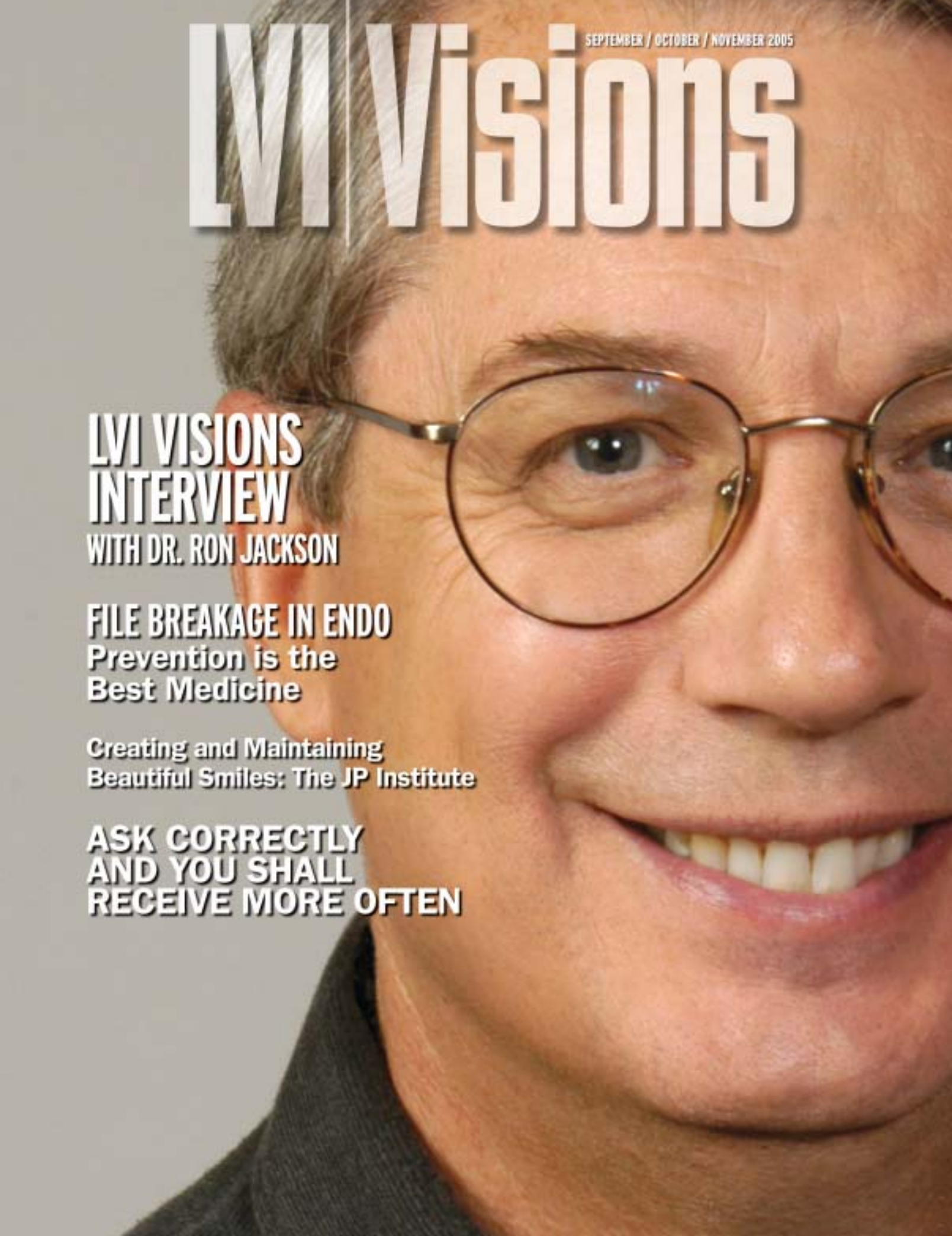
SEPTEMBER / OCTOBER / NOVEMBER 2005

# LVI Visions



## LVI VISIONS INTERVIEW
WITH DR. RON JACKSON

## FILE BREAKAGE IN ENDO
Prevention is the Best Medicine

Creating and Maintaining Beautiful Smiles: The JP Institute

## ASK CORRECTLY AND YOU SHALL RECEIVE MORE OFTEN

# No-interest payment plans can grow your practice.

## It's true—and it makes your patients happy, too.

Many patients put off accepting treatments they want or need because they base their decision on finances.

Turns out, **8 out of 10 patients prefer No-Interest Plans over other financing options** simply because they want more time to pay.

Your practice could experience increases in patient satisfaction and revenue by offering them the No-Interest Payment Plans available with the Citi® Health Card patient financing program. With a payment plan to meet every need, patients can make decisions based on health needs, instead of just finances — **and you schedule more treatments**.

Best of all, the Citi Health Card makes it easy to apply. And with high approval rates, most patients get a credit decision within minutes and can start treatment immediately.


Your patients aren't the only ones that benefit either. You'll enjoy these advantages from the start:

- **No enrollment fee and no special equipment needed**
- **Low Merchant Discount Rate (MDR) saves you money**
- **3, 6, 12 and 18 month No-Interest Payment Plans**
- **Less effort spent on collections saves you time**
- **Payments made within 2-3 business days**
- **Increased treatment acceptance and patient satisfaction**

Find out just how beneficial the Citi Health Card program can be for you and your patients. Even if you already have an existing patient financing plan for your practice, you owe it to yourself to find out more. Call the toll-free number below to get started.

## Get your free information package today: 1-866-352-5202

or visit www.healthcard.citicards.com

# AXIS Dental... now rolling with the Las Vegas Institute!

WELCOME TO Fabulous LAS VEGAS NEVADA

New LS-7541 LVI Esthetic Preparation Set from AXIS Dental

AXIS™ | nti

**Viva Esthetics! Viva Productivity! Viva LVI!** We don't just sell burs, we sell better dentistry. Better dentistry is the goal of LVI and we're proud to be their new partner. In honor of this occasion, we've developed, with LVI, the new LS-7541 LVI Esthetic Preparation Set with everything you need to more efficiently and effectively enhance every anterior, posterior and finishing procedure. Tell your dealer you want to see this new kit and other NTI Rotary Instruments from AXIS.

***GUARANTEED 100% Satisfaction.***

LVI
LAS VEGAS INSTITUTE for ADVANCED DENTAL STUDIES

2003 REALITY Five Star Awards ★★★★★ REALITY'S CHOICES

**The LS-506 CeraGlaze® Ultimate Porcelain Polishing Set** is used by LVI because it gets high shine results! Reality 5-Star results! Diamond impregnated for today's porcelain/ceramic restoratives. See for yourself!

***Buy (1) LS-7541 LVI Esthetic Preparation Set and (1) LS-506 CeraGlaze® Ultimate Porcelain Polishing Set... GET (1) LS-506 FREE!****

*Offer good through December 31, 2004. Send your invoice of purchase from an Authorized AXIS Dealer by January 15, 2005, to receive your free set to: AXIS Dental, Free Goods, 3006 West Story Road, Irving, TX 75038.

**CALL YOUR PREFFERED AUTHORIZED DEALER OR 888.654.2947 OR www.axisdental.com**


SEPTEMBER • OCTOBER • NOVEMBER • 2005

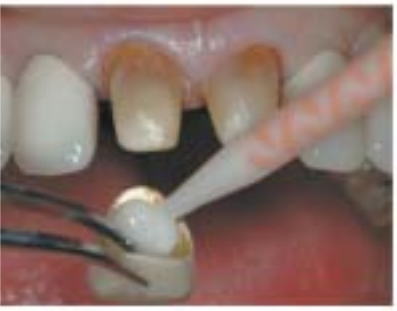
# TABLE OF CONTENTS

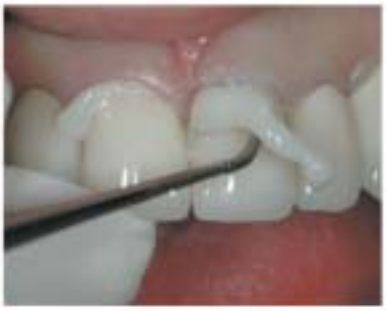


The Las Vegas Institute for Advanced Dental Studies (LVI) publishes LVI Visions. Please send any comments or suggestions to 9501 Hillwood Dr., Las Vegas, NV 89134.
Telephone (888) 584-3237 or (702) 341-7978. Web address • www.lviglobal.com.



# Maxcem.™ Self-etch. Self-adhesive. One-step delivery.






## DUAL-CURE RESIN CEMENT


## Simplicity defined.

- **Superior Adhesion.** Bond strengths are more than twice that of RMGI.
- **Superb Esthetics.** Excellent color stability. Highly translucent shades.
- **Direct Dispensing.** No hand mixing, trituration or dispensing devices required.
- **Bonds to All Substrates.** Dentin, enamel, porcelain, all-ceramic or metal-based restorations.
- **Dual-Cure.** Efficient dark cure when light penetration is limited.
- **Easy Cleanup.** Excess is easily removed in gel state.
- **Multiple Indications.** Crowns, bridges, inlays, onlays and posts.

Explore the science of Kerr at **www.KerrDental.com** • **800.KERR.123**

Kerr


E D I T O R I A L

BY WILLIAM G. DICKERSON, DDS, FAACD, LVIM

# *Becoming the CEO of your Practice*

*The biggest deficiency that new graduates have when they get out of dental school is not technical. The biggest deficiency is in the area of business. Let's face it; we really get no business training in dental school. Most dentists are business uninformed. I know I was. Yet we are required to run a small business when we start our practice. Yes, your practice IS a small business. Probably the biggest boost to my practice was not from the dental publications I read, but the business publications I read. So this article is intent on providing you the tools and guidance to become the CEO of your practice.*


### *Motivate and Lead*

The key to becoming a good CEO of your practice or any business is to make and keep your employees happy. Happy employees will be more productive and the company will prosper. Business psychologists will tell you that beyond a certain minimum level, it isn't pay or benefits that make your employees happy; it's a strong relationship with co-workers and a supportive boss. And be careful delegating this to someone, as they may not always have the best interest in your practice like you do.

### *Be a Visionary for Your Practice*

It's the job of the CEO to set the direction and standards of the office. Most great business tycoons were visionaries, who broke the paradigms of conventional wisdom in their area of business. The great CEO sets high yet realistic expectations. It is your job to convince the team that the goals you set are reachable. Just like you, your team has their perception of reality set by their own paradigms of what's possible. If you can change those perceptions, then the team can accomplish more than you and they ever dreamed possible.

***It's the job of the CEO to set the direction and standards of the office.***

It's also important to be positive and squash any negativity. Like a computer virus, negativity will destroy the rest of the practice. It's infectious. You need to do whatever you can to perpetuate a positive environment and not let negativity infiltrate your team.

Think about Roger Banister. In 1954, it was considered humanly impossible to break the 4-minute mile. No one had ever done it. In just the next couple of years after Roger Bannister broke it, 50 other people broke that milestone. In their mind they realized it was possible. Once you believe something, it becomes reachable. Once the perception of reality has been altered and paradigms shift, things that once were considered impossible become common place.

### *Empower Your Team*

I personally think the worst form of management is "micromanaging". By micromanaging, you don't empower your team to excel on their own. You stifle their creativity and limit their need to "think" on their own. There is no way you can do all the jobs well, so by micromanaging, you have mediocre output in all areas. By empowering your team, you create responsible people who take charge of their work. This is best accomplished by educating your team and leading by example. Take them to courses with you so they are learning as you are and see that you want to be the best. It compels THEM to want to be the best.

By far the dentists who return from LVI and have the greatest success are those who brought their teams.

### *Don't be Insecure*

I think most poor CEOs are insecure. Great leaders or CEOs are secure enough to surround themselves with smart and intelligent people. It's also critical that they give those around them the feeling that they were responsible for a successful venture even though it may have been the CEOs' guidance that created the success. Empowering an employee with the notion that they are high achievers and important to the team will MAKE them high achievers and therefore important to the team.

The successful companies and leaders are those who let others believe they are responsible for the success of the business. Instead of wanting to get the credit, let someone else bask in it. What difference does it make? It is your company and you will reap the rewards for their enthusiasm and efforts.

***Remember, it's just as important to work ON your practice as working IN your practice***

### *Don't Just Work In Your Practice*

Most dentists only think about their office when they are IN it. The successful dentists are always thinking of ways to improve the service they provide their patients. Remember, you are in a service business, not a product business. So constantly think about ways to improve it. If you like the way you are treated somewhere, think if you can apply that to your practice. Read business books and think about the dental equivalent of an idea.

It's when the doctor treats his or her practice like the small business it is, and realizes that they are the CEO of their company, that the practice really takes off. Remember, it's just as important to work ON your practice as working IN your practice.

# "Stop Shooting Those X-ray Films! Let Me Point You In A Better Direction!"

William Dickerson, DDS, FAACD, LVIM

The DEXIS Digital X-ray System has been used exclusively at LVI since 1999. We welcome the opportunity to earn the same privilege in your office.

**Learn more about DEXIS. Call 1-888-88-DEXIS x2.**

2004 REALITY Five Star Award ★★★★★ REALITY'S CHOICES

ADA ACCEPTED American Dental Association

**DEXIS®**

**Digital Diagnostic Imaging**

# IA 2005

Inaugural Conference
July 21-23, 2005
San Diego, CA

IACA

THE INTERNATIONAL ASSOCIATION OF COMPREHENSIVE AESTHETICS

INSPIRING THE PASSION FOR EXCELLENCE

# THE INSPIRATION CONTINUES.

The IACA Board of Directors would like to extend their thanks to the 800 aesthetic professionals who gathered in San Diego to make the IACA's inaugural conference such a resounding success.

This unprecedented exchange of information, knowledge and experience is already bringing our profession to a level only highly enthused collaboration could foster.

*Be there as we inspire the passion for excellence again.*

***The IACA Conference 2006***

August 3rd – 5th

The Fairmont Queen Elizabeth

Montreal


Space is limited so be sure to book early.

Register online at

**www.TheIACA.com**

**1-866-NOW-IACA**

THE LVI VISIONS INTERVIEW WITH

# Dr. RON JACKSON

***What do you consider your greatest accomplishment in Dentistry?***

The dental profession has been very good to me. I am honored when people entrust me with their oral health and when dentists attend my lectures or come to my courses at LVI. It's a tremendous privilege to do both things and I take these "gifts" from others very seriously and with tremendous appreciation.

I started my practice from scratch in a small one stop-light town (Middleburg) in rural Virginia in 1976. At that time, there were far more horses in the area than people but it is a beautiful area located in the foot hills of the Blue Ridge Mountains and the quality of life is high. In spite of the poor demographics (the dental supply house thought I was crazy and was reluctant to sell me equipment), this is where my wife and I wanted to live and raise a family and I believed one of the benefits the dental profession offered was the freedom to locate anywhere. I believed then, and I still believe, in the abundance mentality and if you treat people the way they want to be treated and truly dedicate your practice to excellence (not just give lip service), you will not have to worry about having enough business. So, establishing a successful practice where I wanted to live and after 25 years selling it to become the associate in the same practice, hopefully for another 25 years, is one of the accomplishments in dentistry I'm very proud of. However, there is a second achievement I am equally proud of and that is having the opportunity to share what I've learned.

If by example, or through something I say or show, I can help dentists provide better care for their patients and gain better fulfillment in their practice life, then I, in turn, feel a strong sense of accomplishment and satisfaction. Unlike my practice, which was a specific goal that was planned and executed, teaching was never a goal. And from my viewpoint, it still surprises me that I'm asked to share what I learned.

I can hardly believe that it was 18 years ago when I was asked to give my first presentation to a study club in Baltimore. Since then, lecturing has taken me all over North America and the world. I have seen our wonderful profession globally and have a much deeper appreciation of it than I otherwise would have had. I believe dentists are the #1 most caring profession – they'd have to be or the public would never let us use sharp instruments inside their head while they are awake. No matter where I go abroad, cultures are different, language is different, history and politics are different, but we dentists all do the same thing. It's a common bond and a platform for communication. I have been to most states and met great dentists all over our incredible country. I find dentists to be very clever and innovative. I really believe I'm the one who has been taught and learned the most.

Teaching brought me to LVI eight years ago. Of all the forms of teaching I do this is the one I enjoy most because it's hands-on. I also believe it has the greatest impact. I will forever be grateful to Bill for this opportunity.
Finally, There is no question that none of the above would have worked out as well as it has without the support of my wife of 36 years, Mary Jo. I rely heavily on her opinions and instincts when it comes to decision making and her encouragement and tolerance are, and have been, critical to my life's work.

### *How do you define success in dentistry?*

I define success in dentistry not in monetary terms but as doing those services you like doing, with people you like and for people you like.

When you are doing what you like, you become good at it. You think about it, read about it, and study it because you are interested in it. Eventually it's no longer work, but how you like to spend your time – it becomes your hobby. For example, people who read about golf, watch golf, study golf and play it all the time get good at it. As for working with people you like – you are the boss – don't just settle for a set of hands. On the other hand, you set the example and the standard. It won't work to ask for more commitment from your team than you have. Finally, many dentists have patients in their practices who shouldn't be there. Maybe it's the scarcity mentality or that dentists are such caring and sensitive people that causes us to try to be all things to all people. Given the variety of personalities and values, it simply can't be done. Trying to be everyone's dentist is a prescription for stress and unhappiness – for the dentist and the patient. The only legitimate patients in your practice are people who are coming to you for who you are, what you do and how you do it and for no other primary reason. If dentists would think about who their favorite patients are, I'll bet they are in the practice for the above reasons. The bottom line is you can develop an entire practice out of these patients and retirement will become the last thing on your mind. I know!

***What are you passionate about in dentistry?***

That success (however one defines it) and happiness can be achieved by any dentist. Having a successful, fee for service, insurance independent practice is not something that can be achieved by the "lucky" or "talented" few. It's not something that just happens. Anyone can make it happen if that is what they want. And it can be done anywhere. LVI's success has been built on this premise and thousands of successful dentists who enjoy what they do are the proof.

***What are the obstacles to achieving success in Dentistry?***

I think the biggest obstacle is thinking you can't achieve it. I suspect some dentists even think they are unworthy which is incredible when you consider they spend one third of their life studying to finally get the DDS/DMD degree at great personal sacrifice and cost. Low self-esteem and being too risk averse are other hurdles some dentists face. By the way, LVI treats these "diseases".

Another obstacle is focusing on what the other guy is doing instead of focusing on "being all you can be". It's distracting, and, in many instances, can be a negative barometer. Beyond that, what the other guy is doing is totally irrelevant to one's personal development. Indeed, instead of spending time and energy keeping tabs on what the mediocre are doing, look for people who are doing things very well and copy them. I can't think of any truly successful people who are not more than willing to share what they know. On the other hand, I have also come across dentists who were too arrogant or proud, (both are usually cover–ups for low self–esteem) to approach those in their own vicinity who they could learn from. This stunts growth or at least slows it. The most successful dentists will ask questions and learn from everyone. It's how they got successful in the first place, and continue that way.

Finally, at the risk of sounding self serving, I think a major obstacle to not reaching the levels of success desired and deserved comes from not recognizing the value of continuing education. There are still many dentists who accomplish only the minimum necessary continuing education (or only slightly more) to maintain their license. They see it as an expense and not an investment. Yet, dentists who break out of the average are the ones who budget several times more than what most doctors in their area are spending in time and money on continuing education. It's investing in yourself. LVI was founded on the concept of the ultimate learning experience being hands-on courses. It's how we learned dentistry the first time. Courses with small class sizes and high faculty to student ratios in an intimate high technology learning environment are expensive to put on but nothing a dentist invests in will have as high a return. In my experience, dentists who take much more than the legally required continuing education are happier, motivated, more fulfilled and more economically rewarded than those who practice dentistry as a job.

***If you could give one piece of advice to all dentists, what would it be?***

Stay focused on the patient and what is in the patient's best interest, not yours. This will take you everywhere else. Said another way, do your best for people with energy, honesty and integrity and the reward will follow.

For example, if you truly care about the patient, you will take the time to listen to them. Patients want the dentist's undivided attention. They want your respect and to be understood. In fact, they won't listen to you with trust until such is the case. I love the LVI advertisement showing the roller skates on a hook. If you truly put the patient's welfare first, you will hang up your roller skates, slow down and take the necessary time to thoroughly evaluate the patient and do your very best work. A dentist who runs from room to room is putting his/her "perceived" production ahead of the patient and they know it. And so does the staff. It devalues the work. I'm not against efficiency or profits. In fact, you can't do your best work unless you are profitable. But we have to understand it's not about getting bodies in and bodies out as though people are a commodity. It's about value. In my opinion, the vast majority of dental patients are willing to pay for value which is represented by our best work delivered with care. Oftentimes, the difference between excellent care and mediocre care is sometimes only taking a few more minutes.

***What approach should the New Dentist take?***

From the beginning, I recommend that he/she get in the habit of doing the following with every new patient: Find out who they are, what they want and how they want it. This is a lot more than a comprehensive oral exam (something that cannot be done when meeting a patient for the first time in the hygiene chair for a two minute check-up), it's a comprehensive person exam. Ask questions and listen to the answers. Get their story – forget telling them yours. I can't get into details in this interview but this is something none of us were taught in dental school. We probably would not have listened to it then anyway. But it's critical for success because we aren't treating teeth – we are treating people with teeth. Communication skills and people skills are just as important as clinical skills if we are to maximally serve these people we call patients. Fortunately, these skills can also be learned. I know.

Secondly, I would advise the new dentist to reread my answer above regarding continuing education. Sure its tough for the new dentist to budget for CE when already in so much debt, but I say delay the expensive car, big house, etc. a little longer. I know the dentist and spouse probably think they've waited long enough but getting started right with current, immediate use education (the new dentist has to keep in mind that a license to practice means only the minimum standard has been met) will have a bigger compounding effect than compound interest.

***Who do you admire and why? Any mentors?***

There are a lot of truly great people in dentistry who I've had the opportunity to know and learn from. People from the past like L.D. Pankey, Bernard Jankelson, Ron Jordan and Walter Hailey taught me a lot. A list of others who have taught me (and still do) would include Ray Bertolotti, John Kanca, Ross Nash, "Buddy" Mopper, Bob Nixon, Newton Fahl, Omer Reed, Gordon Christenson, Paul Belvedere, Lee Culp and of course the Bill's – Dorfman and Dickerson. There really are many people who have added significantly to my knowledge by what they wrote, what they said in lectures or conversations or just by the example they set. Outside of dentistry, it would be hard to measure the enormous positive effect reading books like Dale Carnegie's "How to Win Friends and Influence People" as well as Stephen Covey's book "The Seven Habits of Highly Effective People" have had on me.

By far, the most important mentors I've had, who had the greatest impact on my life, were my parents. They taught me faith and to value integrity above all else.

***Anything that bothers you about the dental profession?***

I absolutely love our profession. In my opinion, dentists as a whole, are the nicest, kindest people I know and we've always ranked high in public opinion polls. So why are we not nicer to each other? Why is there so much back-biting and criticism? It really bothers me that we are so judgmental of each other. It starts with criticism of a previous dentist's work and occurs all the way up to personal attacks in interviews as well as journal and newsletter editorials written by even the most respected among us. I've even heard this immature and unprofessional behavior coming from the podium. Of course, this sort of thing is not unique to dentistry – the media and politicians have taken this kind of behavior to a ridiculously obnoxious level. But we shouldn't act this way. I say be a model, not a critic, because you can never build yourself up by taking someone else down. On the contrary, it lowers the stature of the person acting this way.

I'm not saying don't disagree. In fact, it's only through honest collaborative disagreement (I define honest in this case as sincerely looking for the truth and not just serving one's ego) that progress occurs. Disagree with the opinion or premise but always respect the person. A couple years ago, I wrote a response to a Dental Economics Viewpoint article by Joe Stevens. In it, I disagreed with his philosophy and approach to patient care and some of the statements he made about the values dentists hold, but I don't for a minute think Joe was being dishonest in any way. Just the opposite, I think he is sincere in his belief – just wrong! (In my humble opinion.) That last is an attempt at levity.

Which brings me to my last point in this response and that is dentists need to lighten up. Maybe it's because we work in a world measured in microns and we have to be so precise and exacting,, but focusing on perfection (which is impossible) will eat you up. Although excellence is redefined every day, it is possible and that's what we should focus on – being better today than what we were yesterday. We need to take our work seriously, but ourselves less seriously.

***You assist various dental manufacturers in developing new products. What is your main objective when developing a new material or technique?***

Yes, from time to time, I provide services as a paid consultant, to several manufacturers in the development and testing of new materials or technologies. The main objective in developing new products or techniques is to improve the care we dentists can provide our patients. Like all dentists, I'm always looking for a product that will allow me to do something better, faster, or easier. The free market is global and competition to develop a better mousetrap is keen and we dentists and our patients are the beneficiaries.

As an aside, consulting has given me a chance to see the manufacturing side of our industry and to develop an appreciation for the people in it. From the CEOs to the polymer chemists, to the sales people in the field, I've come across dedicated people who are just as committed to dentistry as we dentists.

***What are your thoughts on LVI?***

LVI is an example of what one man with a vision, an ironclad will and consistent, unstoppable perseverance can achieve. I've been there from the beginning and watched it evolve to a two-building campus which is beginning to go global. I am still awed every time I go out to Las Vegas by the numbers of people taking courses at LVI every week and the scope of the curriculum. With Endodontics, Implants, every aspect of Esthetic/Cosmetic dentistry, hygiene practice, assistant courses, lab courses, practice management, occlusion, etc. all aspects of needed dental continuing education are available. There are more than 30 courses in all.

But LVI goes beyond that. We all have a need to be around people who believe in us, inspire us and motivate us toward our vision and that is exactly what LVI does. There is a saying that "when you hang around turkeys all you learn is how to gobble, but when you hang around eagles you will learn to fly."

Besides establishing a foremost learning center, the thing that I admire Bill most for is bringing together 80 of the most uniquely talented dentists from all over the country who are called clinical instructors but who are so much more. These incredibly talented and special dentists work one-on-one with participants in the live patient courses, the hallmark of LVI. They are good at what they do, and along with the LVI staff, are the backbone of the Institute.

Sometimes on the circuit I hear criticism of LVI where someone says that they know a dentist who took a course at LVI and, in their opinion, is not doing good dentistry. My response is to say there are probably graduates of every dental school in the country for whom the same thing could possibly be said. What LVI offers the attendee is a path to remove the straightjacket of mediocrity many of us were programmed to wear, and replace it with the cloak of success. Although some very positive things do begin to happen right away, it is not a quick fix or a magic bullet that requires no effort. Success doesn't happen that way. But for graduates of multiple courses, the learning experience gained at LVI is profoundly significant and life changing.

## *Any final thoughts?*

Our purpose in life is to grow into our maximum potential and you can't do that unless you are happy. It may sound self serving but you simply will not be able to maximally serve others unless you, yourself, are happy and fulfilled in your work. You just won't have the necessary motivation and energy that it takes.

So my advice to dentists, and to anyone for that matter, is to find out what makes you happy and do that. If you don't like the way things are – change them. Don't look for happiness in things – because happiness is a feeling – not a thing. For most people, it will be found in positive relationships where good is produced.

I've been blessed with a 36-year happy marriage that produced two young people who are successfully contributing to society. I went into a great profession which has been good to me. I'm glad Bill Dickerson had the vision and fortitude to build the Las Vegas Institute. I'm glad to be a part of it and I look forward to LVI's even brighter future serving the dental profession.

---

**RONALD D. JACKSON, DDS, FAGD, FAACD**

*Dr. Jackson has published many articles on aesthetic, adhesive dentistry and has lectured extensively across the United States and abroad. He has presented at all the major U.S. scientific conferences as well as Aesthetic Academies in Asia, Europe and South America. Dr. Jackson is a Fellow in the American Academy of Cosmetic Dentistry, a Fellow in the Academy of General Dentistry, and is Director of the Advanced Posterior Aesthetics and Anterior Direct Resin programs at the Las Vegas Institute for Advanced Dental Studies.*

*Dr. Jackson maintains a private practice in Middleburg, Virginia emphasizing comprehensive restorative and cosmetic dentistry.*

## Dr. Jackson's upcoming course dates are:

**POSTERIOR:**
- *September 14 -17 (Sold Out)*
- *October 23-26*
- *December 5-8*
- *February 5-8*

---

**ANTERIOR DIRECT RESIN:**
- *September 19-21 (Sold Out)*
- *March 30 - April 1*

# Ask Heidi

## Clinical Questions and Answers

*Dr. Heidi S. Dickerson is the Vice President of North American Operations. She is a 1994 graduate of the University of Illinois School of Dentistry. She had a private restorative practice in Philadelphia, PA before relocating to Las Vegas to accept her full-time position at LVI. Due to her commitment to excellence, spending countless hours mastering aesthetic and restorative dentistry, including the LVI curriculum, she changed her aesthetic-restorative dental practice into a neuromuscular based practice. As a Clinical Director at LVI, Dr. Dickerson instructs, lectures, and motivates LVI students through their curriculum, enhancing their educational experience. She also practices in the LVI Faculty Practice.*

*Send any of your clinical questions to her at:*
LVI 9501 Hillwood Drive, Las Vegas, Nevada 89134 or via e-mail at hdickerson@lvilive.com

*Due to the overwhelming number of questions from Team members… I have decided to answer some of their questions in this issue of LVI Visions.*

**Q**

Dear Heidi,

I am having one heck of a time hiring another dental assistant. I live in a small town and the "pickin's are slim". I am willing to train someone that does not have any dental experience. I have tried the classifieds and have placed ads in local publications. Any suggestions?

J.J.
Indiana

**A**

Dear J.J.,

Sometimes the best person is right under your nose. Have you used your dental newsletter or posted the position in your office? You may have an existing patient that is perfect! Another great source is your local restaurant. There has been more than one of my dental assistants that first started out as a waitress I would routinely see at lunchtime! The reason why? Well, waitresses are people oriented, service oriented, and can multi-task. Many are looking for a "career" and stable hours and benefits. If you have a person in mind…it can not hurt to ask. Plus, just think about how many tray set-ups he/she can carry at one time!!!!
You'll find the right one soon enough,

Heidi

Q

Dear Heidi,

I am revamping my dental office and changing the color scheme. I know you will make fun of me for this, but my chairs are ORANGE! I am reluctant to buy new chairs because these work great, and our patients always comment on how comfortable they are. Everything else is the office is changing…do I really need to change this too? Can you talk my team into keeping them?

Regards,

J.S.
Indiana

A

Dear J.S.,

I must admit that I giggled as I read your e-mail. Just picturing those orange chairs and imagining your team wanting to get rid of them…and your wanting to keep them! I know "retro" is in…but, I think it is time for a change! How about suggesting a compromise? If they really are in nice shape and if the patients are comfortable in them, just recover them in another color to go with your new office décor. There are many companies that will come out to your office for this service. It usually just takes a few hours for them to recover each one. Ask your local dental distributor if they know anyone in your area.

Hope this will make everyone on the team happy!
Heidi

---

Q

Dear Heidi,

When checking shades for my aesthetic cases, I have the patient walk outside with me and use "natural" light. I know that I can change the bulbs in my operatories to help facilitate this…but, have no idea what to get. Help!

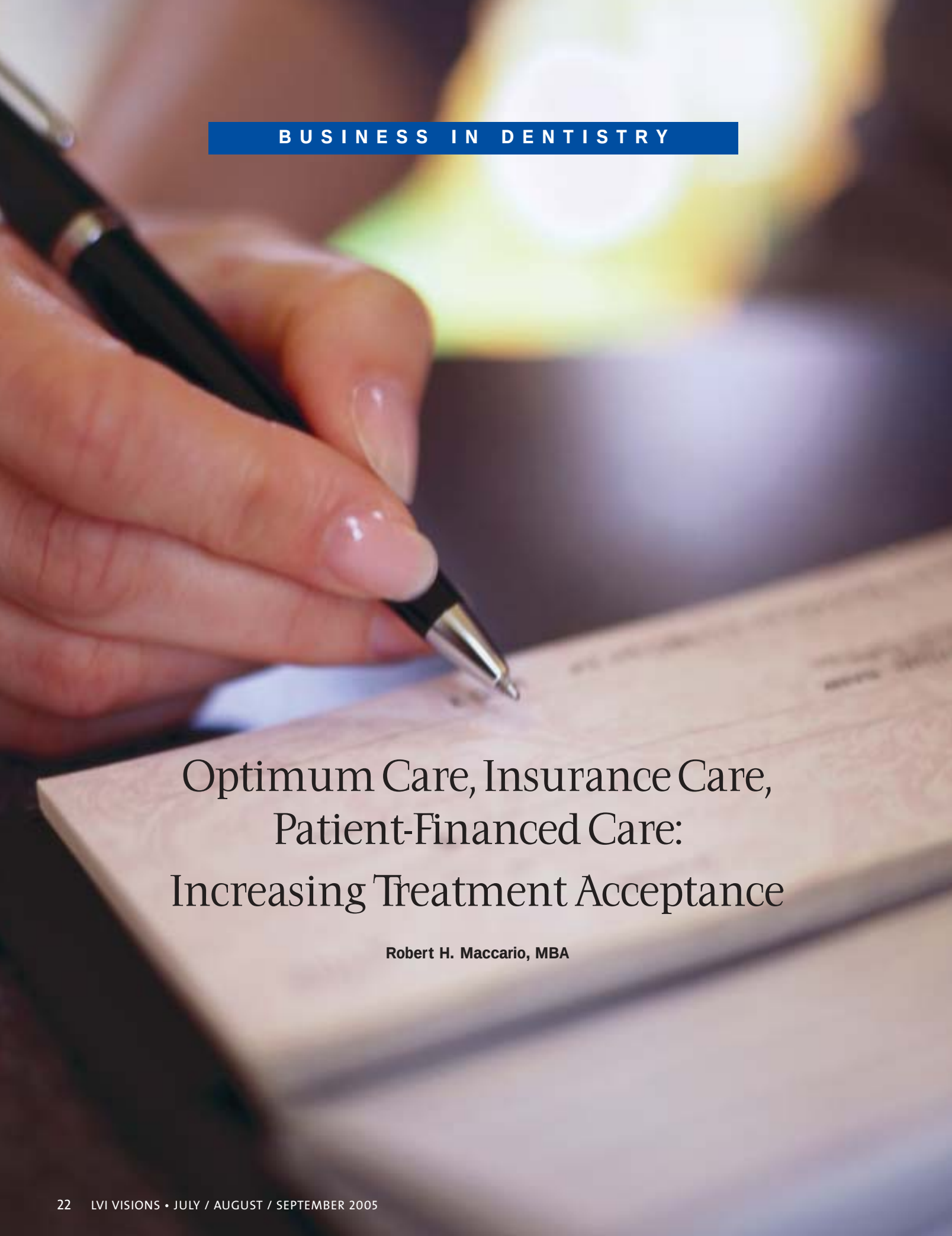
Thanks,
G.R.
California

A

Dear G.R.,

I remember one time I asked a patient to come outdoors with me during a 10 unit try-in…we walked out onto the back decking of the office, and just as I asked her to smile she let out a giant sneeze! #8 flew out of her mouth!! My assistant and I called the rest of the team, and you can just picture the 5 of us searching around the ground for half an hour. We finally found the veneer…and it was that day that I decided to change my lighting situation! By bringing the patient outdoors, you are well ahead of others who just using plain old fluorescent bulbs. However, there is an easier way. You should replace your fluorescent bulbs with color corrected ones. The bulbs you need must be rated 92 or higher on the CRI (color rendering index) to be color correct. Also check for a CCT (correlated color temperature) of 5,000K or 5,500K. If you are wondering who manufactures these bulbs, I know that GE and Philips do. If I were you I'd head to my neighborhood hardware store and pick up a few!

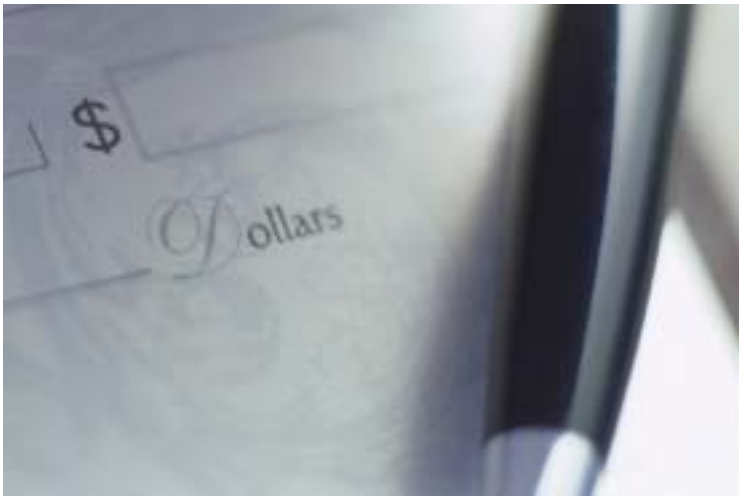
Hope this helps,
Heidi



# Optimum Care, Insurance Care, Patient-Financed Care: Increasing Treatment Acceptance

**Robert H. Maccario, MBA**

**For most patients / guests, optimum dental care far exceeds the limitations and restrictions of their insurance coverage. Yet if you decide to give them the option to say "yes to the best," as taught in the Dental Concierge® program, your practice**




**competes in the lifestyle marketplace instead of being confined in the domain of insurance. This opens entirely new opportunities for your practice and provides choices many people are eager to consider.**

However, the cost of saying yes to the best is significant as compared with relying on insurance-subsidized dentistry, and it must be borne by the patient, of course. But how?

The answer is patient financing. You probably know and understand the need for patient financing as a marketing tool. No doubt you also understand it's not feasible for your practice to become a lending institution, and instead you use an "outside billing service." In choosing these financing partners, have you made sure the options they offer your clientele are consistent with your overall practice philosophy? Are they consistent with the optimum clinical care you want your patients to accept?

The difference between a lender who is aligned with your business vision and one who is not can be as subtle as the difference between creating "just" an aesthetic smile and designing a functionally aesthetic smile. There are also subtleties in patient financing tools, which differentiate partial treatment acceptance from more comprehensive treatment acceptance.

Consider an example. Office managers frequently say they like to offer financing for a year with no interest. On the surface, "12 months, interest-free!" may sound good to patients and even increase treatment acceptance. But many practices are missing the subtle, potentially negative impact of this kind of program. I'll explain.

Let's assume the patient needs $4,500 worth of care. (We'll use this number only to keep the math simple.) Let's also assume the patient wants the care—we have long since overcome the mind-set of doing only what insurance will cover—so now we just need to make it affordable.

We'll also assume the patient is credit-worthy but can afford a payment of only $100 per month. Therefore, over a period of 12 months, the patient could afford only $1,200 worth of care ($100 x 12 months = $1200). On the other hand, if you offer an extended payment program with a competitive convenience fee (60 months at 12.9 percent interest rate), the patient could afford the full $4,500 plan plus the financing costs and still stay within the $100 a month payment budget.

If you offered both financing options, you run the serious risk of the patient prioritizing the financing options over the care recommendations, It's true: 12 months interest-free is an almost irresistible marketing proposition, and as a result, most patients will choose this "deal" over what's best dentally, effectively limiting the treatment to only a portion of the prescribed care. Then you're back to the core problem with insurance-based practices: You're not delivering the best possible care.

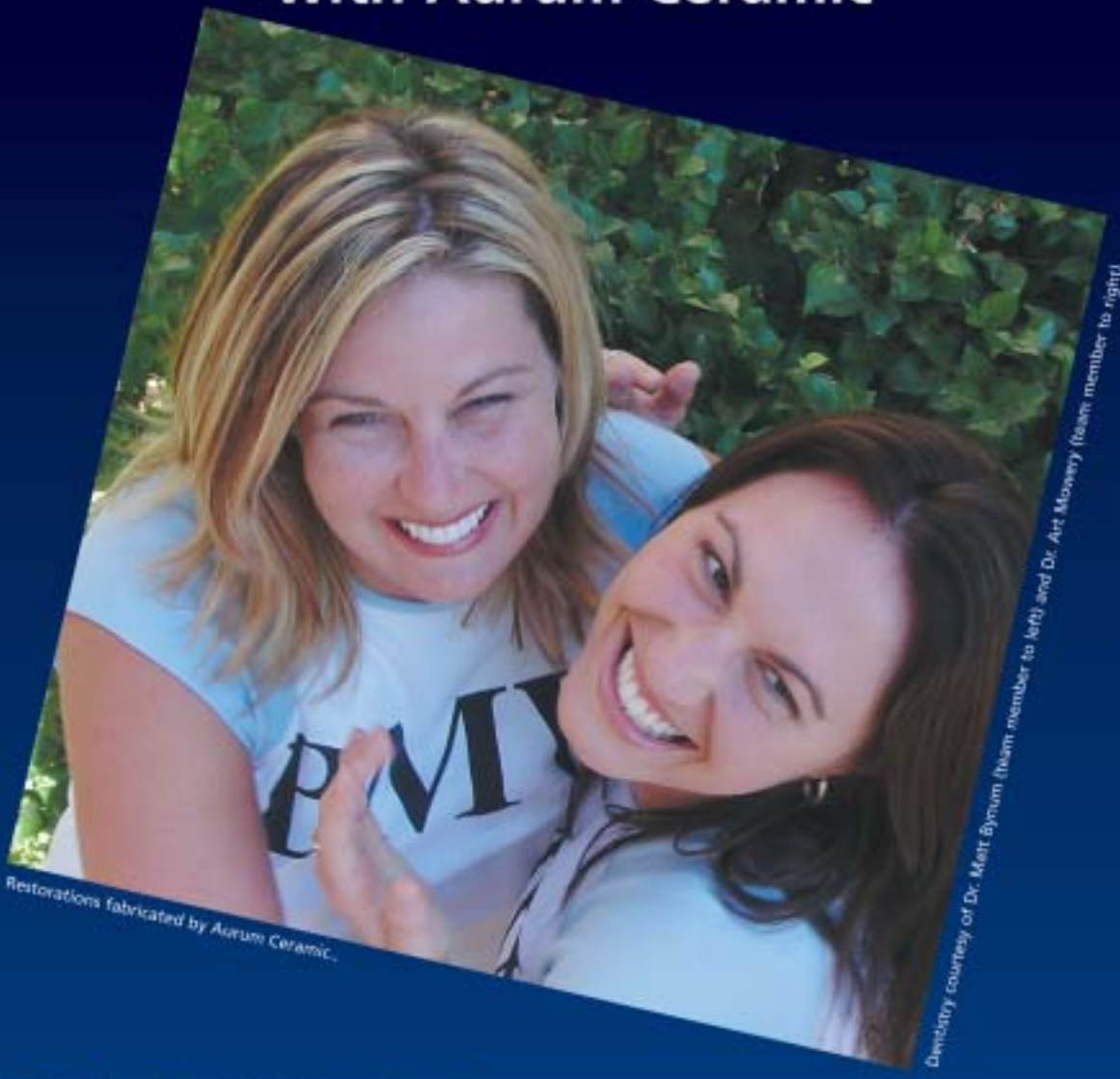
Many times, the desire to offer 12 months interest-free reflects a practice's inability to diagnose and/or communicate the value of accepting comprehensive treatment. They let the "free" money close the deal and therefore let the financing terms dictate the amount of treatment.

It is strongly recommended that you use no-interest, short-term programs (longer than 90 days) only as fall-back strategies, but do not print them on a formal financial options information sheet. They can be effective for larger cases where the patient is affluent and the idea of free money is attractive, but in most cases, these same patients will take advantage of

*You want your business effectiveness to match or exceed the quality of clinical care you provide.*

# Ultimate Smiles

## Create an "Ultimate Smile" on every case with Aurum Ceramic



Restorations fabricated by Aurum Ceramic.

Dentistry courtesy of Dr. Matt Bynum (team member to left) and Dr. Art Mowery (team member to right).

Dr. Art Mowery,
Gainsville, FL

Dr. Matt Bynum,
Simpsonville, SC

**Directors of Achieving Extreme Success, Las Vegas Institute for Advanced Dental Studies**

"When it came time to show our artistry first hand in-office by restoring two of our Team's smiles, there was only one laboratory partner for us – Aurum Ceramic. For consistent 110% performance and exceptional aesthetics, Aurum Ceramic sets the platinum level standard!"

***Call our Advanced Esthetic Hotline***

**1-800-661-1169**

AURUM CERAMIC®
DENTAL LABORATORIES

www. aurumgroup.com

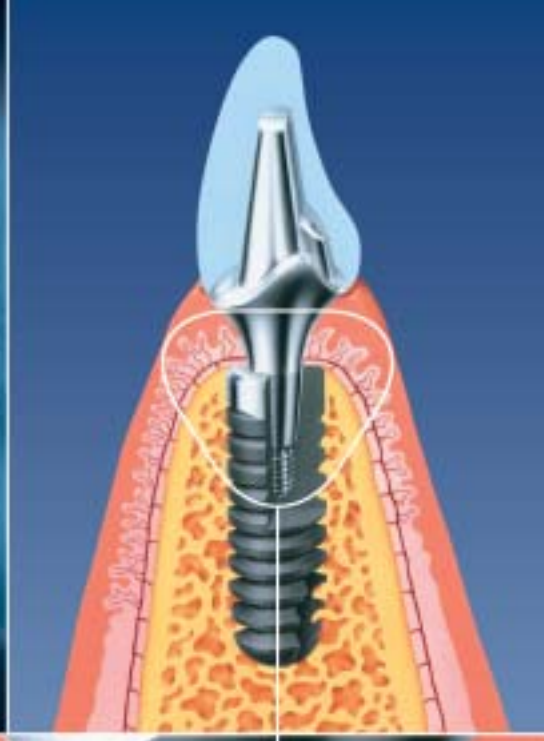
Proud Platinum Sponsor for the 2005 LVI Alumni Gala.

the 5 percent accounting reduction for payment prior to treatment.

Bottom line: Programs offering short-term, interest-free loans can inspire acceptance, but they can also prompt tooth-by-tooth care. Some practices may have a different point of view, but I would strongly recommend that you compare your numbers of diagnosed care versus accepted care, and see if you are prompting small-scale treatment acceptance. You want your business effectiveness to match or exceed the quality of clinical care you provide. In both endeavors, subtlety and finesse are important. Ensure that the value of care always supersedes not only insurance limitations but also your financing programs.

Join Bob Maccario in the Dental Concierge program or the Dental MBA program.

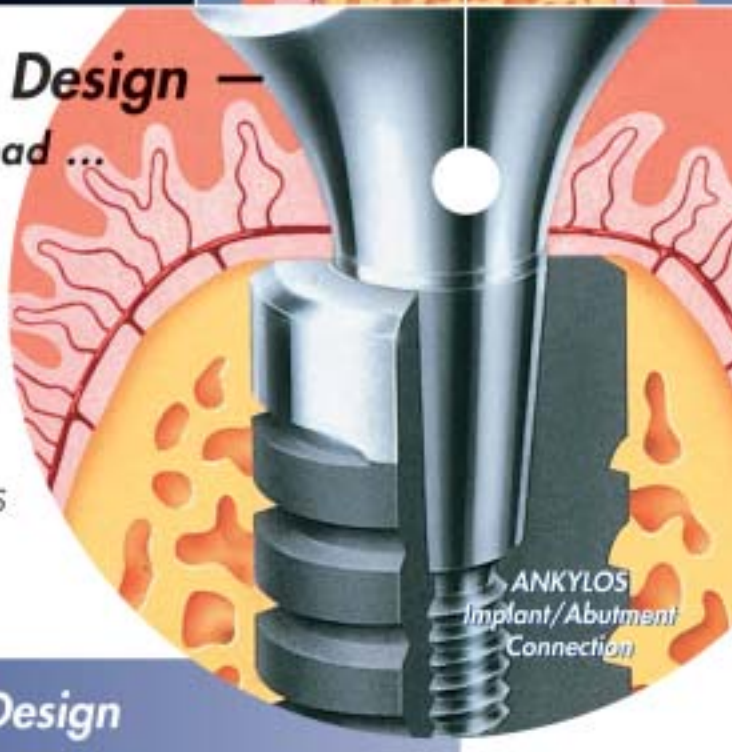
*Mr. Bob Maccario, MBA has 35 plus years background and experience in the dental field. In 1982, Bob graduated from Pepperdine University with a MBA degree. He transitioned his career into practice management and in 1985 opened his own practice management company, Professional Management Sciences, Inc. (PMSI). As a private practice consultant, Bob has evolved a marketing and management program based on proven customer service skills and sound patient financial arrangements. He is a popular and entertaining lecturer on a national basis. Bob teaches the "Dental Concierge - How to Turn Your Patients into Guests" program at LVI.*



# The ANKYLOS® Implant System Design —

## Progress Means Thinking and Moving Ahead ...

*In 1985, Dr. G.H. Nentwig (an Oral Surgeon) and Dr. W. Moser (an Engineer) developed the ANKYLOS Implant System. Their design concept was to combine biology and engineering to create an implant system that would reproduce the prosthetic characteristics of the natural tooth. The ANKYLOS Implant System has been in clinical use since 1987.*




- ••• Conical Connection Design
- ••• Implant Thread Design
- ••• Implant Load Design
- ••• Biological Width Design

***Call DENTSPLY Friadent CeraMed for more information about the ANKYLOS Implant System.***

EVIDENT SUCCESS®

Order No. ML-0565 06Apr05. *All ANKYLOS "Classic Surface" supporting data in JOI Volume 30, Number 3, 2004, and in 510(k)s.

**Distributor North America: DENTSPLY Friadent CeraMed**
Lakewood, CO 80228 • (800) 426-7836 • www.dentsplyfc.com

**Manufacturer: DENTSPLY Friadent GmbH** D-68221 Mannheim/Germany

DENTSPLY
FRIADENT
CERAMED

# Creating & Maintaining

# Beautiful Smiles

## The JP Institute

**Kim Miller, RDH, BS**
Instructor and Senior Consultant with The JP Institute since 1992

**Peggy Sprague, RDH**
Co-Founder of The JP Institute

# AESTHETIC DENTISTRY

*is becoming increasingly popular every day and a new smile comes with new ways to care for it. Just turn on the TV and one can find a variety of "make over" reality television programs featuring smiles that show veneers and other beautiful smile enhancements. Often porcelain veneers, like those produced by LVI doctors, are done so skillfully it may even be challenging for hygienists to detect these quality restorations when patients first arrive in our treatment rooms.*

Proper recare maintenance during hygiene visits should be an important aspect of clinical time management. The dental practice can support the beauty, the durability, and the longevity of porcelain veneers with proper care given in our treatment rooms, and with proper home-care instructions given to the patient. However, the patient must perceive the value of the maintenance interval, and how critical the maintenance system is to their periodontal health, their overall health, and to the investment of their beautiful smile!

This article will review a complete Patient Veneer Care System. Please review the philosophy and patient treatment strategies as a team for continuity, and decide as a group what you feel would work best for your patient base. A great first strategy is to have all team members in agreement regarding your treatment protocols. Written maintenance instructions, accompanied with a compassionate chair-side presentation, can be facilitated by the dental assistant when the veneers are seated. It is important to review your philosophy and protocols with the laboratory you are working with. Exceptional labs, like the ones recommended by LVI, create the art and science of a beautiful smile with you. They can give you new insights on materials, and can be a great asset to successful maintenance support with your patients.

The number one, absolutely critical objective to the supportive maintenance of porcelain veneer restorations is an individualized recare strategy for your patients.

The recare interval should NEVER allow the patient to have bacterial biofilm present long enough to create an inflammatory response. We as clinicians need to take into consideration every variable of the patient's health in order to quantify the proper interval. The following is a list of variables to consider:

1) Current Periodontal Status –
*Is the patient currently periodontally stable?*
2) Current State of Restorations
*Are there any plaque retentive defective margins? (In-complete treatment plans and/or newly defective margins)*
3) Current Co-Therapy Compliance
*Is the patient already compliant with their co-therapy or are they struggling with their daily regime?*
4) Current Immune System Response
*Is the patient's immune system stable, or challenged?*
5) Occlusal Discrepancies
*Is the occlusion a contributing factor to periodontal health?*
6) Current Stress Factors
*Are there are any major stress factors that could effect the immune system response?*
7) Current Health and Medications
*Are there any medications that may be a contributing factor to the periodontal health and the inflammatory response?*
8) Current Nutritional Status and Diet
*Does the patient have a healthy nutrition/diet program?*

The patient has made a significant investment in their new smile. We owe it to our patients to individualize their recare with a well thought out strategic interval to support their periodontal health and the longevity of the veneers. At each and every appointment we perform a risk assessment together with the patient to co-determine an appropriate interval for maintaining health.

The above questions are a list of specific variables that may impact the health of the periodontium. By utilizing a written list and checking off the appropriate variables of concern per individual patient, the patient can truly understand the necessity of the interval for their periodontal health. It is important to communicate the patient's own individual variables with:

1) Visual Documentation of their written variables

2) Visual Brochures that indicate the significance of the immune system response, medications, or any of the periodontal variables.

The visual documentation and review makes a huge impact on the value perceived by the patient. When you take the time to visually review the patient's individual periodontal variables you can significantly decrease the number of cancellations and no shows in hygiene. You also receive a lot less questions as to why insurance does not cover the additional appointments!

A scenario could occur as follows; "Mary, let's take a look together at what we feel would be the best interval for the maintenance of your beautiful new smile." The clinician and the patient would review the written list of

the above variables and discuss which ones were pertinent to shorten the interval. You need to have written documentation that states, "For most adults to stay healthy periodontally they need to be seen between every 12 to 16 weeks"(depending on the current variables some of your patients may need to be seen as soon as 8 to 12 weeks).

The American Academy of Periodontology offers great brochures for credibility and visual demonstration. If you choose to utilize a brochure by the AAP it is important to convey to the patient the sound reliability of AAP research. It would also be valuable for the patient to know that the AAP are specialists in the field of the gum health and jaw bone support. Most patients are aware of the American Dental Association, however, they are unfamiliar with the AAP. Show the patient pictures demonstrating how recession can effect the aesthetics of the veneers. Review with the patient how inflammation will allow the gum tissue to pull away from the cervical margins.

The reward you will receive for co-reviewing the variables with the patient is their true perceived value of their 'Supportive Therapy' interval. The reason why the patient moves away from insurance dictation and will comply to the recommended treatment is because they helped decide the timing of recare intervals, and the importance of the intervals becomes internalized.

Since Dental Hygienists play such a critical role in the maintenance and longevity of today's enhanced smiles, we now need to address the three most common clinical concerns when providing supportive therapy around all porcelain restorations and veneers. First, is it acceptable and safe to use Power Driven Instruments or Ultrasonics near all porcelain margins? Second, how can I proceed with Ultrasonic instrumentation when the patient complains of marginal sensitivity? And third, how frequently and with what products do I polish?

The current standard of care calls for using a combination of ultrasonic instrumentation and hand instrumentation.

State of the Art tunable power driven scalers are not only safe and acceptable around all porcelain restorations, as discussed in this article, they also provide the acoustic turbulence necessary to break up the Biofilm Matrix and bacterial cells. It is important to always follow the use of hand instruments with ultrasonic instrumentation.

When using Power Driven Scalers around all porcelain restorations there are some noteworthy precautions that must be followed. Always use the lowest possible stroke width, which is accomplished by turning the power knob on your unit all the way down, and always use the thinnest insert available to complete the task at hand.

There are many power driven scalers on the market, however not all of them allow the clinician to tune the unit appropriately for use around porcelain margins. You should check with the manufacturer of your unit to determine the parameters. The Dentsply Sustained Performance Scaling (SPS) Unit provides a comfort zone for the patient and allows use of the Slimline inserts at a very small elliptical stroke width while consistently delivering 30k cycles per second to the sulcus or periodontal pocket. If you prefer Piezo technology, the EMS or Satellec Units provide numerous tip selections with a small linear stroke path while still delivering the desired power to accomplish root debridement and Biofilm disruption/ removal. This lower setting keeps the patient much more comfortable and supports increased patient compliance for the use of Ultrasonics during hygiene visits. The small stroke width also decreases the chance of the instrument contacting the 'all porcelain' margin with enough force to cause a chip or break in the porcelain.

***Dental Hygienists play such a critical role in the maintenance and longevity of today's enhanced smiles***

Caution is required however as you enter the sulcus or periodontal pocket. During our workshops and in-office consultations, The JP Institute teaches the following technique:

1) Disengage the instrument by lifting your foot off the rheostat

2) Place the instrument tip in the sulcus or periodontal pocket
3) Engage the instrument staying in the subgingival space
4) Treat the pocket to completion
5) Finish by disengaging the instrument before exiting the subgingival area.

Using this technique will considerably reduce the risk of 'nicking' the porcelain margin. Understanding how the stroke width, inserts and tooth structure interface during Ultrasonic instrumentation as well as implementing the above precautions will greatly reduce the chance of damage to the porcelain margin. A hands-on course to refine your technique is a great contribution to your professional development and patient care.

Clinical data strongly supports using power driven scalers, however, the patients who experience sensitivity during Ultrasonic instrumentation are always a challenge. The solution to this challenge lies in technique, tip selection and power or stroke width (which we discussed above), patient communication, and the application of a desensitizing product. In order for hygienists to perceive value in the use of Ultrasonic Instrumentation they must first understand how the acoustic turbulence created by Ultrasonic Scalers, like water in a blender, can benefit their patients in combination with hand scaling. Often hygienists perceive the use of Power Driven Scalers to be a "time saver" for the clinician, however, once the hygienist understands that use of Ultrasonic technology provides their patients with superior bacterial disruption, their use of the technology increases.

Sensitivity is the number one patient complaint with power driven scalers, therefore, many hygienists avoid using them. Products like Sensodyne Toothpaste include 5% potassium nitrate that desensitizes by depolarizing the nerve fibers and inhibiting the transmission of pain-causing stimuli. The challenge with this method is the patient needs to use the toothpaste for two weeks before they will receive pain control. With Duraphat, Fluoride varnishes form precipitates within the dentinal tubules that block or occlude the open tubule. Oxalates often of potassium mono-oxalate also form precipitates within the opening of the tubule, thus blocking the tubule, such as SuperSeal. Surface sealers or glassionomers, which are usually light-cured, work by sealing the lumen of the tubule.

Polishing all porcelain restorations and veneers is a critical component to helping our patients maintain their beautifully enhanced smiles. To support patient periodontal health, The JP Institute suggests that polishing be done prior to Ultrasonic instrumentation. This allows the clinician an opportunity to flush the subgingival areas leaving them free of polishing paste residue. One of the nation's leading laboratories, MicroDental, has approved the use of Proxyt RDA7 Fine Porcelain Polishing Paste by Ivoclar/Vivadent for use on all porcelain restorations. Even though almost all patients re-care intervals should be more frequent than every 6 months, polishing at least every 6 months with Proxyt to restore luster, to veneers in particular, is highly recommended. Patients who have both porcelain restorations and natural detention should always polish porcelain surfaces first, and then follow with the clinician recommended brand of paste to remove stain from the natural tooth surface.

***As dental professionals we are responsible for patient education regarding periodontal maintenance which supports the longevity of our patients' enhanced smiles.***

As dental professionals we are responsible for patient education regarding periodontal maintenance which supports the longevity of our patients' enhanced smiles. Implementing the techniques and products we have discussed will result in improved patient compliance while adding the importance of the perceived value to your hygiene procedures. To find out more about Continuing Education Courses and Products to enhance your clinical expertise, or to become a JP Certified Hygienist, visit our website at www.jpconsultants.com or call 1-800-946-4944. In the meantime, keep creating and maintaining those Beautiful Healthy Smiles!

*The JP Institute has taught the most advanced clinical protocols, technology, and evidence based science since 1979. The JP curriculum emphasizes team support for comprehensive dentistry. JP specializes in analyzing and refining practice philosophies, strategies and business systems, hands-on implementation of clinical skills, and technology and product integration. Call The JP Institute for a complementary Practice or Career Profile to analyze your professional development, clinical protocols, technology and product integration, management systems, and profit potential.*

**For more information on The JP Institute:**
**1-800-946-4944**
**www.jpconsultants.com**

**Michael Miyasaki DDS, LVIM**

*Dr. Michael Miyasaki is LVI's Vice President of International Operations. A 1987 graduate of USC School of Dentistry, he developed a highly successful reconstruction practice in Sacramento, CA. Following his passion to teach and mentor other dentists, he became associated with LVI in 1996 where he now works full time. Michael practices in the LVI faculty practice, lectures and publishes articles on the latest aesthetic, occlusion and materials available.*

# PRODUCT REVIEWS

## AESTHETIC SOLUTIONS

*This issue will deal with two aesthetic challenges and their simple solutions. The first product, KerrHawe's CompoRoller™ draws on such a simple solution that it will leave you wondering why you didn't see the painting on the wall before. And our second product, AXIS Dental's Achromat and Achromat-HP esthetic fiber post system, offers an aesthetic solution to handle the post and core difficulties of teeth to be restored with aesthetic non-metal restorations.*

# Why Didn't I Think Of That?

*KerrHawe CompoRoller™*

Ever slap yourself on the forehead and say, "Why didn't I think of that?" Here's one of those instances-a dental tool that seems so obvious. When we paint a wall we don't apply it with a flat metal spatula because it would take too long to cover any significant area and it would leave us with a rough surface in need of smoothing. Typically we would use a rolling brush because it offers a broad surface to cover the area more quickly and to spread the paint evenly. Now think about this, how do you apply your composite? We use a flat metal "spatula" or a brush which creates the problems mentioned previously.

So how do you get a paint roller in someone's mouth? Slap your head time. KerrHawe has come up with the CompoRoller™ that works on the same principle as the paint roller. You take a lightweight, ergonomic, two-ended instrument handle and "rollers" made from KerrHawe's proprietary non-stick thermoplastic elastomer material and you are ready to 'paint'. The tips are single-use and disposable that snap onto the ends of the handle and they come in two different shapes-cylindrical and conical. So with one handle you can have one end with the cylindrical shape and the other with the conical.

Time to go to work. With your new instrument in hand you are able to spread your direct resin composite material over a broad surface quickly and easily without pulling and dragging the composite. The CompoRoller's rolling action minimizes the amount of air incorporated into the restorations which should ultimately enhance the physical properties of the restorations. (Direct resins restorations run the risk of having voids incorporated into the material by the patting motion used with spatula-type instruments. Obviously, these voids could ultimately decrease the physical strength of the restoration). Okay, teeth are not all flat surfaces and this explains the two different roller shapes, cylindrical and conical, conical for the large flat areas and conical for the occlusal surface contours. The multiple shapes of these tips allows you to quickly apply the composite in even layers on the different surfaces of the teeth while minimizing the time needed to finish and polish the restorations because the material works with the thixotropic properties of the materials.

Okay, now remove the palm of your hand from your forehead and order a kit-KerrHawe's CompoRoller.

# Achromat and Achromat-HP Esthetic Fiber Post System

Broken teeth and endodontically treated teeth are the aesthetic dentist's nightmare. At LVI we teach techniques to handle the discoloration of the teeth, but what about the post, if one is needed? Posts are used to help retain the final restorations when there is insufficient remaining tooth structure to do so, but use of the metal posts of old created many problems. One is that these posts often caused further discoloration of the core of the tooth which would show through our highly aesthetic and translucent restorations. Another problem with these posts is that would often lead to fracture of the root. A common scenario which plays out in dental offices everyday is the patient who calls saying they have crown that has just come out and they'd like to come into to have it replaced. You look at your schedule and thinking it's just a quick re-cementation tell them to drop by. You know what happens from here. Your patient arrives with crown in hand, post protruding proudly from crown and attached to the post is part of the root. You know you now have to squeeze a much more time consuming procedure into no time in your schedule. Why did this happen you wonder? Think about this, the post was placed within 3-4 mm of the apex of the root where the walls are very thin. Perhaps you thinned the walls further to try to get a wider post in the root. With the everyday forces transferring down through the non-flexing metal post material into the thin apical end of the root it fractures. Another similarity is having an implant fail. No one wants this to happen, but if there was a failure anywhere I'd prefer it to be in the abutment or restoration and not the implant body itself. Another difficulty seen with metal posts is that you have to get a core of some type to attach to it. So you place metal primers and a resin material over the top hoping that the core material attaches to the post and that the core material also blocks out the post's color. Or, in another scenario you have a core cast to the post and now have even more difficulty with the aesthetic color issues. We've discussed the many problems with metal posts and here is a solution.

AXIS Dental Corporation has their Achromat and Achromat-HP Esthetic Posts. Achromatic means it's neutral with no hue. These are posts made of glass resin fibers with incredible strength. So you have a post that is aesthetic and tooth-colored and works great under our translucent aesthetic restorations. These posts are bonded to the tooth and root not cemented meaning extra retention. Being non-metal their elastic modulus is very similar to dentin to prevent the root fractures I mentioned earlier, and being non-metal they cannot corrode like metal posts. When it comes to diagnostic radiography, though they are metal-free, they are still radiopaque. A nice feature of the Achromat-HP post with the retentive "arrowhead" design is that you can countersink the post into the coronal portion of the tooth creating a more retentive post and providing better force distribution. And, finally, they are designed so that the core material placed on them bonds to their serrated and machined surfaces.

Take at look at these products. After you do I'd love to hear your comments. Your suggestions always are welcome-please send them to me at: **mmiyasaki@lvilive.com**

# *Noritake* Introduces

# CZR ERABIEN PRESS LF

## *Now you can do it all*

### Single Unit CZR Press - Stand Alone

Cutback with Internal Staining

Low Fusing Layering with Noritake's CZR LF

Finished Restoration

### 3-Unit Anterior with CZR Press to Zirconia

**CZR PRESS LF:** "Now you can do it all…" One of the greatest challenges facing ceramists today is that of combination cases, where veneers, crowns and long-span bridges are prescribed. Because restorative materials vary in composition, attaining a uniform appearance in the mouth is nearly impossible- that is… until now! Because CZR PRESS LF is indicated for esthetic layering of all types of restorations, it assures a uniform optical refractive index and consequently allows the ceramist to focus on color, contour, occlusion, surface detail and overall esthetics, rather than wasting his craft on disguising the use of different restorative materials.

- CZR PRESS LF is indicated for layering CZR PRESS all-ceramic inlays, onlays, veneers & full crowns, as well as *CZR PRESS-to-Zirconia* crowns, bridges, inlay bridges & implant restorations.
- CZR PRESS LF's lower fusing temperature (850° C) affords greater stability with repeated firings when layering CZR PRESS all-ceramic & *CZR PRESS-to-Zirconia* restorations.
- CZR PRESS LF consists of 15 powders, which include: 3 basic enamels, 4 translucent enamels and 8 opalescent "Luster" overlays.
- One material for many restorative options means predictable esthetic results!

***Exclusively Available from***

**DARBY® DENTAL LAB SUPPLY CO., INC.**
*A Darby Group Company*

| | |
|---|---|
| • NEW YORK | call: 1-800-826-6050 |
| • COLORADO | call: 1-800-828-3393 |
| • GEORGIA | call: 1-800-354-5227 |
| • MISSOURI | call: 1-800-247-2385 |
| • NEVADA | call: 1-800-423-1877 |
| • TEXAS | call: 1-800-539-1038 |
| • TECHNICAL ASSISTANCE | call: 1-888-866-3990 |

**www.darbylab.com**

# Meta

## A dream of dentistry

It was always my dream to become a dentist. In fact according to my mother, it was something I started talking about when I was 6 years old.

In 1983 my dream became a reality when I accepted a position in a traditional family solo practice. The practice included a total of four treatment rooms and three other staff members. For the first four years, I operated out of one treatment room with an assistant, practicing the standard 4-handed dentistry I had mastered in dental school. I also performed my own hygiene until 1987 when I hired my first hygienist. It was "one tooth dentistry" at its best.

Initially, we accepted traditional forms of insurance, filed it for the patient, and waited for reimbursement before billing the patient for the remaining balance. As the popularity of HMOs grew, I became drawn to the promise of large patient rosters and generous reimbursements. This resulted in rapid changes in the way I had to practice. We had gone from the slow, steady growth of a traditional family practice to huge increases in the patient base.

**Chong Lee**

In 1987, we enlarged the office space by adding three additional treatment rooms as well as tripling the size of the front office and reception areas. My hygienist used one of the treatment rooms and I used the other three. Due to the drastic increase in patient numbers, I was forced to change the way I treated my patients.

First, I found myself treating patients based on what a patient's coverage would allow, treating one tooth at a time and reducing appointment times in order to accommodate all of the patients. My hygienist began working with an assistant and seeing patients every 20 minutes for the same reason. We became so busy we rarely stopped for a lunch break. At the time, I thought this was the mark of a successful and lucrative practice.

# morphosis

**meta•mor•pho•sis n. change of shape, substance, character, or transformation**

## The one-stop, corporate style practice

As time passed, my partner and I were ready to expand again. The trend in dentistry at that time was to build large "corporate-like" practices, include on-site specialists, and offer "one-stop" dentistry. In 1993, we took on another general dentist and expanded the office space from seven to nine treatment rooms. We also hired a part-time pediatric dentist, an oral surgeon, and a periodontist. I thought I was at the pinnacle of my career. On an average day, I might have treated 20 to 25 patients for anything from a one surface amalgam to a three-unit PFM bridge in addition to checking 25 to 35 hygiene patients. There was no shortage of work if we were willing to work hard, and we were.

I also began working toward my AGD fellowship. I have always been driven to learn the latest techniques and to use the most current equipment and materials. Our practice grew, and for the next five years, we made few changes in staffing or office size. In 1999, we expanded the number of treatment rooms to twelve and constructed a much larger front desk area.

LVI graduates are familiar with the quote, "you don't know what you don't know" and at this point I was beginning to know that there were better ways of practicing. I could not ignore the voice in my head any longer and decided to pursue my ambition of attending LVI.

## The LVI journey begins

After 19 years in a successful, large, traditional family practice, the original practitioner and I decided to go our separate ways. This left me and the other remaining dentist together, as he also wanted to become involved in the LVI program. Initially, the split seemed like somewhat of a setback. After all, the theory ingrained in me from dental school was that a bigger, faster, "get 'em in get 'em out" style of dentistry was the mark of success.

We divided the physical space, so with two dentists and one hygienist we had a total of six treatment rooms. With the encouragement of my family and staff members, I immediately signed up for my first LVI class in the spring of 2002, Advanced Anterior Aesthetics. I had been doing veneers for years and thought my skill level ranked among the best. At LVI, I saw what was truly possible and my approach to dentistry was forever changed.

I met John Levitka of Dental Ceramics at this course and now have a true appreciation for the importance of a good lab relationship. John and his techs listen to me, understand my style, and have consistently delivered exceptionally beautiful restorations.

*And best of all, the experience of working at this exceptional new office is an overwhelmingly positive one. There is nothing like doing work you are proud of and the emotions associated with the transformation of our patients' smiles make it all the more meaningful.*

If you want a good example of what I'm talking about, ask my hygienist. She was very happy with the veneers I had created for her 12 years earlier and it was only after three months of me harassing her that she finally agreed to let me change them. She still says that of all the things I've tried to talk her into or out of, this was the best decision she ever made.

My partner, Dr. Joseph Oh, began his LVI journey in 2003 as I continued to sign up and take as many classes as I could. Soon, we began taking our team with us to LVI. Before we knew it, the entire scope and focus of our practice had changed. We began treating our patients much more comprehensively, evaluating their entire oral anatomy at each visit rather than on a tooth by tooth basis. This enabled us to reduce the number of patients treated in a day and allowed us to increase the length of each appointment, thus providing better care. That one change immediately eliminated a great deal of stress for everyone and our production skyrocketed.

## Evolving my vision

With each successive LVI course I completed, my vision for dentistry and my practice grew. To this day, I feel blessed to be able to offer my patients something far better than status quo dentistry. I know from their letters and comments that they appreciate it. My partners and I are excited about introducing the latest techniques and materials to our patients and there is nothing more rewarding than watching the way their confidence and self-esteem is elevated by the beautiful aesthetic restorations we create for them. Transforming smiles truly can transform lives.

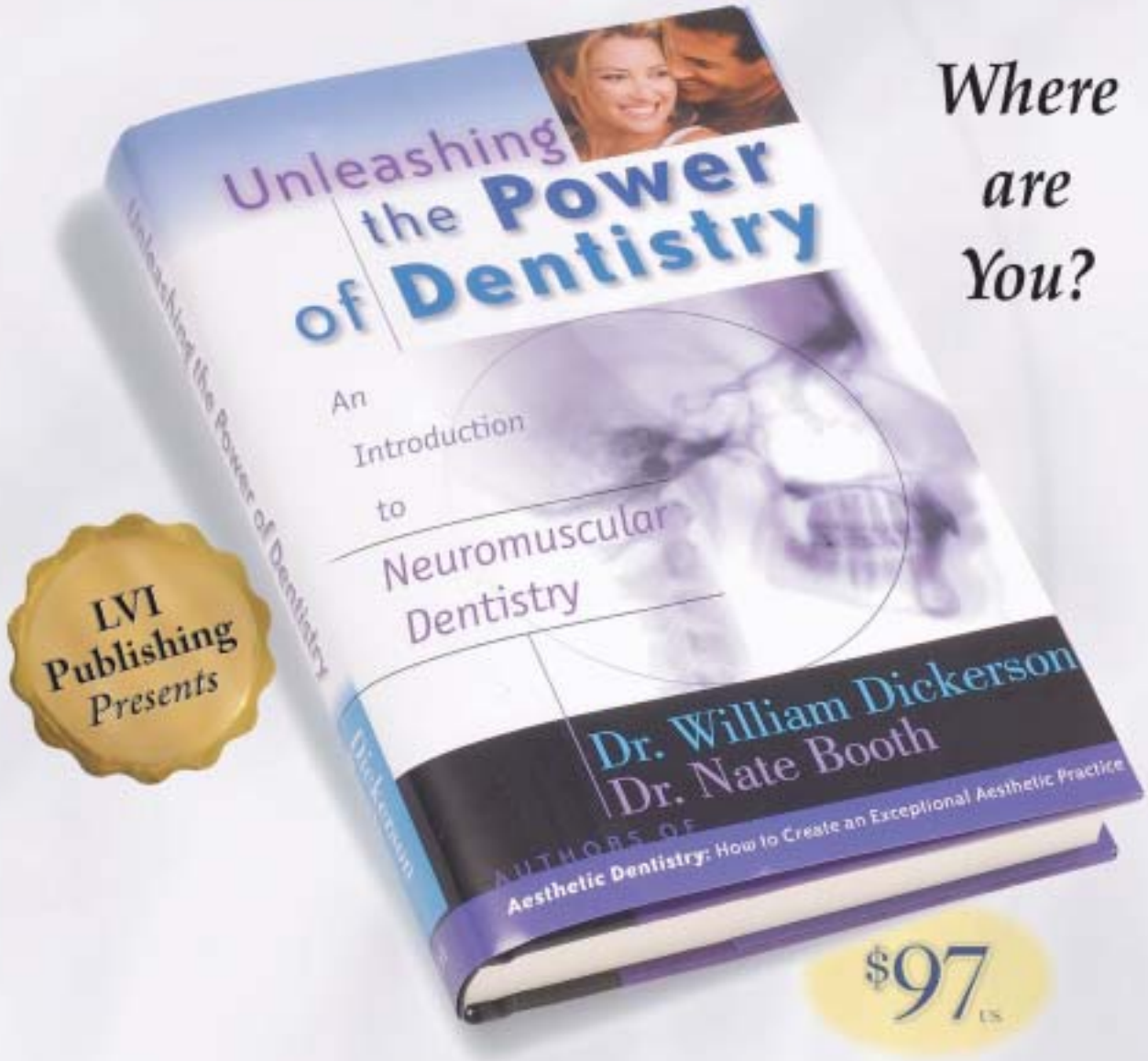
## The determination to succeed

Having finally discovered a style of dentistry I could completely believe in, I was determined to bring this level of care one step further. In August of 2003, we were pleased to open a second office designed in the LVI fashion. Fortunately, we were able to implement the LVI strategies and techniques from day one. I had Bob Maccario come to my office and teach the teams from both locations how to raise our patient's expectations of what dentistry should offer. I started working with GPM to develop my brand and my marketing. I'm proud to say that we significantly exceeded our practice goals for both the first and second year.

And best of all, the experience of working at this exceptional new office is an overwhelmingly positive one. There is nothing like doing work you are proud of and the emotions associated with the transformation of our patients' smiles make it all the more meaningful. Meanwhile, we continue

*Continued on Page 70*

# THE FUTURE OF DENTISTRY IS HERE.




## *Where are You?*

- *Why are so many dentists adopting the neuromuscular approach to dentistry?*
- *Why are those that are skeptical being convinced of its value?*
- *Why are many so successful in implementing these concepts into their practice?*
- *Why is case acceptance higher with neuromuscular dentists?*

It's all here in this comprehensive book on this fascinating subject. ***Unleashing the Power of Dentistry: An Introduction to Neuromuscular Dentistry*** by Drs. Bill Dickerson and Nate Booth can show you how to enhance patient care as well as increase your practice success and professional fulfillment through the practice of neuromuscular dentistry.

This amazing book:

- introduces the basics of neuromuscular dentistry
- uncovers the myths surrounding the science
- features 16 success stories of neuromuscular practices told by the dentists themselves
- shares marketing and case acceptance secrets
- shows you how to implement change in your practice

**Order your copy today** - call **888-584-3237** or visit our web site **www.lvilive.com**


As a doctor offering high-end elective dental services, you understand the value of appearance. After all, you've made it your profession. ***So have we.***

From complete marketing plans and advertising campaigns to logos, brochures and websites, GPM offers the custom services you need to create an engaging practice identity and position yourself as the doctor of choice in your market.

Enhance your image. Distinguish yourself from the competition. Make an impact on your market and your bottom line. Call GPM today.

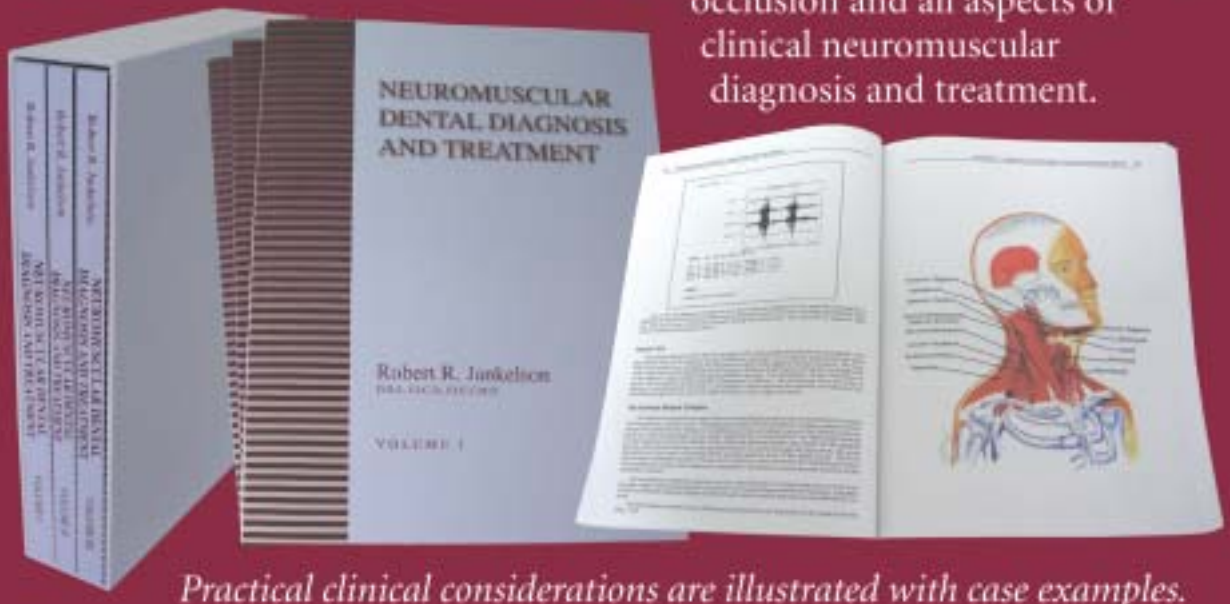
GPM
Golden Proportions Marketing
1.866.590.4GPM (4476)
www.goldenproportions.com

BRAND DEVELOPMENT · CREATIVE SERVICES · CUSTOM PHOTOGRAPHY · MEDIA MANAGEMENT

# THE REFERENCE BOOK THAT NO DENTIST SHOULD BE WITHOUT.

The definitive textbook of neuromuscular principles in dentistry. Newly updated by the author, it is now available in a 736 page, three-volume boxed set with most illustrations in full color.

The role of muscles and joints in occlusion is significant in every major dental procedure. This book covers the rationale of neuromuscular occlusion and all aspects of clinical neuromuscular diagnosis and treatment.




*Practical clinical considerations are illustrated with case examples.*

## *Topics include Neuromuscular Treatment for:*

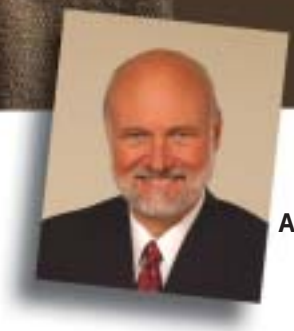
- Aesthetic Reconstruction
- TMD: Diagnosis and Treatment
- Coronoplasty
- Dentures
- Orthodontics

MYOTRONICS
*Helping Build the Perfect Bite*
SINCE 1966

**Available from Myotronics.**
**Call 800-426-0316 or visit our website at www.myotronics.com.**

# FILE BREAKAGE IN ENDO

## PREVENTION IS THE BEST MEDICINE



**Arthur "Kit" Weathers, Jr. DDS**

*I just hung up the phone after talking with a dentist who was very concerned about file breakage. He had broken seven rotary files in the past three years, and he wanted to know if that number was excessive.*

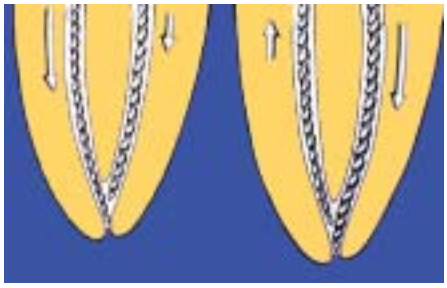
I suggested that most of the files he had broken were probably in the mesial roots of lower molars; they were most likely not the first files used in the canals and most, if not all, of the teeth were probably still functioning asymptomatically.

"Are you psychic?" he asked. "The last file I separated was in tooth #19, and most of the others were also in lower first molars. And all of the teeth are still functioning normally." I'm not psychic, I replied, but I did have an uncle who was both psychic and telepathic, so we called him a psychopath.

I was kidding of course, but the conditions that routinely lead to file breakage are so predictable, I often appear to be a mind reader when I quickly diagnose them over the phone.

This doctor's questions reminded me that now might be a good time to review the most common reasons for the un-timely separation of rotary files. The following suggestions apply to all rotary-filing techniques:

### Beware the mesial roots of lower molars



Any time two canals join; the possibility of file separation is increased. This situation occurs almost half the time in the mesial roots of lower first and second molars, and these teeth represent the most likely sites of file breakage. (Mesio-buccal roots of maxillary molars and lower anteriors containing two canals can also be candidates for file separation.)

Fortunately, awareness of why these teeth are more prone to "grab" and hang onto file tips makes avoiding problems relatively easy.

First, we must determine if the two canals join, and at what level they come together. Insert a hand file to working length in each canal. If the canals join, only one of the files will go to length at a time. If one of the files stops short, withdraw the second file that is blocking the juncture, and the first file should go to length.

Preparing the straighter of the two canals usually presents no problem, but if the file in the second canal is

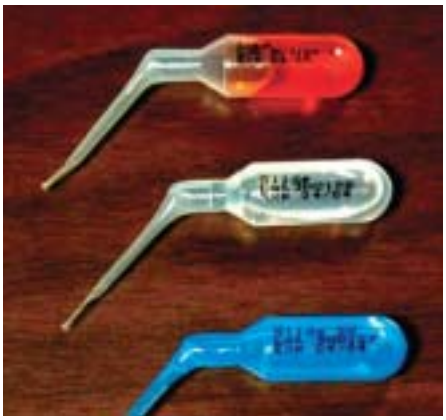
deflected around the turn, it can bind as you force it to length. Don't do that!

Once you have determined where the canals join, prepare the straighter of the two canals (usually the mesiolingual) to length, and don't go beyond the junction in the other canal. Incidentally, two canals with a common apex can occur in the distal roots of lower molars, so be aware of that possibility.

## Inadequate lubrication

All rotary instruments cut easier in the presence of lubrication. Just ask any machinist about the importance of flooding the cutting area with oil when drilling through metal.


I inject KY jelly in the pulp chamber to lubricate rotary files as they are inserted in the canals. You can also use RC Prep, Glide or other such lubricants, but KY jelly is inexpensive, contains chlorhexidine gluconate as it's main active ingredient, and is water soluble, so it flushes easily from the canal.



This article is about preventing file breakage so I've only mentioned lubrication. In a future article, I will discuss the importance irrigation, dissolving tissue with solutions such as sodium hypochlorite and removing the smear layer with materials such as EDTA.

## Proper handpiece selection

Please do not attempt to use rotary files in a slow-speed handpiece, simply "backing off" the rheostat. Speed fluctuations can be very hard on rotary nickel titanium files. For years, I used a 20,000-rpm air-driven slowspeed combined with a 64:1 reduction angle to achieve approximately 300 rpm. The trick was always to run the handpiece at maximum speed. Now, I use an electric handpiece, which is quieter, lighter and better balanced with a more precise adjustable speed control. Best of all, this handpiece costs very little more than the air driven. The only drawback to the electric handpiece is the separate foot switch.

I do not use a torque control handpiece at this time, but as this technology improves, I may add that feature to my armamentarium. The current generation of torque controlled handpieces do not have enough settings to account for every size, shape and design of rotary file, and even if they did, adequate studies have not been done to determine the amount of stress that can safely be applied to each and every file.

While we are discussing handpieces, don't overlook the importance of using a sonic or ultrasonic handpiece for increased irrigation efficiency, and even more importantly, reduced stress on your rotary files.

I firmly believe that every dentist should use a sonic handpiece in conjunction with rotary nickel titanium preparation. Whenever your rotary file does not easily go to place, use a #15 sonic file (I like Shaper Sonic or Rispi-Sonic files from Medidenta) to loosen things up and prevent stressing rotary instruments.

## Keep things moving

Rotary files are designed to drill a precise-sized hole, and continuing to go in and out after they have reached apical length is counterproductive. Make certain the file is rotating as you enter the canal, slowly advance a millimeter at a time, and as soon as you reach the working length, withdraw and proceed with the next size file.

## Good access is essential

If you obtain unimpeded access into the canals, you will greatly simplify your canal preparation. Good access means you can close one eye and see all of the canals without having to move your head or the dental mirror.

If you use a crown-down approach and eliminate undercuts, preparation will be a breeze.

## Let the files do the work

How much apical pressure can be safely applied to rotary files? A good rule of thumb is to push no harder than it takes to cut the first millimeter. If you get to a point that you must press harder, go to the next size file. Light pressure is the watchword. Let the files do the work as you slowly advance to the working length

## Discard files frequently

Finally, do not over-stress rotary instruments! Rotating an instrument in a curved canal has the same effect as repeatedly bending a coat hanger back and forth – in both cases the metal will eventually break. The coat hanger will break sooner, but you can dramatically reduce the possibility of separating rotary endo files by following the manufacturer's recommendation to use each instrument only one time.

Definitely throw rotary files out after a single use if you observe any unwinding of the file flutes. (Unwinding is sometimes preceded by a slight "clicking" or chattering of the file as the tip repeatedly gets stuck and breaks free, and you should stop and carefully inspect the file if you hear that noise.)

If the file has received minimal stress, many dentists elect to re-use rotary instruments, but if you do so, please do not use them on more than four or five canals (not teeth) to prevent dulling and weakening that may lead to breakage.

If you follow the rules outlined in this article, you don't have to be a mind reader to realize that you may never have to worry about file breakage again.


**ARTHUR "KIT" WEATHERS, JR. DDS**

For more than thirty years, Dr. Kit Weathers has lectured and published papers on technologies, products and processes designed to simplify the practice of endodontics. Dr. Weathers pioneered a simplified system of nickel titanium files to enhance patient comfort with a one visit endodontic procedure. His popular Endo Root Camps, presented at L.V.I. and the C.E. Magic! multi-media learning center in Griffin, Georgia, offer multi-day hands-on training to improve dental techniques while explaining the theory of "Endonomics," the economics of endodontic case management.

Dr. Weathers can be contacted at
770-227-3636,
or by e-mail, at
drkit@ce-magic.com.
You can also visit his website at
www.CE-Magic.com.

LVI GLOBAL

CHANGING DENTISTRY. CHANGING LIVES.

# LVIlase™

## Taking Your Practice To The Next Level!

***Cost effective, lightweight and easy to use.***

*The LVIlase™ features a fiber spool to allow for fiber management as well as easy removal for sterilization.*

*No more cart. Unplug and off you go, lightweight and portable makes the inconvenience of moving from room to room a thing of the past. The touch screen is enhanced to allow for visibility from any angle and in any lighting.*

*The LVIlase™ diode soft tissue laser is ideal for tissue sculpting, treating periodontal disease and eliminating the need to pack cord!*

*Achieve an instant return on your investment while realizing a higher level of care for your patients.*

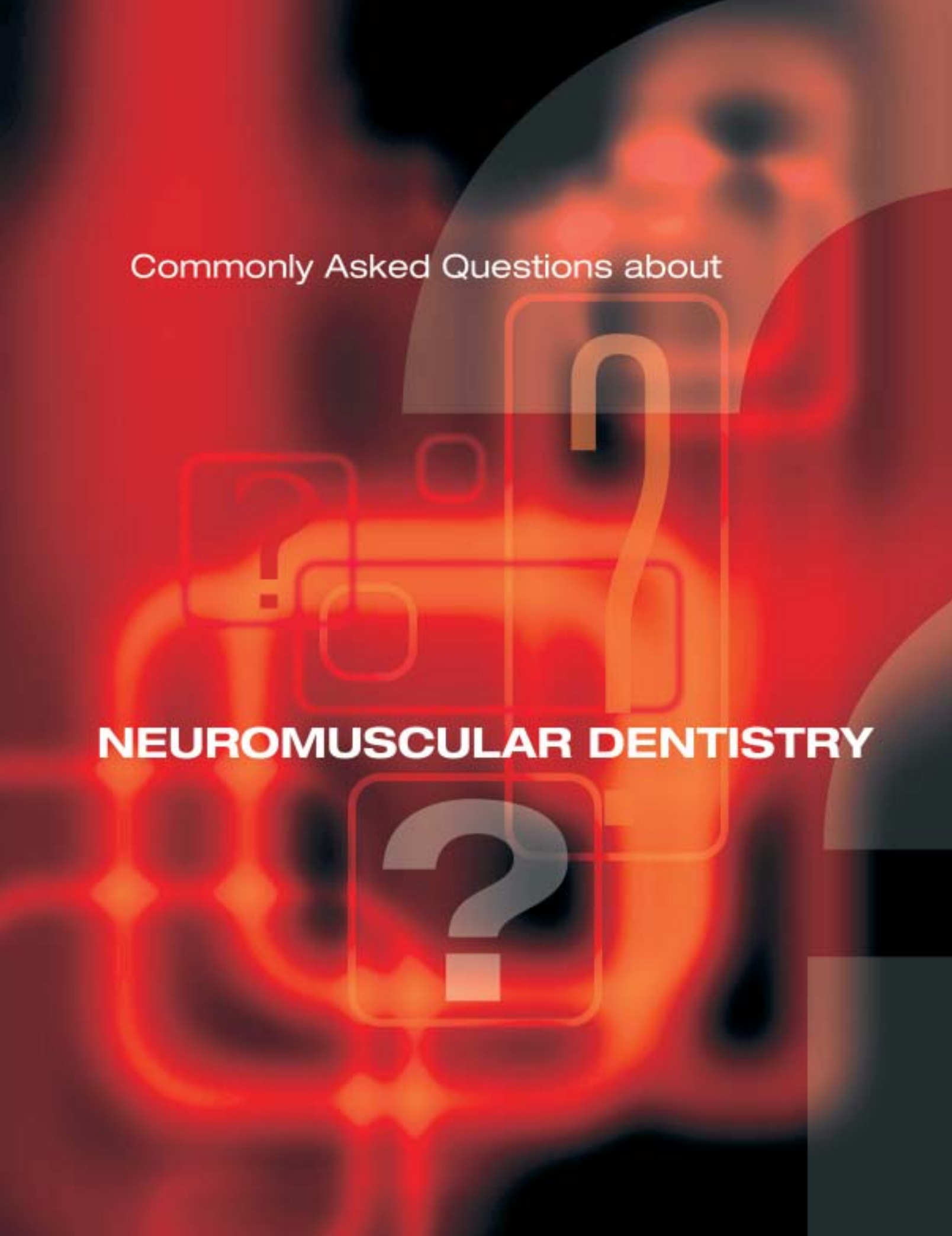
**$9,995**


## LVI Visions Special!

*Order today and receive $500 off the one and one-half day Laser Certification Course!**

** Sept. 19-20, Nov. 14-15*

*Contact Jane Shewman with LVI Global at (888)584-3237, x 235 or lvilase@lviglobal.com*


Commonly Asked Questions about
NEUROMUSCULAR DENTISTRY

*Anger is the most impotent of passions.*
*It affects nothing it goes about,*
*and hurts the one who is possessed by it*
*more than the one against whom it is directed.*

LORD CLARENDON

Why are so many people so defensive and adamant that their view of dentistry is the right one? Why are experts in the same field of dentistry disagreeing with each other? Who's right and who's wrong?

I've been surprised by the visceral reaction of some dentists to others' opinions in the area of occlusion. The anger generated in some dentists is incomprehensible. People have been threatened because of their contrary beliefs. Friendships have been destroyed, all because someone believes differently than they do. So what? Why does everyone think they are so right, and everyone who disagrees with them is so wrong?

## The Story of the Elephant

I believe the answer can be found in the elephant story. Here's how it goes. Six blind people who had never seen an elephant were asked to describe it after they felt it. The first one felt the tusk and said, "This animal is very much like a saber – long, hard and pointed."

The second person felt the trunk and said, "This animal is like a snake – long, pliable and blunt on the end."

The third felt the ear and said, "This animal is like a fan – flat and big."

The fourth felt the leg and said, "This animal is like a big tree – round and thick."

The fifth felt the side of the body and said, "This animal is like a wall – wide, flat and tall."

The sixth felt the tail and said, "This animal is like a rope — thin and long."

After each had felt the elephant, the six blind people got together and shared their descriptions. They couldn't agree on anything. It was like they had collected evidence on six completely different animals. They proceeded to argue, each calling the others stupid and misinformed. They were all so sure their description of the elephant was the right one. Unfortunately, because they were blind, they couldn't see the whole elephant.

The same thing happens all the time in dentistry. One person, or one group of people, is informationally blind and doesn't see the whole picture, only the part they have personally "felt." They only know their section of the animal, but they're certain they are right because they have felt the beast with their own two hands. I believe people who criticize NMD do so because they have tunnel vision and haven't seen the whole picture. They only see and collect evidence that fits in their picture and overlook the rest. This reinforces their limiting beliefs and makes them even more rigid.

## Your Questions Answered

The purpose of this article is not to discredit those who have different views. The purpose is to answer some of the questions dentists have about Neuromuscular Dentistry (NMD) – to take the next step in explaining our view of the elephant. Here are the seven most commonly-asked questions about NMD.

**Question #1:**

***What are the basic differences between the gnathologic approach to occlusion and the neuromuscular approach?***

**Answer:**

Gnathology is the first and oldest occlusal philosophy. Gnathology is based on the belief that the temporomandibular (TMJ) joints hinge on an axis of rotation in the glenoid fossa of the skull. All occlusion is guided and brought together in a finely tuned order, determined by the axis of jaw joint rotation. The emphasis is on occlusion and joint position. In gnathology, ideal occlusion is called centric relation (CR).

The neuromuscular approach is based on the understanding that the temperomandibular joints are in a physiologic resting position based on the guidance of muscles and stabilized by the occlusion of upper and lower teeth.

In a nutshell, gnathology says that the most comfortable position of the mandible is determined by joint anatomy. The neuromuscular approach says the most comfortable position is determined by muscles.

**Question #2:**

***I've always put my patients into centric relation. Why doesn't NMD do that?***

**ANSWER:**

Of all the joints in the body, the most complex is the TMJ. It's complex for four reasons.

1. There are two joints controlling one bone, the mandible.
2. To accomplish its many functions, the TMJ has a vertical and horizontal rotation and a translatory motion.
3. It is the only joint that has a hard stop: the dentition.
4. The TMJ can be very adaptable to a poor occlusion. But sometimes, if the joint has to make structural accommodations to adapt to a malocclusion for too long, it can cause pathological conditions in the face, neck, shoulders, head, back and spinal column.

Here's how the above relates to centric relation (CR). The concept of CR has been a cornerstone of dentistry for more than one hundred years. Dentistry began using CR to align the jaws for denture construction. The retruded mandibular position in CR served as a reliable method for obtaining reproducible occlusal records in edentulous mouths since there were no teeth to dictate a bite. The retruded mandibular position concept was later adopted for patients with teeth. Early dentists considered CR a physiologic starting point. Patients whose centric occlusion (CO) coincided with the retruded mandibular position (CR) were said to be in the terminal hinge position. This was thought to be the most desirable position for the mandible. The assumptions that CO should equal CR and that each person's CR is genetically predetermined have historically been considered facts. As a result, all diagnosis and treatment was based on these two assumptions.

I believe that the concept of CR as the ideal position for the mandible is not valid for two reasons. First, just because something is reproducible doesn't make it comfortable or right. I could take your left arm and twist it behind your back as hard as I can ten times and the arm will end up in the same position. That doesn't make the position right, and it certainly doesn't make it comfortable. Second, very few people who are restored in CR stay in that position. The mandible will always search for its most comfortable position.

***A prudent question is one-half of wisdom.***

FRANCIS BACON

**Question #3:**

***If you typically don't reposition the mandible posteriorly, do you ever reposition it anteriorly?***

**Answer:**

Sometimes. To prove a point, do the following exercise. Relax your mandible; just let it hang in the most relaxed and comfortable position. Now, forgetting about your normal occlusion, imagine you have a helium-filled balloon attached to your chin. The balloon is naturally lifting your jaw. Where did you hit first? Most people hit in the anterior. What does this tell you about your most comfortable resting position and most comfortable and natural occlusion? Many people's bites lock the mandible into a position that is posterior to its most comfortable and natural position. This is one reason many people wear the heck out of their anteriors.

Here's another revealing piece of evidence. Have you ever fallen asleep in an upright position? As your muscles relaxed, your jaw moved down and forward, right?

Remember this. *Teeth dominate. Muscles and joints accommodate.* It's the accommodation of joints and muscles to the wrong bite that cause many of the problems you see in your office everyday.

As a general dentist, I look at the entire stomatognathic system – the muscles, nerves, joints and teeth. The biology, physiology and anatomy you learned in the first two years of dental school do apply to what you do everyday. It's just that conventional dentistry forgets about muscles completely and pays very little attention to the joints. Teeth are the main, and sometimes only, focus.

*Teeth dominate.*

*Muscles and joints accommodate.*

**Question #4:**

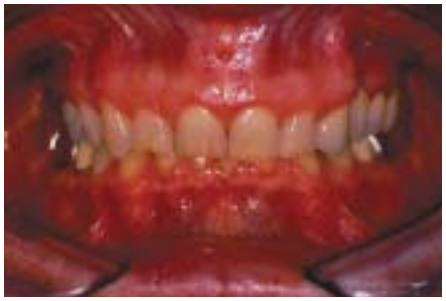
I was taught never to open patients vertically, and that if you did, they will always return to their original vertical. With NMD, you sometimes open vertical. Why doesn't it relapse?

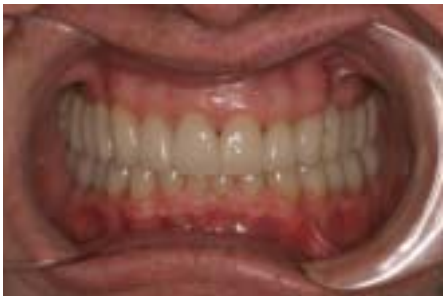
**Answer:**

Conventional thinking says the vertical dimension is established by the muscles' repetitive working length balanced by the eruption of the teeth. Thus, the vertical dimension is relatively fixed. It's believed that any attempts to increase the vertical dimension with the teeth would reverse over time by the muscles going back to their previously established muscle length. This is typically a more closed position, which means the bone or teeth would have to accommodate.

With NMD, we establish our treatment vertical dimension according to the optimal physiologic muscle length. So, yes, if the vertical was over-opened, even with NMD there could be intrusion. This would occur because we exceeded the physiologic parameters set forth by the muscles. But establishing the correct NMD vertical position, which is determined by the correct physiologic vertical muscle length, means the vertical dimension will be stable for years to come.

Increasing the vertical also lengthens the patients' lower faces. It's like an instant face lift. Take a look at the before and after photos on the next page to see what I mean.





To propose that you should never open the bite is pure nonsense. Orthodontists open bites every day. Tell them it can't be done! I'm sure you've opened the bites on some of your full denture patients. Didn't they look better and chew more efficiently?

**Question #5:**

I need an occlusal technique that's reproducible. With NMD, how can you consistently measure mandibular position?

**Answer:**

One of the problems with locating a repeatable mandibular position with methods where dentists manipulate the mandible is human error. It's impossible to perform the procedure the same every time. Inconsistencies will result when the pressure applied during manipulation is harder with the left hand or the right hand or if the overall pressure varies.

In NMD, we use a TENS unit to eliminate the inconsistencies described above. With TENSing, the patient's muscles are relaxed and his muscle engrams are erased. When TENSed, the lowest position of the patient's mandible is the physiologic rest point. When closed, the mandible travels along its proper anterior–posterior trajectory established by the relaxed muscles to the proper physiologic bite position. In this position, we inject a bite registration material between the teeth to capture this relationship between the maxilla and mandible. Then a mandibular repositioning device is fabricated.

This is the initial bite relationship, not the final one. With a mandibular repositioning device in place, the muscles will continue to relax and any inflammation in the joints will begin to resolve. As this healing occurs, the mandible finds a new physiologic home and the mandibular repositioning device is adjusted accordingly. There will come a point when the changes needed in the mandibular repositioning device will become negligible, and the patient will report being completely comfortable. Once this state is attained, this final bite relationship is transferred to a set of mounted diagnostic casts. Now, the final treatment plan is developed. The mandibular position is repeatable, as it has been established by the healthy muscles.

**Question #6:**

I have a fair amount of breakage with my restorations. I would do more comprehensive cases if this didn't happen. Can NMD help me?

**Answer:**

In a word, yes. Happy muscles that move the mandible from a comfortable resting position along the correct path of closure to ideal occlusion don't break teeth. Patients who have happy muscles have no reason to brux.

Teeth contact each other primarily during chewing and swallowing. When you look at the wear patterns on the upper and lower anteriors of your patients, ask yourself these questions: (1) Where did the mandible have to position itself for this wear to occur? (2) How many thousands of times did the mandible move to that position to cause the wear on the enamel, the hardest tissue in the body? (Hint: you swallow 2000 to 3000 times a day.) Most anterior wear cases are overclosed vertically, which pushes the mandible posteriorly. The mandible would prefer to be down and forward. When it's not in the position it wants to be, the muscles aren't happy. The unhappy muscles break restorations in an effort to achieve a more relaxed mandibular resting position. With NMD

- happy muscles are the starting point for creating an ideal occlusion;
- muscle tension can be measured so you know you've accurately found the happy muscle position; and
- the path of closure is precisely created so the teeth occlude properly.

In traditional occlusion theories, the position of the condyle in the

LVE

# las vegas **esthetics**

LVE has achieved the perfect blend of art, science and service.

**Experience perfection.**

**before**

**after** (Empress®)

"This case is one example of the advantages of partnering with LVE—my patients and I get superior products in both function and esthetics and, equally important, I appreciate the personalized service. With the combination of the knowledgeable LVE team and my extensive LVI training, I am confident that I can continue to provide my patients with the highest quality, state-of-the-art dentistry."

Steven A. Stec, DDS PC
Grand Island, NE | LVI Preferred Dentist

Providing LVI extensive lab support for 8 years.

**Request us when registering for your next lab-supported course.**

**LVE's Services:**

**Composites**: BelleGlass/Cristobal/Concept/Sinfony/Sculpture/Gradia/Tescera • **Cercon** • **Diagnostic Wax-ups** • **Empress/Eris/Empress Esthetics** • **Full-Mouth Reconstruction** • **Gold Inlays/Onlays/Crowns** • **Implants** • **Orthotics**: LVI Fixed and Removable • **Porcelain Fused to Metal** • **Press 2 Zirconia**

**Contact us:**

Ray A. Foster | President/CEO
2545 West Cheyenne Avenue
Las Vegas, NV 89032 | 800.711.6011
www.**lvesthetics**.com

fossa is all-important. The muscles are forgotten, and unhappy muscles wear teeth and break restorations. It's not nice to fool Mother Nature. She has ways of getting back at you.

**Question #7:**

I hear that dentists who practice NMD only do full mouth reconstructions. Is that true?

**Answer (by Dr. Bill Dickerson):**

Absolutely not. One of the primary NMD tenets is to "leave the hand piece in the holster" until you have identified the cause of a problem and the proper treatment to eliminate it. Full mouth reconstruction is one of many treatment choices. The other choices are doing nothing (not every problem requires an intervention), coronoplasty, neuromuscular orthodontics, single restorations, and one arch restoration.

It all begins with proper diagnosis. To arrive at a proper diagnosis, you need to spend the time to gather information. You need to ask your patients what their concerns are and if they are experiencing any discomfort of the muscles, joints, teeth, and any other areas they may not attribute to their bite. Examples are pressure behind the eyes, ringing of the ears, vertigo, headaches and neck aches.

In addition, you need to assess your patients' periodontal health, their restorative needs, and soft tissue health. Look for conditions such as scalloping on the lateral border of the tongue, which may indicate insufficient space for the tongue leading to forward positioning of the tongue. Look for patterns of occlusal wear, aberrant tooth loss, and rotating or tipping of the teeth. Examine the joints. Pay attention to clicking, popping, and limited opening. It's exciting to know that the more you learn, the more you see. Be an astute clinician who combines knowledge, experience and education to develop the proper diagnosis.

For each patient you will have one diagnosis but different treatment options. If you diagnose that the patient's mandible is not in its ideal position, you may select from a number of possible solutions. You may have the patient wear a hard lower orthotic at night and/or during the day. This allows the mandible to position itself in the most comfortable position, which decompresses the joints and allows the muscles to relax. You may choose to use orthodontics to create a larger airway with expansion of the arches, and/or to correct the jaw relationship and occlusion of the teeth. You may elect to surgically reposition the bones to allow for better mandibular positioning. You may elect to restore the patient with restorations that create enhanced function and aesthetics. You may do a neuromuscular coronoplasty. Each of the appropriate treatment options should be discussed with your patients so they can make the informed decisions that are best for them.

As you can see, the neuromuscular concept of occlusion is not based on doing full-mouth reconstruction cases or bite opening for every case. It is based on creating balance in your patients so that their teeth occlude optimally, their jaw joints decompress and their muscles return to a natural physiologic position where they function most efficiently. The real power of the neuromuscular approach is demonstrated by the effects you will see on the entire musculature and skeletal system of your patients. Once you see this, you will be in awe of the tremendous influence you have on the lives of the people who walk in your door every day.

*Continued on Page 70*

***One accurate measurement is worth a thousand expert opinions.***

GRACE HOPPER

# *We change the past and inspire the future.*

BEFORE

*Request Dental Ceramics*
*for your next LVI hands-on course.*

dental ceramics, inc.

*Aesthetic Dentistry Through*
*NeuroMuscular Dental Laboratory Concepts*

Ceramist • John Lavicka
Dentistry • Dr. James D. Klim

5299 East 98th Street, Garfield Hts., Ohio 44125
1-800-647-8748 • dcempress@aol.com
www.dentalceramicsinc.com

SUPPORTNG LVI
SINCE 1998

# Debilitating Centric Relation case resolved using Neuromuscular principles

Dr. Shamshudin (Sam) Kherani BSc, DDS, FAGD

Kathy came to see me when she had a mouth full of temporaries and constant head, neck, shoulder and joint pain. She was a patient in the Orognathic Bioesthetics International ("Bioesthetics") Level 1 to Level 4 course. The participating dentist, in this course, takes a patient from start to completion using a non-manipulative mandibular technique that allows the condyles to "seat in centric relation". Kathy developed much more discomfort after this treatment.

A more popular Centric Relation ("CR") technique is called bimanual manipulation whereby the dentist cradles the patient's head and using his hands rotates the mandible around an imaginary axis with an upward force hoping to seat the condyles into the glenoid fossa. This technique does not take into account the physiology of the muscles that form a major part of the stomatognathic system. The "Bioesthetic" technique uses a bite plane in the anterior leaving the posterior teeth free. This device is called a "Maxillary Anterior Guided Orthosis" (M.A.G.O.). This device creates a pivot in the anterior allowing the muscles of mastication ( especially massetors ) to seat the condyle in centric relation. Both of the techniques mentioned above lead to the "overclosure" of the posterior segment and cause posterior hypo-occlusion. This result causes a decrease in the joint space around the condyles leading to muscle imbalance and joint compression witnessed as pain in the head and neck. Some other courses teach a modification of this technique whereby they use a composite ball between the upper and lower incisors. Whilst this gives a better form of the teeth because of more room in the anterior, it collapses the bite in the posterior leading to a compressed joint.

Neuromuscular principles on the other hand allows the dentist to find a mandibular position determined by "isotonic" muscles of mastication. This position allows joint de-compression and muscle balance. Depending on the pathology of the patient, it may take some time to enable full joint decompression.

Armed with the above knowledge, I felt that Kathy was suffering from posterior hypo-occlusion. Therefore, the very first thing I did was to apply ultra low frequency TENS to the muscles of mastication and obtain a myobite. Kathy felt relief right away. Since she is a dental technician, I asked her to mount the case as per the myobite and wax up the case at the new increased "Posterior Shimbashi". During the time that she was waxing up the case, she wore the myobite since it felt so good. Her neck pain, head pain, limitation of rotational movement of the head, joint pain and general malaise were all corrected with just the myobite which she wore for three weeks. ( see picture – she even broke it into 2 pieces and was still wearing it )

New temporaries were fabricated at the new bite using the new wax up. She was very comfortable. After nearly six months, we set out to finish the case. She is all finished now and is very happy and pain free. The dentist who treated her initially has since taken Advanced Anterior and Occlusion 1 at LVI. This I admire since this dentist is thinking outside the box and we need more such dentists in our profession.

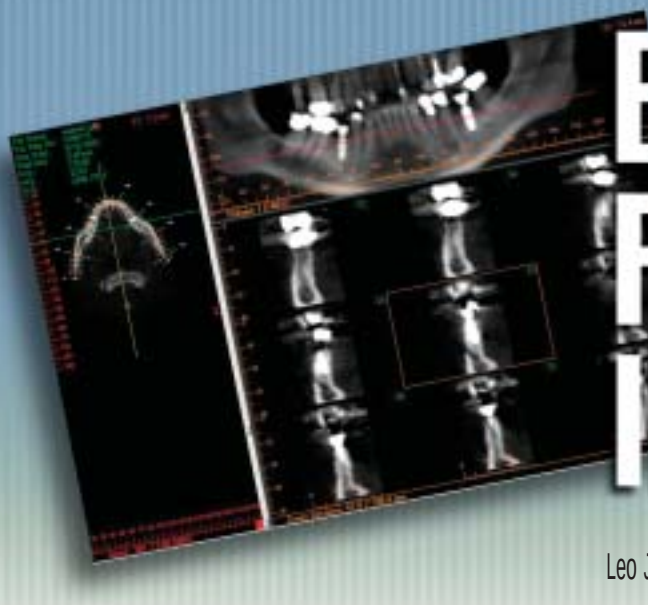
Kathy says: "I can now turn my head to shoulder check while I am driving and I can even lift my head when in the hot tub at home to look at the stars above" "As a dental technician, CEJ to CEJ in the molar region means a lot more to me than supposed seated condyles".

Manipulative and non-manipulative CR techniques all cause joint compression, muscle imbalance and "posterior hypo-occlusion" and thus lead to pain and discomfort in many cases. This is also another reason why dentists using these techniques have to resort to building in a long-centric to free the mandible. Physiological position rather than an anatomical position of the mandible results in an occlusal scheme which is physiologically sound and ensures patient comfort. Most importantly, we changed Kathy life. She can enjoy every minute of every day of every year.

**Dr. Shamshudin (Sam) Kherani BSc, DDS, FAGD**

Dr. Kherani is a senior clinical instructor at the Las Vegas Institute for Advanced Dental Studies, a Fellow in the Academy of General Dentistry and a member of the Board of the International Association of Comprehensive Aesthetics. As a life long student, he has been exposed to many different philosophies in dental occlusion throughout his 25 year dental career.

Dr. Kherani emphasizes comprehensive restorative and aesthetic dentistry in his practice in Calgary, Canada.



# BLUEPRINT FOR A SIMPLE IMPLANT CASE

Leo J. Malin, DDS

In my recent articles in the LVI Visions Magazine, I have discussed the top down approach to implant placement. There may appear to be a fine line between the placement of an implant in an area of the most bone, and the placement of an implant by the top down method; but the distinction is obvious to most neuromuscularly trained dentists. We cannot balance occlusion if we cannot control the placement/location of the individual teeth. Whether we perform orthodontics, full mouth reconstructions, or implant placements, our goal is to effect tooth position for a balanced occlusion. Therefore, along with other types of treatment, implant placement needs to be a result driven process.

Often times, presentations on how to perform dental procedures show all possible choices at each step in the process, so that pertinent aspects of the case are not missed. This type of presentation, although complete, can be very confusing. I am going to attempt such a presentation while trying to keep such confusions to a minimum. What I would like to present here is a straight forward implant case with the various decisions that have to be made during the process. My motive is not to make the process look complicated or confusing, but to shed light on those specific areas where decisions have to be made. Once those areas are identified and put into the framework of a specific implant site, I think that you will find that the confusions are really just choices, and the choices are often limited by the specific implant site that you are dealing with. The implant process is just a process and once occlusion has been established, it is simply a matter of placing an implant there. It really isn't complicated.

***Case Presentation:***

Patient Data: The patient was a 40 year old female, non-smoker with good oral hygiene. No significant medical history reported. She was missing tooth #29 and had tooth #19 extracted. Approximately 4 months after the extraction, the patient came to my office for a consultation to replace the missing teeth. All alternative treatment plans were discussed with the patient along with treatment plan fees, etc. Patient declined bridges and the option of a full mouth rehabilitation to address all of her occlusal signs and symptoms. The patient's final decision was to have 2 individual implants placed to replace her missing teeth into her current occlusal scheme.

An initial implant evaluation needs to be made from available models, x-rays, and clinical exam. Is this patient a good candidate for implants? If yes, the following questions/decisions need to be made.

***First Decision:***

***Type of Surgical Stint***

a. A Full Mouth Reconstruction requires a neuromuscular orthotic to use as a surgical stint.

b. For 2 or more adjacent sites, a lab fabricated stint is recommended to get an accurate wax-up of the proposed final tooth positions.

c. For Individual Implants I can make a vacuumed formed surgical stint in my office using study models.

My Patient: Chose 2 individual implants. Therefore, I chose a vacuumed formed surgical stint.

When using a vacuumed formed surgical stint, I need to determine the location of final restoration in order to place the Restoration Plug on the model:

The process I used for making a vacuum formed surgical stint using NIS products:

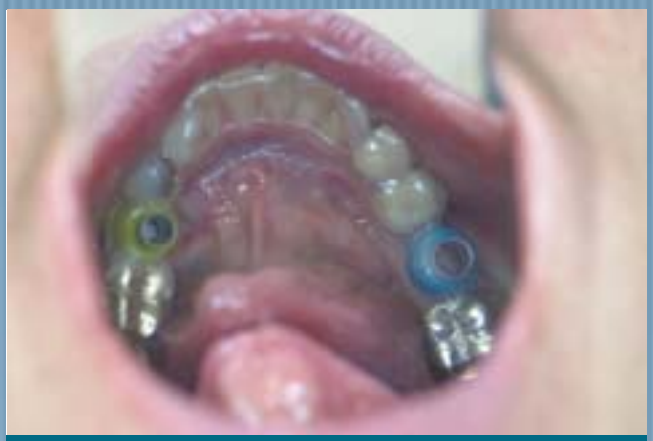
1. Create a study model.

2. Place NIS Restoration Plug on the model at the proposed site of the final restoration.

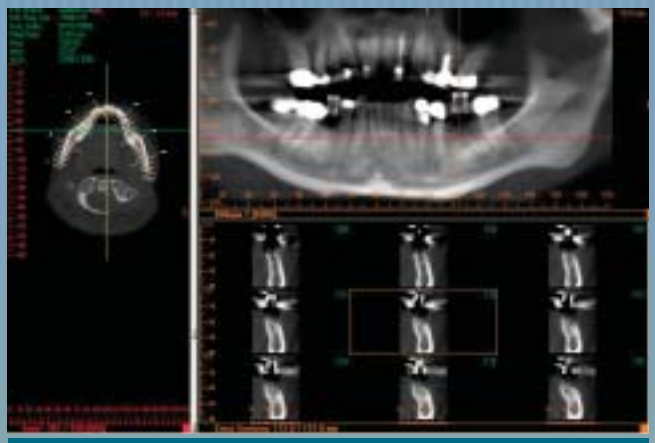
a. The restoration plug is placed slightly lingual to the existing occlusal plane to give plenty of buccal latitude in order to allow for the best aesthetic result.

b. This slightly lingual position allows for the planning of a straight line occlusal force from the crown down to the implant.

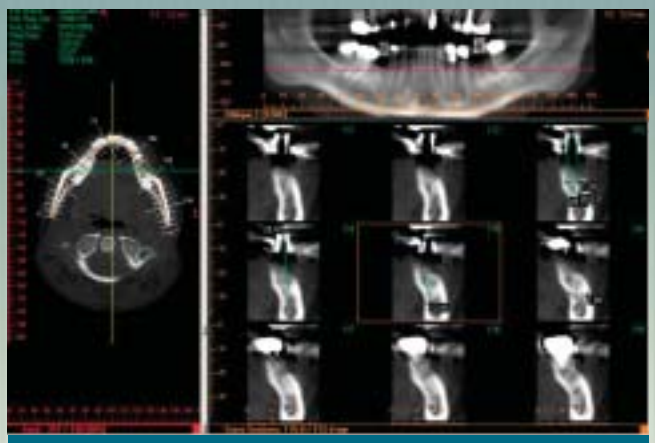
c. Our end goal on any implant placement is to have only straight line forces acting on both abutments and implants. Angled abutments will result in greater lateral forces being exerted on the implant which will result in a greater chance of failure. This is not always



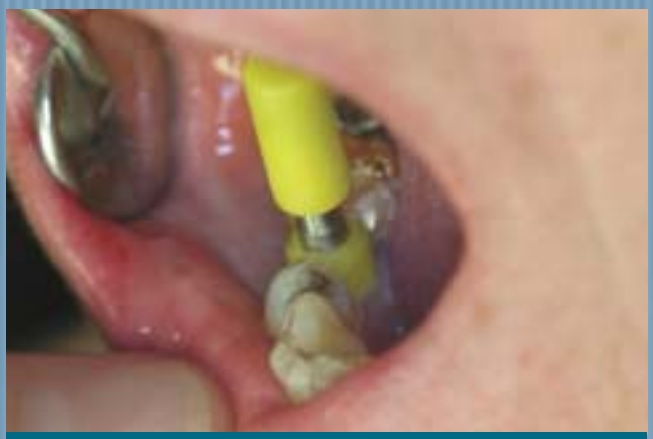
VACUUM FORMED STINT FABRICATED AND INSERTED IN PATIENT'S MOUTH.



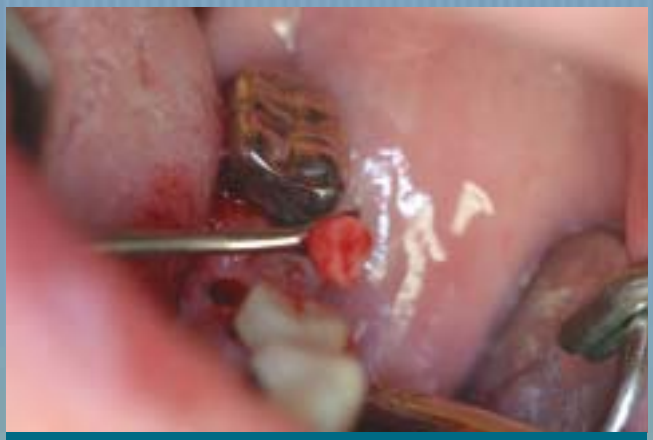
PICTURE OF THE SCOUT FILM WITH THE SURGICAL STINT IN PLACE PRIOR TO ADJUSTMENT.



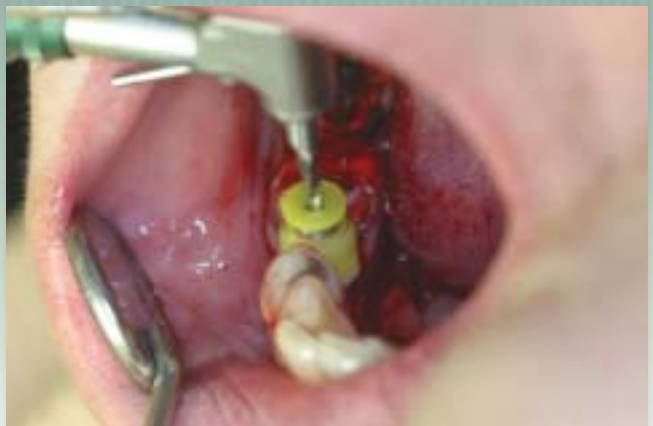
CT SCAN WITH ADJUSTMENTS MADE TO SURGICAL STINT TO ALIGN THE DRILL GUIDE WITH THE IDEAL IMPLANT PLACEMENT POSITION. MEASUREMENTS OF BONE WIDTH AND HEIGHT DISPLAYED.



Tissue cutter inserted in surgical guide.



Tissue tag removed after cutting with tissue cutter.



Picture of first reducer inside guide tube which guides pilot drill.

possible on the anterior maxillary arch due to the boney anatomy, but should work uniformly in other areas of the mouth. Angled abutments in the premaxilla are sometimes required.

3. Cement NIS plugs to model using Triad material and a curing light. (The NIS plugs are used to represent the crown. Place the plugs where you want the final restoration.)

4. Create a vacuumed formed stint over the restoration plugs on the study model.

5. Discard the Restoration Plugs.

6. Use stint punch to create the appropriate size hole in the stint for the drill guide. (The punches coordinate with the size implant that I will be using.)

7. Glue in the adjustable drill guide into the stint.

8. Adjust the drill guide to the position of my "best guess" at this point.

***Second Decision:***

***Angle of Implant Placement:***

Place the surgical stint into the patient's mouth.

Take a CT scan of the patient with the surgical stint in place.

Review the CT scan to evaluate the angle of the surgical guide.

Adjust the angle of the surgical guide (Up to the limitation of the guide which is 20 degrees maximum in any direction) to get the safest placement in relation to the other teeth and the vital structures. There is no guess work when using a CT scan. Am I going to hit the mandibular nerve or puncture a sinus? With 1 to 1 magnification, just measure the distance and

chose the appropriate angle to avoid complications.

My Patient: Required Adjustment of #19 in the lingual direction to avoid perforation of the buccal plate as seen in the scout film.

***Third Decision:***
***Bone Grafting or No***

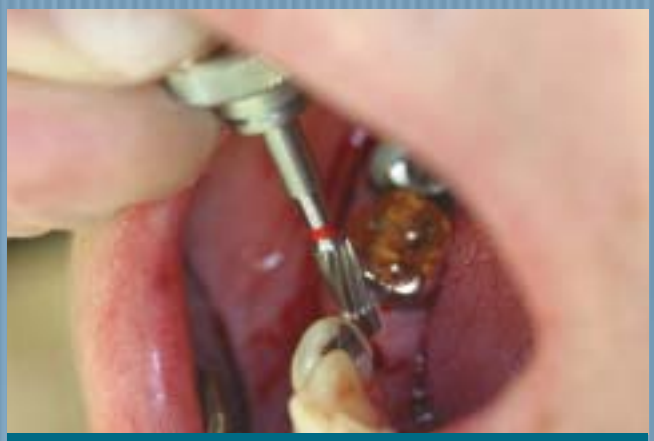
Bone Grafting: There is no real problem making a decision when you have a CT scan or tomographic image of each implant site. Do you have enough bone width and depth to support an implant where you want the implant? The minimum dimensions for this Ankylos implant system are 3.5mm diameter by 8mm length. I have already determined the entrance point of the implant and the angle I am going to place the implant using the CT scan. Do I have enough bone to go 8mm down? Do I have enough width for a 3.5mm width implant?

My Patient: I had enough bone to perform implant placement without grafting at both sites.

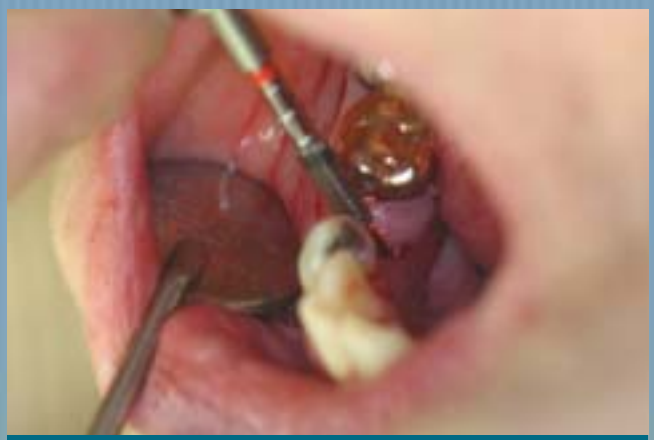
***Fourth Decision: Size of Implant:***

I chose a 4.5mm diameter by 11mm length implant, because I had approximately 14mm of bone from the height of contour on the lingual plate to the top of the Inferior Alveolar nerve. This placement would position the implant at the crestal ridge on the lingual aspect of the implant and approximately 2mm sub-crestal on the buccal aspect of the existing bone.

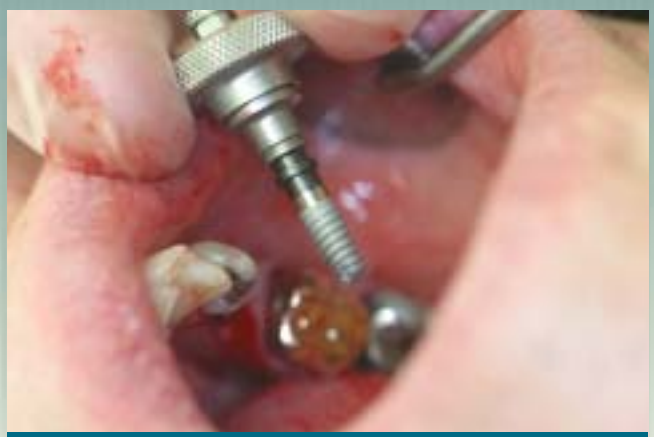
I chose a 4.5mm diameter implant because of the available bone in the buccal-lingual dimension at the proposed implant angle. Because of my chosen implant angle which was



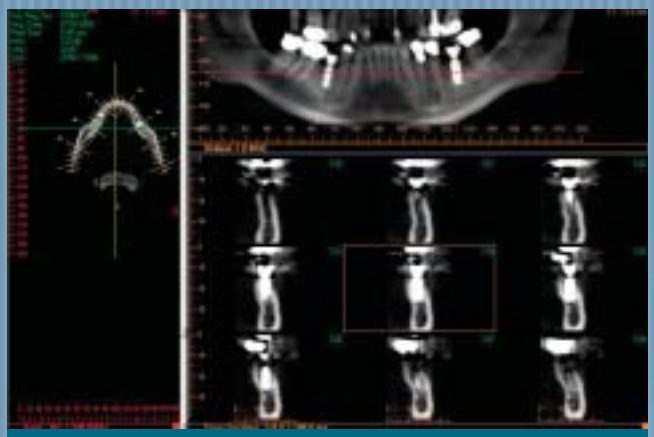
Picture of bone reamer which is used after the final drill to form a tapered osteotomy which matches the chosen implant size of the tapered Ankylos implant.



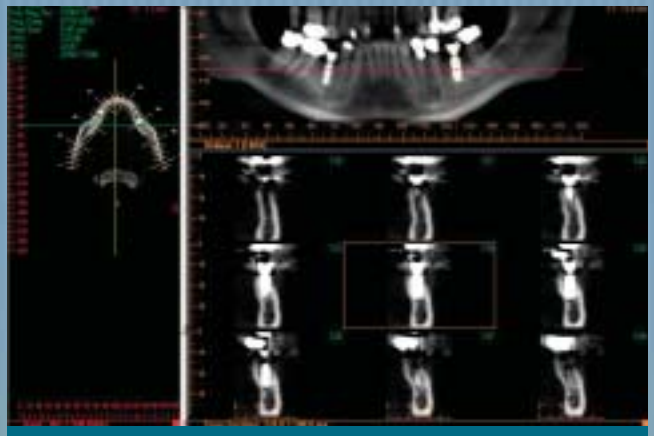
Picture of the tap used to thread the osteotomy to prepare the site for the implant.



Ankylos implant with placement wheel.



Post operative CT scan showing implant #19 placed.



Post operative CT scan showing implant #29 placed. Note position of implant as it relates to the buccal nerve and foramen.

dictated by occlusion, this is the widest implant body I could use without perforation of a boney plate. Remember, the angle is dictated by desired straight line forces from the proposed occlusal table. The tube in the stint is assumed to be the position of the final restoration. Placement is driven by occlusion. As you can see, the measurements marked on the CT scan shows 5.2mm of available bone width. The next available implant size is 5.5mm. There is not enough bone for a 5.5mm implant. As we stated earlier in the article, most of the decisions are dictated by the specific implant restoration site.

My Patient: Implant size determined using CT scan.
#19 - 4.5mm with 11mm depth.
#29 –3.5mm with 9.5mm depth.

In Summary, the choices I had to make for this procedure were:

The type of stint: A Vacuumed formed surgical stint was chosen.

Bone Grafting: No bone grafting was necessary.

The angle of surgical guide: #19 needed to be adjusted.

The size of implants selected: #19 - 4.5mm with 11mm depth. #29 - 3.5mm with 9.5mm depth.

It is important to note that no invasive procedure has yet been done to this patient.

Because the tomography allows us to look inside the bone and other structures, we aren't required to lay flaps to physically look at boney structures. Laying flaps is the single most invasive part of any implant surgery that may cause severe discomfort to the patient. Laying flaps also tends to destroy the papilla and

often results in less than appealing aesthetic results. A surgical flap is only required when bony recontouring is need or the patient requires an augmentation procedure.

All decisions have now been made. Now let's do the surgery… I'm back to drill and fill… Drill through the surgical stint and fill with an implant.

***Surgical Procedure:***

I used a punch technique to remove tissue only over the implant site. This punch is placed through the drill guide, rotated circumferentially, and the small oval tissue tag is removed. I have only removed enough tissue to drill the osteotomy and place the implant without tissue interference, but no more. I then measure the distance from the top of the drill guide down to the bone after the tissue plug was removed in order to determine the correct drill depth. The first site was 10mm from the top of the guide to the crest of the bone. There is a depth gauge included in each NIS assembly that allows me to do this. For tooth #19, I measured over 14mm of bone along the selected trajectory and decided to place an 11 mm Ankylos implant at that site. Since I wanted to place this implant 2mm sub-crestal, I needed to drill a 13mm depth osteotomy at site #19. From the top of the drill guide to the bone was 10mm. Therefore, I need to adjust my total depth gauge to 23mm. That's 23mm from the top of the drill guide to the bottom of the osteotomy. That's, 10mm from top of drill guide to top of bone, 2mm sub-crestal placement along with an 11mm implant depth.

Once the total depth gauge was set, I started the osteotomy. Tooth #19 was selected for a 4.5mm implant. To drill to that size, I started with the pilot drill size of 2mm. Each NIS assembly comes with reducers that fit inside the drill guides which correspond to the sequence of drill sizes required to upsize the osteotomy from the pilot size (2mm) to the size of the implant. Each NIS kit corresponds to each implant company's individual drill sizes. Once the osteotomy is drilled to depth and size, the implant is placed. Individual implant companies have differing methods of placing implants. I used an Ankylos implant in this case so the next step after the osteotomy was drilled to depth and size was to probe the osteotomy to make sure no boney plates were perforated. With the NIS drill guide system, this is a rarity. Then the Ankylos reamer is used to create the final shape of the osteotomy. Once the reamer has shaped the osteotomy, a tap is used to create threads in the walls of the osteotomy that will accept the threads of the implant. These two steps are performed by hand, no power drill is used. The implant is placed by hand as well. After both implants were placed using the steps outlined above, I took off the cover screws on both, and replaced them with sulcus formers. These sulcus formers are the same shape as the abutments and help form the soft tissue around the implant sites. The emergence profile of the Ankylos abutments is about half the diameter of the implant. This difference allows

***We cannot balance occlusion if we cannot control the placement/location of the individual teeth.***

the bone to grow over the top of the implant while maintaining maximum soft tissue. That is why Ankylos implants are recommended to be placed 1 to 2 mm sub-crestal.

Since the implants were placed in the posterior mandible in a non-esthetic zone, no temporaries were placed. Impressions were taken for final restorations at the completion of surgery. The final restorations will be placed in approximately 4 months. I was able to do this because I had minimal tissue trauma and expect no post surgical recession. It generally takes two appointments to complete these implant cases, once the treatment plan is accepted. One appointment is required to place the implant, and take the final impression for the restorations. A second appointment is scheduled to place those restorations. The time frame between these appointments is generally one to four months, depending on the clinical situation. The surgical appointment was a 40 minute appointment. I expect the restorative appointment to take an additional 40 minutes as well. Little doctor time is required to complete these cases.

What are the financial results of this two-implant case?

In our classes at LVI, we present in great detail the financial implications of accepting implants into your practice. This is a group exercise where the numbers for both the revenues and the costs are selected from the class participants. We will examine the incremental revenues and costs this particular case generated in my office. The revenues generated were:

| | |
|---|---|
| Consult | 100 |
| Model | 100 |
| Stint | 350 |
| Tomo | 300 |
| Surgery | 1,600 X 2 |
| Restoration | 1,450 X 2 |
| Total | $ 6,950 |

**The costs incurred were:**

| | |
|---|---|
| Model | 20 |
| Stint | 25 |
| NIS Drill Guide | 97 X 2 |
| Implant & Abutment | 300 X 2 |
| Restoration | 450 X 2 |
| Assistant | 25 |
| Consumables | 25 |
| CT scan | 300 |
| Total | $ 2,089 |

The gross profit on this single two-implant case was $4,861 ($6,950 – 2,089). What equipment did I purchase in order to make this case possible? I needed a surgical kit and implant motor. I received these at no cost from a major implant company as long as I purchased 25 implants. So I can either count the implant and abutment as a variable cost as I did above ($300 X 2), or I can increase the gross profit by $600 ($300 X 2) and add the motor, surgical kit and the first 25 implants as fixed costs in my analysis. I chose the former. I needed a vacuum forming machine to create the acrylic stint used in this surgery. That cost me $500. I also needed to acquire a CT image in order to accurately place the implant. There is a mobile CT service that currently charges $300 for the implant series of scans (about 4 per patient.) Total fixed costs = $500.

If I saw 11 more patients just like this one, what would my overall profitability on the twelve patients be? $4,861 X 12 = $58,332 minus $500 equals $ 57,832

With proper training and tools, most general dentists can place simple implants as was presented here. As was stated in previous articles, the implant market is growing quickly, implants are now the standard of care, and patients are requesting this treatment much more frequently. We in the dental profession need to position ourselves to provide this requested optimal care. It is professionally rewarding and profitable treatment, that we should be offering patients that choose us as there dental provider.

In a future article, I will present the steps for a clinical case where a lab fabricated surgical stint is required. These cases involve multiple implant sites and changes in mandibular position to establish neuromuscular occlusion.

Dr. Leo Malin graduated from Marquette University in 1991. He maintains a private practice in LaCrosse, WI, where he has been utilizing occlusal based dental concepts since 1998. With the help of other experts in the fields of radiology and occlusion, he has developed an implant placement technique which focuses on occlusion (and cosmetics) for implant placement and crown restoration. Dr. Malin lectures throughout North America on full mouth reconstructions and implant placement.

# Find out what you and your patients are missing.

Invite your patients into a world of comfort.

Midmark's unique and innovative operatories reflect you and the care you provide. And, you can complement your suite with Midmark modular casework; the strength of steel with the warmth of wood.

Isn't it time you invested in the efficiency and comfort you, your staff, and your patients deserve? Now you can have it all... from a trusted company who's been in business for over 88 years.

**To find out what you're missing, call 1-800-MIDMARK or visit us at any of the major trade shows in 2004.**

20 THE DENTAL ADVISOR

+++++

Editors' Choice

MIDMARK

Because we care.

Midmark Corporation 60 Vista Drive, P.O. Box 286 Versailles, OH 45380-0286 1-800-MIDMARK Fax: 1-877-725-6495 midmark.com

# ASK CORRECTLY

Nate Booth, DDS

# AND YOU SHALL RECEIVE MORE OFTEN

If you don't like the answers you get when asking patients to accept comprehensive, aesthetic treatment plans, maybe you need to ask better questions. After watching hundreds of case presentations, I've discovered that one of the primary reasons patients don't accept treatment plans is because the case presenter never asks them for a commitment to proceed. Instead, the presenter asks wimpy, non-action-producing questions. Here are the two most common wimpy questions asked at the end of a case presentation.

*"Mediocre people have an answer for everything and are astonished at nothing."*

## Wimpy Question #1:

"So, Mary, do you have any questions about what we just discussed?" If Mary doesn't have any questions, the conversation fizzles out and Mary walks out the door saying she will think about it. Two weeks later, the dentist wonders, "Where did Mary go? I was sure she wanted to get started."

## Wimpy Question #2:

"So, Mary, what do you think?" Mary says, "I'd really like to have it done, but that's a lot of money. I need to go home and talk to my husband." Mary walks out the door, never to be seen again.

The Bible says, "Ask, and you shall receive," not, "Beat around the bush and you shall receive." So why don't case presenters like to ask patients if they want to proceed? I believe there are three answers.

1. Case presenters are afraid the patients might say, "No," and the presenters will feel rejected. People will do more to avoid pain (feeling rejected) than they will to gain pleasure (having a treatment plan accepted).

2. Case presenters believe the patients don't need the treatment. I've heard it said that people don't need cosmetic dentistry no matter how much they may want it. This way of thinking really bothers me. Cosmetic dentistry can transform someone's life—isn't that just as important as a root canal or filling?

3. Case presenters believe that if patients can't afford comprehensive aesthetic treatment, asking them to proceed will make patients feel bad. Don't fall into this trap. You can't know how much money someone has. More millionaires drive Ford F-150 pickups than any other vehicle. If patients (or their helpful relatives in many cases) feel the need, they will find the money.

Here are two effective methods of asking patients to proceed.

## Method #1:

Present your very best comprehensive aesthetic treatment plan and ask, "Would you like to go ahead with this?" If they can't proceed, present the next best option (usually phased care) and ask, "Does this work better for you?"

I often see case presenters offer the very best care and then fail to ask if the patient wants to proceed with this plan. Instead, they move to phased care immediately, offering a lower-priced option as if they're doing the patient a big favor. However, phased care often adds expense. Patients are going to pay for their comprehensive care, whether they have it all done now or spread the treatment over time. If they finance their care with a home equity loan, it can be less expensive to have everything done immediately. If the patient waits, the cost of care will increase each year and any emergency situations will add to the total price. In other words, phased care can be more expensive than doing everything now. Look at it from the patient's viewpoint. When comprehensive aesthetic dentistry is delayed for years and then finally completed, how often do patients say to you, "I'm glad I waited to get this done"? They almost always tell the dentist, "I wish I'd done it sooner." Make it easy for them to do it sooner: present the very best

care plan for them and then ask them if they want to proceed.

### Method #2:

Give patients more than one treatment option and ask, "Which option works best for you?" Of course, the option you highly recommend is comprehensive aesthetic dentistry done right away.

Now that you've asked your patients if they want to proceed, they're going to say one of three things: (1) "Yes," (2) "No," or (3) "Maybe," in the form of "I need to think about it," "I need to talk to my spouse," or "I need to check my finances."

If they answer, "Yes," make the financial arrangements and schedule their appointments quickly.

If they answer, "No," ask them, "Do you mean 'no, never' or 'no, not now'?" If they answer "No, never," you either keep them in your practice or refer them to another dentist who loves doing emergency dentistry. If they say, "No, not now," discover what is keeping them from doing it now. It's usually money. Maybe you can help them with your financing options. If not, tell them, "I understand. We'll take good care of you until you're ready."

If they answer, "Maybe," answer, "I understand completely. This is a big decision." Then take one of the following three options.

1. Schedule them for a final consultation by saying, "Let's have you back in a week for a final consultation. You can bring your spouse to that appointment and check your finances in the interim. I will answer everybody's questions, and we can decide what we're going to do."

2. Agree on a decision date by saying, "When do you think you will have made your decision?" If they answer, "By next Wednesday," you reply, "Great, give us a call next Wednesday. If we don't hear from you, would it be okay if I called you on Thursday? We know we need to get started with the perio therapy and those two areas of decay quickly."

3. Get started with something by saying, "Mary, while you're thinking about doing the whole treatment plan, let's begin the perio therapy and restore those two decayed teeth. We know we have to take action on that part of the treatment plan." Often, when you start the care and they experience how wonderful you are, they will decide to proceed with everything.

Following the suggestions above will accomplish three positive outcomes. First, more patients will accept your comprehensive aesthetic treatment plans. This will improve their lives and your bottom line. Second, it will move you away from the "Take it or leave it," all or nothing attitude I occasionally observe in dental offices. You present the very best that dentistry has to offer, give your strong recommendation and then allow the patients to choose what's best for them right now. Some people are slow to be motivated. If they feel pushed they will never completely trust you, or they will go to another office will they aren't pressured.

Third, you will treat your patients the way you would like to be treated. This just isn't trite advice; it's good business. When I do my two-day, in-office coaching program, doctors frequently ask me which case acceptance method of two choices they should use. I always answer, "Which way would you like to be treated?" The answer to that question invariably is the one that's the right thing to do and is the best for creating greater case acceptance.

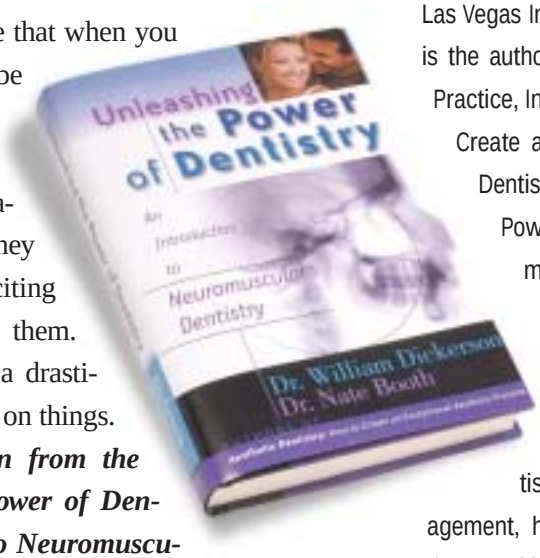
French artist Eugene Delacroix said, "Mediocre people have an answer for everything and are astonished at nothing." Mediocre people are satisfied. They never improve. You're different. You're reading this issue of Dental Visions. You realize that mediocre isn't all that it's cracked up to be. You want to be great. One way you can do that is by asking patients to take action. Nothing changes unless people take action. But change doesn't begin with them. It begins with you. As Mahatma Gandhi said, "You must be the change you wish to see in the world."

*Dr. Nate Booth is the author of the books, Thriving on Change, The Diamond Touch, and 555 Ways to Reward Your Dental Team. With Bill Dickerson, he is the co-author of the book, How to Create an Exceptional Aesthetic Practice. His in-office, video-based training program, The "Yes" System: How to Make It Easy for Patients to Accept Comprehensive Dentistry has helped hundreds of dentists do more big cases. Through his telephone coaching program, Nate assists dentists in creating the practices of their dreams.*

*Continued From Page 54*

### Be a Leader

I hope this article has helped you see a new part of the elephant – the Neuromuscular Dentistry part. I firmly believe that when you embrace NMD, you will be one of the lead "horses" in the parade of dentistry. The lead horses in the parade have the best view. They can clearly see the exciting road that unfolds before them. The trailing horses have a drastically different perspective on things.




***This article was taken from the book, Unleashing the Power of Dentistry: An Introduction to Neuromuscular Dentistry by Drs. William Dickerson and Nate Booth. It is available from LVI Press at 888-584-3237.***

Dr. Bill Dickerson is the founder and CEO of the Las Vegas Institute for Advanced Dental Studies. Bill is the author of the books, The Exceptional Dental Practice, In Search of the Ultimate Practice, How to Create an Exceptional Aesthetic Practice – Ten Dentists Who Have Done It and Unleashing the Power of Dentistry: An Introduction to Neuromuscular Dentistry. The Las Vegas Institute for Advanced Dental Studies is a 63,000 square foot post-graduate training facility in Las Vegas. With programs on Neuromuscular Dentistry, cosmetic dentistry, business management, hygiene, endodontics, orthodontics, implants and laboratory courses, LVI has led the way in continuing education becoming the world's premier dental, post graduate educational center.

**METAMORPHOSIS** • *Continued From Page 40*

to transition our other office into a complete LVI practice and exciting events occur there every day as well.

Last September, we welcomed Dr. Mike Mortazie to the practice. I met Mike while I was teaching the Posterior class at LVI and knew he would be a perfect fit. Together, the three of us are completely committed to continuing our LVI education and providing our patients with the excellent care they deserve.

## Communicating my passion to others

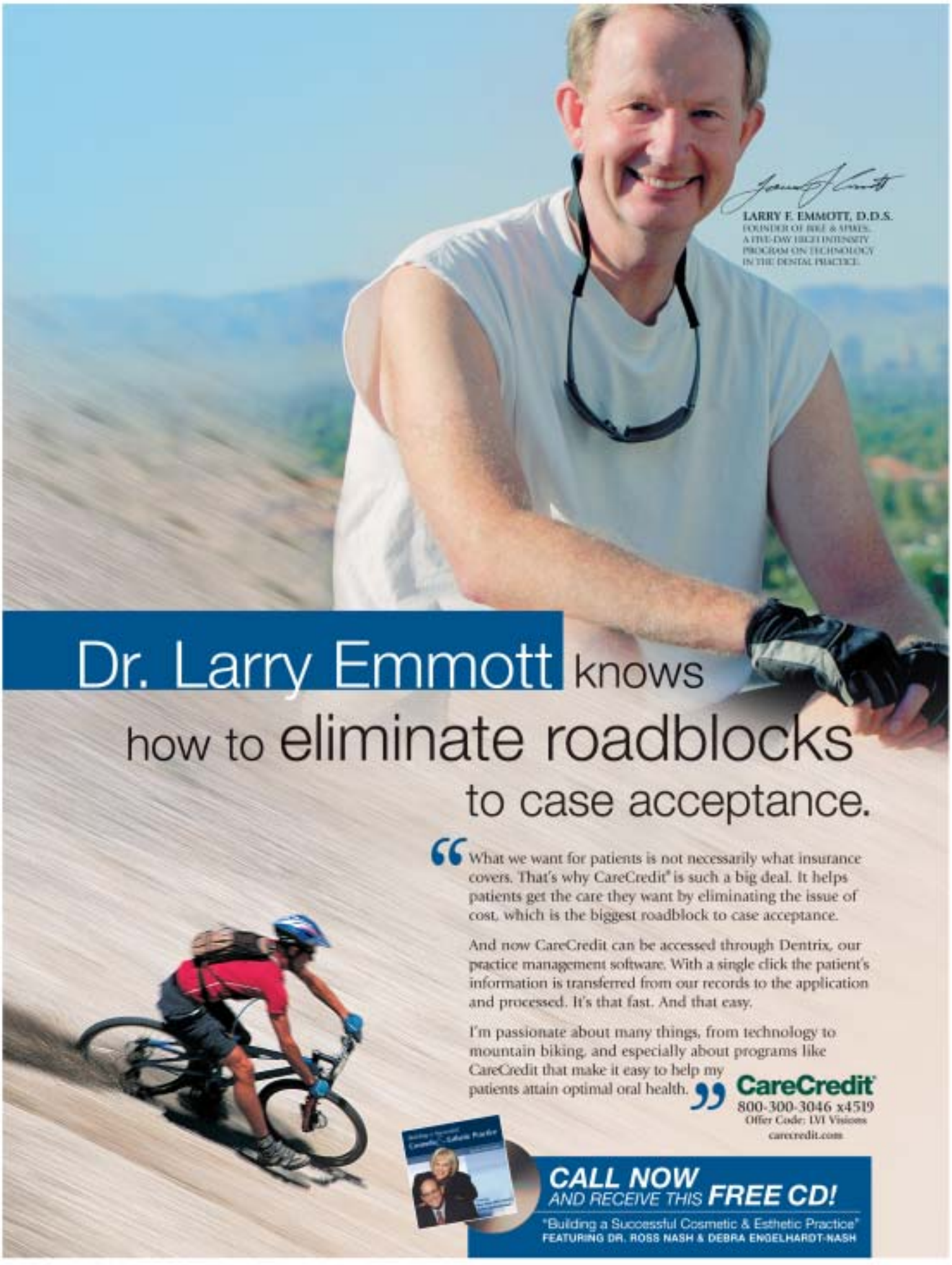
When you believe in something as strongly as I believe in LVI, there's nothing quite as rewarding as sharing your passion with others. Within the last year, it has been my honor to become a Clinical Instructor at LVI. I find it both challenging and rewarding to help dentists become the best in the nation by teaching them how to provide their patients with state-of-the-art care.

My strong belief in continuing education also inspired me to form the Metro LVI Study Club in 2004 so LVI graduates in the Washington Metro area could connect and share information and patient cases. The club continues to grow and has been very well received.

## Into the future with LVI

Whenever anyone asks me what I see as the elements that go into building a successful practice, I say vision, determination and passion. You need a vision of what you want your practice to be, the determination to take it there and the passion to enjoy it and believe in it every step of the way.

*I am proud to be where I am right now, in my practice and in my life. Thanks to LVI and the exceptional doctors associated with the Institute, such as Bill Dickerson, Heidi Dickerson, Clayton Chan, Mike Miyasaki, Norm Thomas and Ron Jackson, I am now living my lifelong dream of providing my patients with exceptional dental care – the type of care that is far superior to anything I ever imagined. Taking that first class at LVI back in the spring of 2002 started me on a journey that truly changed everything for me.*


LARRY F. EMMOTT, D.D.S.
FOUNDER OF BEE & SPIRES,
A FIVE-DAY HIGH INTENSITY
PROGRAM ON TECHNOLOGY
IN THE DENTAL PRACTICE.
Dr. Larry Emmott knows
how to eliminate roadblocks
to case acceptance.
"What we want for patients is not necessarily what insurance covers. That's why CareCredit® is such a big deal. It helps patients get the care they want by eliminating the issue of cost, which is the biggest roadblock to case acceptance.
And now CareCredit can be accessed through Dentrix, our practice management software. With a single click the patient's information is transferred from our records to the application and processed. It's that fast. And that easy.
I'm passionate about many things, from technology to mountain biking, and especially about programs like CareCredit that make it easy to help my patients attain optimal oral health."
CareCredit®
800-300-3046 x4519
Offer Code: LVI Visions
carecredit.com
CALL NOW
AND RECEIVE THIS FREE CD!
"Building a Successful Cosmetic & Esthetic Practice"
FEATURING DR. ROSS NASH & DEBRA ENGELHARDT-NASH

*You've seen it on TV.*
*You've heard all the talk about it.*
*Now, coming to your area…*
*an opportunity to find out for yourself.*

**THE LVI EXPERIENCE**

# Unleashing Your Power In Dentistry

## A 2-DAY LVI EXTRAVAGANZA

*It's the talk of the profession…*
*Find out why thousands of dentists are fanatical about what LVI has done for them, their team… and their patients*

*This life changing seminar will change the way you practice dentistry… a more satisfying, wonderful world of dentistry*

*7 experts will show you a better way to practice dentistry with pearls that you will be able to implement on Monday.*

**LOCATIONS**

| | |
|---|---|
| September 16-17 | Green Bay, WI |
| October 14-15 | Ottawa, ON |
| | Halifax, NS |

---

**SEMINAR TUITION**

Dentists / Lab Technicians: $495 each • LVI Graduates: $350 each • Team Members: $195 each

**To register, call LVI at (888) 584-3237**

# Now comfort and protection can live in harmony.

## Introducing COM-FIT™ Groovy Mask.

The NEW! COM-FIT™ Groovy Mask combines comfort and protection with a hip tie-dye design that you, your staff and especially your patients will enjoy!

**Super Protection.** Feel safe knowing the Groovy Mask achieves the highest standard of fluid resistance for a face mask (based upon ASTM F1862, the only standard to prove fluid resistancy) and provides 99.9% Particulate Filtration at 0.1 micron.

**Cool Comfort.** Improved breathability over leading fluid resistant masks keeps you cool and dry. Anti-fog strip keeps glasses/goggles clear.


***Special Introductory Offer!***
*Purchase 10 boxes and receive a free Groovy poster, a wall bracket to dispense your masks and a proper mask usage wall chart**

*To redeem, send a copy of your dealer invoice and this ad to: Sultan Chemists, 85 West Forest Ave., Englewood NJ 07631. Offer expires 12/31/05.

**Fab Looks.** The groovy, tie-dye design will keep you looking good and keep your patients feeling mellow, too!

**Call your dealer today and try the New COM-FIT™ Groovy Mask.**

**Sultan Chemists, Inc.** 85 West Forest Avenue, Englewood, NJ 07631 • Phone: 201-871-1232 • Toll Free: 800-637-8582 • Fax: 201-871-0321 • www.sultanchemists.com

# Micro Advanced Cosmetics and MAC veneers™

*the reasons are clear...*

$1,000,000 consumer awareness campaign

Patient referral program

Lowest remake percentage industrywide

Lifetime guarantee*

Successful longstanding partnership with LVI

Small teams of LVI educated technicians

*Lifetime guarantee does not apply to all products. ©2005 MicroDental Laboratories.

*be part of it*

*Put all of our resources to work for your practice today.*

800.229.0936

www.macveneers.com // A Division of MicroDental Laboratories

MAC™
MICRO ADVANCED COSMETICS