spend a fortune on external marketing when the

*Word of mouth  
wins hands down  
absolutely  
every time.*

best resource is right at hand...your family of patients. You care for them and they care for you. Otherwise, why would they keep coming back? Nurture these key relationships. Tap this resource. Create a buzz amongst your patients.

Internal marketing is developed in many ways. The first, and most basic, is to simply let your patients know that you welcome new patients. Many people assume that your practice is full! All team members should be involved in informing patients that, if they are happy with the care and treatment they receive, they should let their family and friends know. **"We always welcome new patients!"**

At the end of treatment, patients should be given two business cards for their family and friends. **"The extra card is for a friend or co-worker who might need us."**

What is it then about a dental office that brings quality patients back and encourages them to refer their family and friends? That is the key question.

First impressions? Energy? Atmosphere? Doctor's skills? Team per-

*"We want to make your experience with us as pleasant as possible."*

*"We care about your comfort."*

## Creating a **Buzz**

*"I am giving you my time and full attention."*

*"We are listening to your wants and needs."*



sonalities? The patient experience? Technology? All of these elements contribute, but most importantly, it is the good feelings patients experience when they are in your dental office. That is what brings them back.

It all starts from the first visit ... or should we say, it should start before the first face to face in-office encounter. From the first telephone inquiry, notes in a new patient file can help everyone in the office understand specific needs. A telephone call by the treating dentist or hygienist a day or two before the first visit can truly set the new patient at ease. A few simple, friendly questions break the ice. Rapport is immediately started. This service showing above routine care is totally unexpected. In advance of the first personal meeting, a message is sent. A first impression, a very

positive impression, is made. Our experience has been that many new patients talk about this first call to their coworkers and family. The marketing process has begun even before the patient steps into your office.

New patients should be greeted upon arrival by name. **"We are expecting you and are happy that you have chosen our office."**

An office tour with introduction to team members begins to establish a comfort level. The idea is to diminish any anxiety the new patient may be feeling. A sense of well-being is being created. **"Our goal is to take care of you."**

While the dentist sets the physical atmosphere of the office by way of décor, background music, lighting, etc., it is the support team who sets the emotional ambiance of the care

environment. Your team members contribute greatly to your patients' experience. The collective energy of co-workers who enjoy each other's company is infectious. The sound of pleasant voices interacting with positive energy is comforting. This good feeling is so important today in this world of hustle, bustle and stress. **"We want to make your experience with us as pleasant as possible."**

Good communication is important in creating a great patient experience. Imagine the impact of having your Treatment Coordinator or your Dental Assistant making post-treatment follow-up calls or having your Hygienist following up after an "uncomfortable" appointment. These calls show a superior level of care by your total team. **"We care about your comfort."**

## Creating a **BUZZ**

*“We understand you.”*

*“We are different.”*

Note that consistent care and attention to detail are vital to retaining patients. How many times has a patient been lost because of lack of follow up, perceived lack of the doctor’s interest, breakdown in communication?

All patients should receive the same level of care. Many patients know each other and may compare experiences. If one patient is called after a major treatment and another is not, what impression does that leave? One individual is more important than the other? That is the impression the patient may have, but the reality is that there is a breakdown in consistency. Establishing a protocol is very important.

Have you ever considered the amount of time you allot to each patient? Dare to be different! Be willing to take your time with your patients. This effort is very much appreciated by patients. They do not want to feel rushed. Taking the time to enjoy our patients’ company is fundamental in our own practice. Making the time to connect on a personal level by not over booking, allows us to learn more about our “family” of patients. Patients recognize this as a superior level of care.

Taking this time also creates a personal bond that allows for better treatment acceptance. As you know, treatment acceptance is heavily based on the rapport between the patient and the dentist. Allow yourself the time to build that rapport. Take the time to show you care. **“I am giving you my time and full attention.”**

If you feel that spending this extra

time - non clinical treatment time - is not a realistic business model, then find a solution. Increase your fees. Most patients realize your office serves them differently and are willing to pay for your superior service.

***“It is a humbling journey and if you approach the new science with humility you will learn so much more effectively than if you approach the subject with the attitude ‘I already know that’.”***

Dr. Norman Thomas

These wise words apply to all aspects of the patient-centered clinic. Getting to know peoples’ wants and needs goes beyond just treating a “broken tooth”. Assume nothing before asking and listening. Treat as you would wish to be treated. **“We are listening to your wants and needs.”**

We know that our patients are all different, a mix of many personality types. Some patients are outgoing and gregarious. Many can be shy, quiet and contemplative. A few come across as demanding or seemingly aggressive. Then there are the scientific detail driven, curious and questioning types. Understanding these

character traits helps us guide care in a positive direction while respecting individual needs and wants. We must determine how to communicate and interact with the different personality types. Good communication enhances treatment acceptance. **“We understand you.”**

Don’t be afraid to promote yourself. Your team should be encouraged to inform patients about you and your special skills, continuing education efforts, awards, volunteerism efforts, etc. You are unique and your patients should know about your successes. Your team should ask patients for their testimonials about their positive experiences in your office. Compile these accounts and place them in the waiting area. **“Our patients think that we are the best.”**

The practice of dentistry has changed and improved tremendously in the last decade. The use of so much technology can be imposing to our unfamiliar “guests”. Team members should take the time to show off the office’s amenities. Please do not forget many patients, especially new visitors to modern clinics, are just not used to these new technologies. Educating our patients as to the efficiency of these systems helps them understand the scientific progress we have made these days. Noting that all this helps provide outstanding care for THEIR situation sets a distinct comfort zone for the uninitiated. **“We offer state of the art treatment and technology.”**

The general population unfortu-



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*“We offer state of the art treatment and technology.”*

*“Our patients think that we are the best.”*

nately has the idea that all dentists are the same. All dental offices are indeed similar, unless an example of something special is experienced in a consistent manner. You and your team must work together to make your practice stand out. **“We are different.”**

Our patients deserve the best of our undivided attention. We need to be totally focused on THEIR situation while beside them, treating them, and listening to their needs and wants. Our patients deserve the best of our intention. To do that which we know is the best we can do for them, to the best of our abilities, respecting the choices they have made. To

do less is unacceptable.

It’s all about our patients feeling comfortable, connected, appreciated, listened to...special. When they feel special, they think you are special

and they want everyone to know. It’s the proverbial win/win situation.

Until the pen hits the paper again ... stay well and continue to create a buzz!

**Dr. Terence Yacovitch B.Sc. (Chem.) D.D.S.**



A 1979 DDS graduate of McGill University in Montreal, Dr. Yacovitch has accumulated more than 2500 hours of professional development over the past 31 years. Terry was a clinical demonstrator and lecturer at his alma mater McGill for over 15 years, educating the next generation of dentists. A member of the IACA, CDA, ADA, QOD, QDSA, AADSM, ACCD (Board of Directors member since 2006), and founding member of the “Al Dente” Montreal Study Club. Attending multiple courses at LVI since 2004 re-ignited his passion for learning. As a Cad Cam educator and Team / Technology Integration and Development coach, Dr. Yacovitch along with his wife, Suzanne, present

in English and French to doctors and their teams seeking to enhance their skills. Dr. Yacovitch maintains a private practice in Montreal, Quebec.

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# HR IQ

*Tim Twigg*



**Q** I purchased my practice in Camden, NJ, approximately eight years ago and my 46 year old assistant came with it. Her work performance during the last three to four years has not met my expectations. I have not confronted her regarding this gradual deterioration in her work because I do not want to rock the boat. However, I can no longer accept this level of work performance, and I want to terminate her at-will employment. How should I handle this matter?

L.P., New Jersey

**A** Since your assistant is over 40 years of age, it places her in a protected group. Your state applies discrimination in employment protections to employees with all

employers as is also true in fourteen other states. You have not documented your assistant's performance deficiencies, and you did not mention if your personnel policies, other communication or verbal representations, establish your at-will prerogative or undermine it. Based on these facts, immediate termination is risky and inadvisable. Your personnel policies are essential to being able to provide a definitive response. Although it will result in you having to retain your assistant longer than you wanted, it is much safer to establish documentation that may be called upon to demonstrate a later termination is legitimate and non-discriminatory if she files a complaint alleging discriminatory treatment. Contact us at our website for counseling and termination forms.

**Q** One of my front office staff turned in her resignation to be effective a month later. The month was a nightmare since her work became less team and customer service oriented. In the future, do I need to honor the effective date the resigning employee specifies?

R.H., Minnesota

**A** Assuming your personnel manual has firmly established your prerogative to have employees serve "at-will" and you have a legitimate business reason to move up the last day of work, you may do so. Wages owed the departing employee are based on "time actually worked" so you would only pay through the adjusted date. Make sure the exiting



employee has submitted a written letter of resignation for essential documentation purposes then respond with an acceptance letter moving up the effective date. When moving the date up, many of our clients will provide in-lieu-of-notice pay rather than allow the employee to continue to work. We recommend that you also provide the employee with her/his final paycheck, on whatever final day you choose, as well as any other required paperwork (insurance continuation, exit interview, reference checking waiver, etc.). Please contact us for help with the recommended forms.

---

**Q** I am not sure I am using the proper I-9 form. What version should I be using? And what is your recommendation for filing and records retention?

K.C., California

**A** The most current I-9 form that must be completed for any new employee has a revision date of

8/7/09 and states it “Expires 8/31/12.” We strongly recommend that your completed I-9s not be filed in the employee’s personnel record files (either regular or confidential). Instead, I-9s should be filed in a separate file apart from general personnel records and other employment documents. In the event you are audited by the U.S. Immigration and Customs Enforcement Agency (ICE), they will then only have access to only these documents. Remember that you do not have to make or retain copies of any supportive documents provided. The only requirement is that you certify that you have seen the original documents. Certainly, you may retain copies, but employers are often choosing not to because of the risks relating to potential identity theft.

---

**Q** I have several Hispanic employees who converse with each other in Spanish in the office. My non-Spanish speaking employees and one of my patients have complained that they are uncomfort-

able because they don’t know what my Hispanic employees are saying. Can I require that only English be spoken by my employees at work?

J.H., New Mexico

**A** Language restrictions must be reasonable and based on genuine business needs. The fact that other employees and a patient are uncomfortable is not sufficient to mandate that only English be spoken. Guidelines as to what constitutes a legitimate business reason according to the Equal Employment Opportunity Commission include: “for communication with customers or co-workers who speak only English; when a common language helps promote workplace safety; to assist in cooperative work in which speaking only English promotes efficiency; and to help a supervisor who speaks only English to monitor work-related interaction”. During breaks, lunches or otherwise behind closed doors, employees are allowed to communicate in Spanish if they choose.



Tim Twigg is a nationally recognized speaker, consultant and author, including a regular column in *Dental Economics* entitled: “Focus on Human Resources”. Tim is the President of Bent Ericksen & Associates. Bent Ericksen & Associates is an LVI corporate partner. For over 30 years the company has been the recognized leader and most trusted name for human resources products, services and support for health care practitioners nationwide. This is why Bent Ericksen & Associates was chosen as the “go to” company for LVI and represents your resource for Human Resources and Personnel related questions and/or issues. Send your questions to us at our web site, [www.bentericksen.com](http://www.bentericksen.com) and state “New Visions Question” as the subject.

# PRODUCT

## REVIEWS

**Mark Duncan, DDS, LVIF**

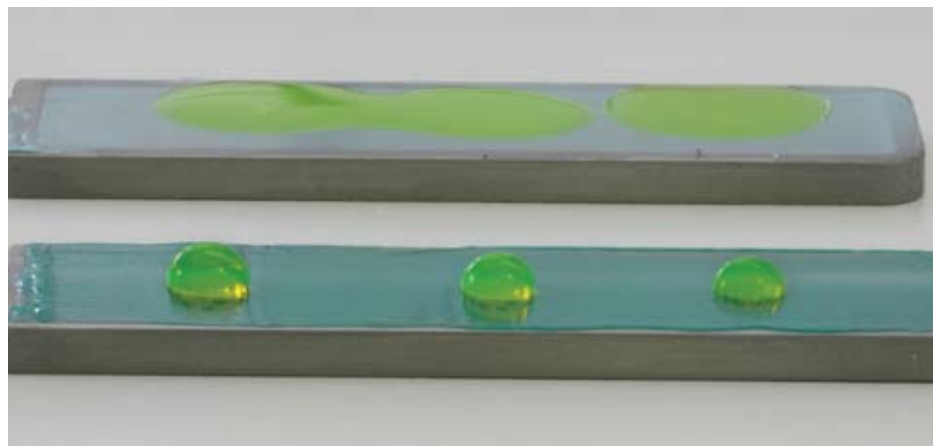
As leaders of the free world in development of new technologies and new approaches, it is easy to begin to assume that we have the very best of everything right at our fingertips. It is easy to get drawn into the idea that we have and use the best of the best. The reality often happens to be somewhat different though. To start, it isn't accurate to think the newest developments even come from this side of the pond and on top of that, there are a lot of things being used on the world market that are virtually unknown in North America.

One of the materials that fits this description has been used and promoted by Aurum Ceramic for years and only recently has it become more known in the United States. It happens there is a company called Kettenbach that was founded in 1944 by August Kettenbach in Germany. Through the years there have been a number of great materials offered to the world (well, most of it) and sev-

eral very insightful advantages that can be gained by using the impression materials that Kettenbach has developed.

In 2007 the company launched their support of the US market and now offers a number of benefits in their product line that simply outshines other materials on the market, and as it turns out, they aren't done yet! They have made amazing strides in fighting the balance between hydrophilicity and material handling properties.

One of the greatest frustrations in taking impressions in the mouth is combating moisture. To begin with, the mouth is wet! But the added issue is that there is fluid in a healthy mouth that will seep up from the gingival tissues as well as bleeding from damaged tissues or from periodontal tissues that are poorly managed and not totally healthy. All of this stands right in the way of taking accurate impressions of the finer details of the teeth, and the greatest challenge in getting an impression is

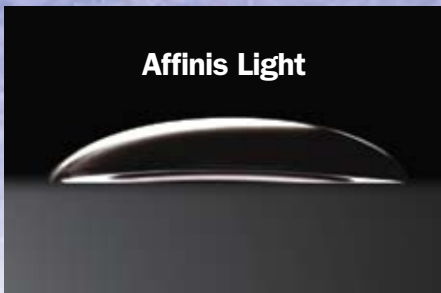


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at the very same places that are most likely to get wet while we are in the process! While there are materials available that are hydrophilic, they don't offer the huge handling and set advantages of vinyl polysiloxane materials. Finally that has changed!

Issues like tear strength and flow and stackability have been well managed by a number of materials, and accuracy and resistance to deformation is not uncommon. Quite simply, we have a lot of good materials to take very accurate impressions of the mouth. The problem is that they all work better if the mouth is dry, while we know that not only is it impossible to actually get the mouth dry through the impression, the more we try to do that the more likely it is we create sensitivity as the body rebels against our procedures. That is precisely what Panasil initial contact has solved, and it manages that on both fronts.

There are two phases to getting the material to act hydrophilically; the initial contact and over the set time in the mouth. The initial contact hydrophilicity can be measured using video and high resolution imaging and measurement of the contact angle. The more hydrophilic the mate-

rial is, the more the water drop can disperse across the material and the flatter the water drop will become. As can be seen in the photos, there is no comparison between the hydrophilicity of Panasil and the other materials; even ones known to work well in moist environments.

In fact, when using Panasil, it is an advantage to leave the mouth moist! Obviously some sort of retraction like the Optragate to manage the buccal mucosa, but after that all you need to do is make sure the mouth is clean. The residual fluids and moisture will literally attract the material and result in a better impression!

Kettenbach is a new name in the United States and is rapidly gathering strength in the market. With developments like Panasil initial contact it is easy to see why. Keep an eye out for this company as they are continually developing newer approaches and better materials to make our days smoother. In a future article I will share some amazing insight into Identium, a totally new class of impression material! In the meantime, check out Panasil and see if you too are amazed at what it can do for your impressions!



A 1995 graduate of the University of Oklahoma, Dr. Duncan vigorously pursued continuing education to grow beyond what was taught in dental school; twice being recognized as the leader in Oklahoma for Continuing Education. He completed the surgical and prosthetic sections with the Misch Implant Institute earning a Fellowship with the Institute as well as holding Diplomate status with the International Congress of Oral Implantologists. He has also earned the Fellowship with the Academy of General Dentistry in the shortest time period allowed by the Academy. He considers his real advance in education to have started with his journey through the Las Vegas Institute where he earned a Fellowship and currently works full-time as Clinical Director. Dr. Duncan is a member of the International Association of Comprehensive Aesthetics (IACA) and holds a position on the Board of Directors.

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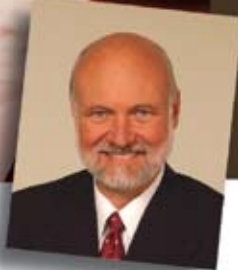
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# THE WEATHERERS' REPORT



Arthur "Kit" Weathers, Jr., DDS

## Six Simple Secrets to Prevent File Separation

One of the main reasons that people avoid the use of rotary nickel titanium file systems is the fear of breakage. Today we will discuss six simple secrets to avoid the dreaded file separation syndrome and virtually eliminate the major fear associated with rotary files.

A recent attendee at one of my Endodontic "Root Camps" sent me an X-ray showing a separated file. The sad part of this story is she had just returned from my Endodontic Root Camp and broke the file on her very next root canal (See figure 1). She asked me what went wrong, and how could she avoid having this type of situation occur in the future.

The answer to her question will be revealed in the following six simple secrets. Follow the directions in each of these categories, and I can guarantee your incidence of broken files will virtually be eliminated. Secret number six will explain exactly why the file shown in figure 1 separated, but first let's explore the first five secrets.

### Secret Number One *Straight-Line Access*

One of the major causes of file separation is not creating straight-line access into all canal openings. If a rotary file has to bend in order to gain entry into the canal, the stress on the file is very similar to bending a coat hanger back and forth. If you bend it

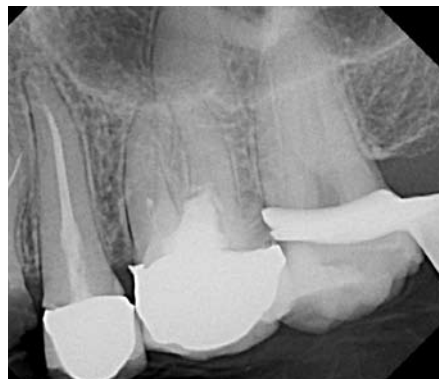


Figure 1 – Note the broken file on the far left side of this x-ray. The cause of this mishap will be explained in secret number six.



Figure 2 – Straight-line access can be accomplished with minimal removal of sound tooth structure.



Figure 3 – An example of minimal tooth structure removal while maintaining straight-line access.

*Follow the directions in each of these categories,  
and I can guarantee your incidence of broken files  
will virtually be eliminated.*



Figure 4 – The new light-weight sonic handpiece from Medidenta.

long enough, the coat hanger (or file) will break. So, the number one secret for preventing file separation is to make certain the file goes straight into the canal without bending.

In the past, most dentists, including myself, would tend to over enlarge the access opening to make certain the files would go straight toward the canals. In figure 2, the red line shows the typical path chosen by most dentists to obtain “straight-line” access into the distal root of the lower molar. The file does go straight toward the canal, but the distal root is at an angle, making the ideal approach to the canal start at the center of the tooth. The green line shows my suggested new approach and the blue area shows the amount of sound tooth structure that will not have to be removed if you follow this advice. Because of the angled approach in the “New Access”, the occlusal opening is much more conservative as seen in figure 3.

### **Secret Number Two** **Single Use Saves Files**

Ideally, rotary endo files should be used only once, but most dentists tend to use them multiple times. Reusing rotary files is risky because they get duller with each use, and the inevi-

table flexing of files in curved canals shortens their life. If you can't bring yourself to toss the files after only one use, try the following tip. Use a brand new set of files on every molar, and if they didn't get over stressed, use them a second time on an anterior, single rooted tooth. This will cut your file cost in half and you won't feel so bad when you toss them out.

If you decide to use your files more than two times, I suggest you at least give your patients the following option. “Would you like me to use brand new instruments on your case, or would you prefer I continue using the old files until they break? Incidentally, there will be a \$30 additional charge to cover the cost of using new files.” Yes, that sounds ridiculous, so a better idea is to stick to what I call the dental golden rule: “Drill unto others as you would have them drill unto you.”

### **Secret Number Three** **Sonics Smooth Canals**

I used to say that a sonic handpiece is a nice adjunct to rotary, crown-down instrumentation, but I now believe that it should be used in all cases. Not only does sonic irrigation facilitate thorough irrigation, the sonic handpiece

can help you get down canals your rotary files cannot easily negotiate. When a file gets stuck in the canal, it's usually not the tip of the file that is binding. Usually, the file will bind somewhere along the shaft, and 30 or 40 seconds with the sonic will remove most interferences.

I have been using the Shaper Sonic files from Medidenta for more than 20 years and I would not consider doing a root canal without sonics. Incidentally, studies have shown that there is no significant difference between sonic and ultrasonic irrigation, but preparation with a sonic handpiece is reportedly slightly more efficient and the sonic handpiece is usually less expensive than ultrasonic.

Incidentally, Medidenta just came out with a new, light-weight sonic handpiece (see figure 4) that is more comfortable to use, and has an improved file gripping mechanism for easier inserting and removing the sonic files. This handpiece can also be used with Medidenta's Sonic Irrigator to activate sodium hypochlorite, greatly reducing the time necessary for dissolving organic material in the canal. Sodium hypochlorite activated with this file for two minutes is equal to letting the solution soak in the canal for thirty-two minutes.



**Secret Number Four**  
***A Soft Touch Helps***  
***Prevent Separation***

Let the files do the work by not forcing the instruments to working length. Use a soft touch and don't push any harder than it would take to break the lead in a mechanical pencil or a very sharp lead pencil. A simple way to determine if you are pushing too hard is to insert a rotary file into the canal and do not push any harder than it takes to cut the first millimeter. Some people suggest taping a thumb-tack with the point where your index finger will rest on the handpiece and avoid pushing hard enough to draw blood. Personally, I think that that might be a little extreme.

In a curved canal (and most canals are curved), when a rotary file gets to working length, it has done its job, and in sharply curved canals, there is no need to return to working length multiple times. Leaving a rotating file in one position in a curved canal also tends to weaken the file if left long enough and it will try to straighten out and possibly create a ledge.

It has been shown that by preflaring a canal prior to rotary file placement to the full working length, there will be a significant reduction in breakage compared to canals with no preflaring. Preflaring is usually accomplished within the coronal two thirds of a canal. The opening of the coronal portion of the canal reduces the stress and binding of files on the

canal wall. After preflaring the canal, a modified crown-down technique should be used to prepare the apical third of the canal.

Due to the concern for file separation at this point in the canal preparation, the mistake most dentists make is not allowing the individual rotary files enough time to work within the canal. Therefore, when the next larger file is used, it does not go to the working length due to the dentinal constriction that the previous file did not remove. The dentist then compensates for this by placing more pressure on the handpiece. This added pressure causes binding of the file while the shaft is still rotating, thus increasing the likelihood of file breakage. By using an up and down hand motion the clinician should work the file until it is passively moving in and out of the canal before changing to the next, larger file size. The additional time using the smaller file is relatively brief, amounting to a few up and down motions with the electric slow-speed handpiece.



**Secret Number Five**  
***Slide File Slowly to Length***  
***with Slide Lubricant***

Slide is the name of the lubricant sold by EndoSolutions, or you can use Sodium Hypochlorite or even KY Jelly to reduce the stress produced by cutting dry. EndoSolutions also sells single use pipettes containing a combination of Slide Lubricant

and Sodium Hypochlorite (Slide SH). This combination lubricates and dissolves residual nerve tissue as you sonically clean the canals. After the preparation has been completed I recommend using another single use pipette containing EDTA (Endo Dialator) for 20 or 30 seconds to remove the smear layer.



**Secret Number Six**  
***Slow Speed Handpiece***

Always use a slow speed, electric handpiece for consistent 350-rpm rotation. The electric handpiece will run much smoother and quieter than an air driven slow speed. The speed will also run at a more consistent rate than you can get with an air driven handpiece.

The broken file shown in figure one was caused by using an air-driven, slow speed handpiece, and estimating the ideal speed of 350-rpm instead of using a constant speed electric motor. Using a rheostat to slow down the speed of rotary files can result in sudden changes of rotational speed that often cause instant separation of rotary files. In this case, the doctor didn't want to wait for the electric motor to arrive.

**One Final Suggestion**

If your file (hand or rotary) shows signs of unwinding, indicated by a shiny spot when you rotate the file under your dental light, toss it immediately, or you may wind up obturating with the "Dual-Obturation" technique (half gutta-percha and half nickel titanium). (See figure 6)





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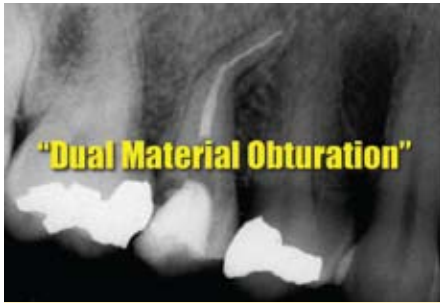


Figure 6 - This dreaded “Dual Material Obturation” was a result of ignoring the slight unwinding and re-inserting the compromised file.

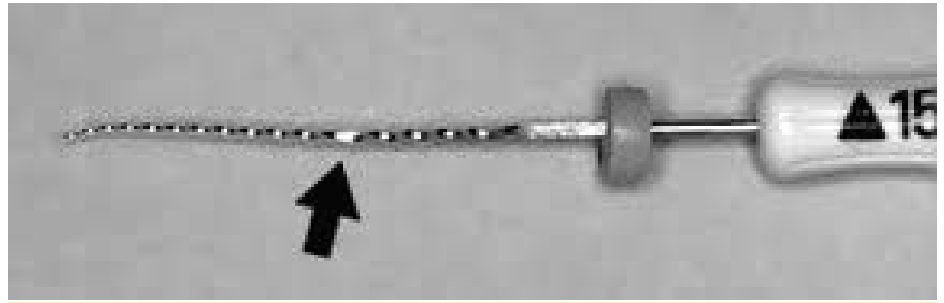


Figure 5 – When you see a slight unwinding of a rotary file, you should immediately discard that instrument.

## Summary

It is a common misconception that a broken file is the specific cause of conventional endodontic treatment failure. However, the basis of endodontic treatment failure after a file breaks is the inability to remove the remaining vital or non-vital pulp tissue due to the impediment that the separated file poses, which can lead to inflammation or infection. Crump and Natkin found that in most instances a broken file does not have an adverse effect on tooth prognosis. Saunders and colleagues demonstrated no significant difference in bacterial leakage comparing teeth obturated with gutta-percha and sealer versus teeth obturated with gutta-percha, sealer, and a separated instrument in the apical third of the canal.

It has also been proven that if you do not take action within 72 hours of learning new information, the odds are you will not apply what you have learned. There are ten secrets for eliminating procrastination that I teach at all of my “Root Camps,” but I will have to cover them at another time. Meanwhile, the six simple secrets in this article will help your avoid file separation, and it is now up to you to implement these techniques into your root canal therapy.



For more than thirty years, Dr. Arthur “Kit” Weathers has lectured worldwide on technologies, products and processes designed to simplify the practice of endodontics by the general dentist. The developer of a range of dental products, Dr. Weathers pioneered the EndoMagic! Nickel-titanium file system for general dentists seeking to improve both the quality of care and the economics of

the endodontic services they offer. As the clinical technique developer of the X-tip Intraosseous Anesthesia System, he has assisted practitioners in need of patient-friendly anesthetic application methods.

Dr. Weathers serves as the Director of Endodontics at the Las Vegas Institute for Advanced Dental Studies (LVI). Lecturing extensively to dental organizations, Dr. Weathers integrates an academically grounded approach to his subject with humor, magic, and mnemonics to enable his audience to recall his well-accepted techniques. As the founder of the Practical Endodontics “Root Camp,” Dr. Weathers offers numerous twoday, hands-on training sessions at the Las Vegas Institute and his facility in Griffin, GA.

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