

# COURSE PREPARATION MATERIALS



**Core V Live**

**Beginning of Physiologic  
Rehabilitation Case**

**Important Risk Management  
Packet Included**

LVI Global  
1401 Hillshire Drive, Ste 200  
Las Vegas, NV 89134  
[www.lviglobal.com](http://www.lviglobal.com)  
888.584.3237



# Live Patient Treatment

Congratulations on your desire to advance your education and become the best dentist you can be. The 6-day Core V Live program features live-patient treatment with hands-on learning. You will benefit from one-on-one instruction while working on your own patient, as well as view and help diagnose the other course participant's cases.

This course emphasizes function as well as aesthetics. You will learn how to handle more complex cases (bruxers, restoring vertical dimension, restoring severely dark teeth without subgingival margins, creating biologic pontics that appear to be growing out of tissue, etc.). You will also learn subtle porcelain contouring and chairside customization both before and after final placement that will take a case from good to outstanding. Your LVI experience will not only enhance your professional growth but your patient will be the direct recipient of some of the best dentistry available.



# Case Selection and Patient Requirements

This course features live-patient treatment. You must bring a patient from your practice. You will need to send a diagnostic cast (poured up) along with a physiologic bite to LVI for case approval. Models must be trimmed for proper occlusion!

## Recommended Cases:

- ▶ Bite Change case is the objective of the course.
- ▶ Full arch reconstruction cases with vertical dimension. Lower splint construction will also be necessary as part of the treatment.
  - Complex veneer and anterior crown cases, including gap closures, discolorations, instant orthodontics, anterior bridge(s), tooth lengthening or a combination of any of these are acceptable.
  - Complex combination cases where crowns and veneers are needed are also acceptable.
  - If pre-approved by the Clinical Director, all ceramic bridge cases and the use of fiber-posts for endodontically treated teeth or implant cases are acceptable.

## Unacceptable Cases:

- ▶ Patients who have not had a comprehensive exam or cleaning in one year or more will not be approved.
- ▶ Likewise, patients with poor gingival health are not recommended and may not be approved.
- ▶ Absolutely no patients with active TMJ pathology or dysfunction.
- ▶ Reconstruction on the mandible is not acceptable

## Patient/Clinic Times

Your patient needs to be present only during your assigned clinic time. Your clinic time will be assigned by the Clinical Director after case approval and Risk Management material is completed. Availability is on a first come, first served basis.

LVI is not able to write prescriptions for your patient, so if you anticipate a need for any prescription medication while at LVI, please make arrangements for your patient in advance.

## What to Bring With You

The LVI Global Aesthetic Inlay/Onlay Kit - by Komets USA will be provided supplied to you in the clinic during the prep session. Don't hesitate to bring anything else such as your own favorite instruments, favorite burs, loupes, light source, etc. If your patient has implants you must bring all the necessary supplies to treat the implant. **Please be sure to bring the Bur Kit back with you for seat or there will be a fee to purchase a new one.**

**Special Note to Auditors:** Auditors do not need to bring a patient as they do not participate in the hands-on portion.



# Course Preparation Checklist

Please send the following items to LVI for approval **immediately**.

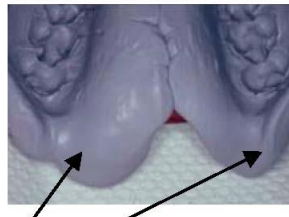
To maximize your considerable investment in this course we ask that you prepare by using this checklist. It is designed to prepare you for this course, thus eliminating as many problems as possible during the program.

## Models & Physiologic Bite Transfer

For case approval you will need a set of upper and lower models with hamular notches mounted to your physiologic bite (poured from polyvinyl siloxane (PVS) impressions) and a physiologic bite transfer. Send one set of models and physiologic bite transfer to LVI and send the other set of models and physiologic bite transfer to an LVI trained lab. (Please confirm with LVI which lab you will use on the Lab Information form). Please do not send impressions to LVI, only the models. Label each model with your name only. Package models and physiologic bite transfer in standard packing materials.



**PVS Impressions  
(DO NOT use Alginate)**



**Hamular Notches**



**Stone Model**



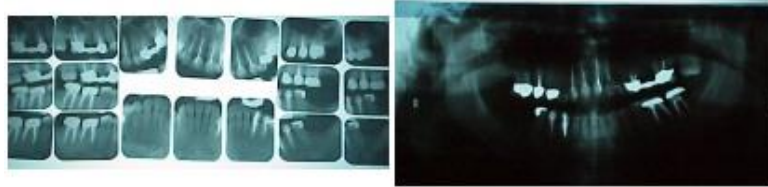
**Physiologic Bite**

## Photos

Please refer to the Core V Live & Core VI Live Required Photographs sheet within this packet for specific required photos and information on uploading them to LVI's website. Please send your photos in digital format only (JPG's). DO NOT SEND PRINTS. Digital photos will also accepted on CD or flash drive.

## Radiographs/CBCT

Send LVI your duplicates; please do not send the originals. Digital radiographs are also acceptable on CD or flashdrive. Label with your name. Refer to the 'Core V Live & Core V Live Required Photographs' sheet within this packet for instructions on how to upload them to LVI's website. You may also bring or upload your CBCT.



## Vertical Measurements in Natural CO and Orthotic

Anterior/Posterior (Left & Right): This will be used for bite management in the event of changing the vertical. Please write down these measurements on the Case Approval Worksheet.



**Right, Anterior, and Left Vertical Measurements in Natural CO**



**Right, Anterior, and Left Vertical Measurements in Orthotic (fixed or removable)**



# Important Information Checklist

Send enclosed Risk Management forms 6 weeks prior to the course date. These vital documents are the first step in getting your patient's case approved. Please fax to 702.492.1947 or email to [riskmanagement@lviglobal.com](mailto:riskmanagement@lviglobal.com) Please fill out all documents completely, do not assume any portion is non-applicable!

These documents are legally required and used to award you CE's based on the time spent preparing your patient for this course.

- Student Information
- Release of Liability
- Information Verification
- Patient Informed Consent
- Patient Education Regarding Interim Treatment
- Records Release & Consent
- Documentation of work done in Home Office
- Medical History
- Periodontal Evaluation
- LVI S.M.I.L.E.S. Evaluation (optional)
- Case Approval Worksheet
- Musculoskeletal – Occlusal Signs Exam (optional)
- Have an original certification of licensure sent from your state board to: LVI Global  
Attention: Core V Live C/O Risk Management, 1401 Hillshire Dr. Suite 200, Las Vegas, NV  
89134
- Current copy of your malpractice/liability insurance with policy expiration date valid  
through seat date of this course.
- You will be given a burr kit during the prep session. It is very important for you to bring it  
back for the seat session

**For case approval you must send the following 60 days prior to the course:**

- Upper and lower models (MOUNTED) and case approval worksheet mailed to:
  - LVI Global Attn: Core V Live C/O Risk Management 1401 Hillshire Drive Suite 200  
Las Vegas, NV 89134
- Radiographs and photos and CBCT scan in digital format uploaded to:  
<https://www.hightail.com/u/LVIRiskManagement>
- BioPak Scan Rest and CO Rest

**In the absence of the above requirements, LVI cannot undertake the approval of a case.**

Once your case has been reviewed and accepted, you will receive notification of your clinic assignment. We advise that you not make any travel plans until the case is officially approved by the Clinical Director at LVI. You will then receive an email with your instructors contact information as well as your clinic time. You must send your case directly to your lab. We **DO** **NOT** forward these models. Submit all pertinent information and materials directly to your lab.



# Patient Discussion

**Please read this prior to reviewing the Risk Management Documents with your patient.**

It is imperative that your patient is thoroughly informed of the procedures to be performed on them here at LVI Global. It is very important that your patient realizes that although you are a licensed dentist that you will be in a training situation and applying newly learned techniques. Your patient should always understand that they have options to the proposed treatment for this program including no treatment at all. It must be explained to your patient that they have the right to change their mind and refuse treatment prior to the treatment plan being started. Do not leave any portion of the Risk Management forms blank. Please make certain the patient consent form is completed and explained before being signed by your patient.

As a doctor it is important that you and your patient understand that there is always some potential harm in having any procedure performed. The more forthright you are in relaying and explaining the possibility of adverse effects to your patient the better protected you both will be; no matter how obscure you may perceive these effects to be.

As of January 2008, we are now required to obtain a certification of licensure, sometimes referred to as verification of license. This must be requested from your state board and mailed directly to LVI Global. This is not to be confused with your certified license as those are only sent to you and should stay at your practice. We will keep your license on file and update it online for you for future live patient courses you attend - provided your state has this feature available.

Please do not hesitate to contact us with any questions or concerns you may have.

888.584.3237 [riskmanagement@lviglobal.com](mailto:riskmanagement@lviglobal.com)





# Student Information Form

Please complete this form and mail or email: [riskmanagement@lviglobal.com](mailto:riskmanagement@lviglobal.com)

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## Personal Information

First Name Preference: \_\_\_\_\_ Last: \_\_\_\_\_ MI \_\_\_\_\_

Office Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Circle one: Designation **DDS DMD Other** \_\_\_\_\_

Office Phone #: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Home Fax: \_\_\_\_\_

Mobile Phone # \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

AGD #: \_\_\_\_\_

License #: \_\_\_\_\_

## Educational Background

Dental School: \_\_\_\_\_ Degree: \_\_\_\_\_ Year: \_\_\_\_\_

Graduate Residency: \_\_\_\_\_

Do you teach? \_\_\_\_\_ If so, where? \_\_\_\_\_

How many years have you practiced dentistry? \_\_\_\_\_

### Do You Consider Yourself:

Beginning esthetic dentist

Experienced esthetic dentist

Intermediate esthetic dentist

Highly experienced esthetic dentist

### Do You Operate:

Right Handed

Left Handed

What procedures do you prefer doing the least and why?

What is the main reason you are attending this program?

What do you hope to get out of the program?

What are your main concerns about cosmetic dentistry?

How many of the following procedures do you do a month?

Porcelain Veneers \_\_\_\_\_ Direct Resin Restorations \_\_\_\_\_ PFM's \_\_\_\_\_

All Porcelain Crowns \_\_\_\_\_ Indirect Resin Restorations \_\_\_\_\_ Amalgam Fillings \_\_\_\_\_

Gold Inlays/Onlays \_\_\_\_\_ Non-Metallic Bridge \_\_\_\_\_ Direct Resin Veneers \_\_\_\_\_



# Agreement for the Dentist Participant

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I, \_\_\_\_\_, am a participant in a continuing dental education program, Core V Live, at the Las Vegas Institute for Advanced Dental Studies on \_\_\_\_\_ 20\_\_.

Pursuant to class curriculum, I willingly agree to participate in a clinical situation at or sponsored by the Las Vegas Institute for Advanced Dental Studies. I understand and agree that I will be required to conform to the institute policies and procedures during the time I spend in the clinic. I understand and agree to take direction from the clinic faculty and his/her designees.

I hereby verify and confirm that \_\_\_\_\_  
Patient's Name is my patient of record. I also agree that I am responsible for all the follow-up remedial care on my patient for this course.

**My current liability insurance coverage is with:**

**Name of Insurance Company** \_\_\_\_\_

**Participating Doctor's Signature** \_\_\_\_\_

**Printed Name** \_\_\_\_\_

**Date** \_\_\_\_\_

(\_\_\_\_\_) I have requested a certification of licensure from my state board on \_\_\_\_\_.  
**Initial** **Date**



# Release of Liability Form

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**Please complete this form and mail or email:** [riskmanagement@lviglobal.com](mailto:riskmanagement@lviglobal.com)

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## Release of Liability Agreement

I am participating in the LVI Course, Core V Live on \_\_\_\_\_, 20\_\_\_\_.

In consideration of the opportunity to participate in this program, I hereby release the Las Vegas Institute for Advanced Dental Studies, their officers, directors, employees, and agents from any claim, damage of liability for or arising out of an injury or death which could result from my own actions or omissions or the actions or omissions of any employee or agent of the Curators of the Las Vegas Institute for Advanced Dental Studies.

\_\_\_\_\_  
Print Name of Dentist Participant

\_\_\_\_\_  
Signature of Dentist Participant

\_\_\_\_\_  
Date



# Information Verification

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**Please complete this form and mail or email:** [riskmanagement@lviglobal.com](mailto:riskmanagement@lviglobal.com)

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Please complete the first line exactly as you would like it to appear on your participation award and on the second line exactly as you would like it to appear on the name tag you will wear while on campus.

**Attendee's Full Name:** \_\_\_\_\_  
(for awards, certificates and continuing education credits)

**Nick Name:** \_\_\_\_\_  
(if applicable, for name tags)

**Degree or Title:** \_\_\_\_\_  
(for awards and certificates)

**Dental License #:** \_\_\_\_\_  
(for continuing education credits)

**Attendee Signature:** \_\_\_\_\_



# Patient Informed Consent

Please complete this form and mail or email: riskmanagement@lviglobal.com

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## Core V Live: Beginning of Physiologic Rehabilitation Case

Patient Name \_\_\_\_\_

Nature of Treatment to be Rendered: Esthetic / Restorative treatment of the upper anterior teeth including teeth # \_\_\_\_ - \_\_\_\_

Benefits of Treatment \_\_\_\_\_

### Patient to Initial Each Line

	Potential Consequences:		Alternatives to treatment:
Patient Initials		Patient Initials	
	Future need for further restorations or treatment		Full coverage crowns
	Future need for endodontic therapy		Cement retained full coverage crowns
	Potential for sensitivity		Orthodontics
	Potential for fractured restorations		No treatment
	Potential for debonding of restorations		Other:
	Other:		

I hereby verify and confirm that I am a patient of record of Dr. \_\_\_\_\_ (“my Doctor”). I agree and hereby consent to my Doctor performing dental work for and upon me as part of a “live patient” continuing dental education training course my Doctor will be attending at Las Vegas Institute for Advanced Dental Studies (“LVI”) in Las Vegas, Nevada. I understand the primary purpose of this continuing dental education course is to educate and train my Doctor, in a “live patient” training situation, on techniques and procedures to be performed upon me in my Doctor’s office and in the clinic at LVI. I further state that the nature and extent of the techniques, procedures, and treatment I will be receiving (my “Treatment Plan”) have been explained to me by my Doctor. My Doctor has informed me about the potential risks of using the techniques which will be applied by my Doctor as part of my Treatment Plan, and I understand my Doctor may have limited experience with such techniques he/she will be learning at LVI. I further understand that my Doctor, who will be performing such dental services for and upon me during or as part of his/her participation in a “live patient” course at LVI, will be doing so as an independent professional, and my Doctor will not be performing such services in any way as an agent or employee of LVI or any benefit of LVI or any of its employees.

My Doctor also has informed me of alternative procedures that are available to me and my options with respect to each such available alternative procedure. I am aware that one such option that is available to me is that I receive no treatment at all. Having considered the options and alternative procedures available to me, I have agreed to the specific Treatment Plan to be completed by my Doctor. I am aware that I have the absolute right to discontinue treatment at any time. I have been advised by my Doctor of the post-operative care that is necessary for me to receive after the procedure is performed at LVI, and I am aware that such post-operative care will occur at my Doctor’s office. It is my understanding that all follow-up/ remedial care will be rendered by my Doctor.

**PATIENT:**

**WITNESS:**

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Witness Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name



# Records Release & Consent Form

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**Please complete this form and mail or email:** [riskmanagement@lviglobal.com](mailto:riskmanagement@lviglobal.com)

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During certain educational courses at LVI, your photographs may be used for educational purposes. Use of the photos, may include but not be limited to presentation in a course teaching manual and/or presented in a power point lecture. As a patient, we request that you sign the attached release form, prior to the use of your photographs.

I, \_\_\_\_\_, consent and authorize an instructor and LVI to use my name or a photograph, photographs, video, slides, K7 scans or any other image as may be necessary of me, with or without my name, or with a fictitious name for advertising, trade, or any other lawful purpose and I release and forever discharge either or both of them from any claim, demands, or liability on account of such use or for the quality of the reproduction of the photograph or photo copy provided.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Printed Name: \_\_\_\_\_

Treating Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Treating Doctor Printed Name: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Printed Name: \_\_\_\_\_



# Patient Education Form Regarding Interim Treatment

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Please complete this form and mail or email: [riskmanagement@lviglobal.com](mailto:riskmanagement@lviglobal.com)

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## Treating doctor must complete this form with the patient before starting the course

As a patient of Dr. \_\_\_\_\_, I \_\_\_\_\_ understand the following information regarding my treatment in the Core V Live Course at LVI on \_\_\_\_\_, 20\_\_\_\_.

I understand that my treatment is based on Physiologic science and that this science utilizes an orthotic on the lower teeth as a functional temporary mandibular repositioning appliance until my treatment is finalized by completion of permanent restorations on my lower teeth.

I further understand that to properly complete the occlusal changes my doctor will begin, in this course, Physiologic science must be considered in order to protect the restorations that will be placed by my doctor.

I also understand that a fixed orthotic will be placed on my lower teeth at the final appointment for this course and that it should not remain in place more than 6 months due to limitations on proper oral hygiene. In the event that I am not able to have the lower restorations placed within the 6 month time period, I understand that I am responsible for making an appointment to have my doctor place a removable orthotic to protect my oral health. I also understand that treatment with a fixed orthotic requires me to have further permanent restorative treatment on my lower arch and I am committed to that further treatment as has been explained by my doctor.

The upper restorations and lower orthotic will be completed and placed on \_\_\_\_\_, 20\_\_\_ at Las Vegas Institute for Advanced Dental Studies, LVI Global.

Patient Signature: \_\_\_\_\_

Treating Doctor's Signature: \_\_\_\_\_

It is recommended that you review this with the patient. Keep the original in your patient record, provide a copy to your patient, you must submit a copy with the risk documentation prior to the course.



# Documentation of Work Done at Home Office

## DOCUMENTATION OF WORK DONE AT HOME OFFICE IN PREPARATION OF THE PATIENT AND TREATMENT PLAN

Please complete this form in its entirety. **Do not leave any portion of question #3 unanswered.** This should be completed from both a liability and dental standpoint. **Note:** Do not make travel plans prior to receiving approval of your case. The earlier that you get the case information in, the easier it is for you to plan.

**1. Please indicate any radiographs and/or tomograms you have taken of your patient in preparation for this course and the date taken.**

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**2. Please indicate if a Smile Analysis was completed, and the date the diagnosis was determined.**

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**3. Please indicate the Treatment Plan including:**

A) treatment options that have been presented to your patient,

B) option you and your patient chose,

C) age and sex of your patient

D) exact treatment plan to be performed (including detail).

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I hereby verify and confirm that \_\_\_\_\_ is my patient of record.

Patient's Name

I also agree that I am responsible for all the follow-up remedial care on my patient for this course.

**Participating Doctor's Signature** \_\_\_\_\_

**Printed Name** \_\_\_\_\_





Prep Date  
 BP \_\_\_\_/\_\_\_\_  
 P\_\_\_\_  
 Seat Date  
 BP \_\_\_\_/\_\_\_\_  
 P\_\_\_\_

## MEDICAL HISTORY

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

<input type="checkbox"/> Y	<input type="checkbox"/> N	Abnormal Bleeding	<input type="checkbox"/> Y	<input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A/	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke/use tobacco?
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Bones	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	If you are female:
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking birth control?
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HIV & AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	If yes # of weeks: _____
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<b>Allergies:</b>
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Defect Cosmetic	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Surgery Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pneumocystitis	<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	

Other:

\_\_\_\_\_

Are you currently taking any medications (including aspirin)? If yes, please list:

\_\_\_\_\_

Is there any disease, condition or problem that you think this office should know about that is not covered above? If yes please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent or Guardian if under 18)





## LVI PATIENT INFORMED CONSENT

As a patient at **LVI Global**, I \_\_\_\_\_,  
understand that I will be participating in hands-on training in the use of  
certain diagnostic techniques and procedures used in Physiologic dentistry.

If you have any of the following conditions you are advised **NOT** to TENs:

- Pregnant
- Pacemaker
- Temporal Arthritis
- Active Cancer
  - Yes No
  - 5 Years Cancer Free Yes No
  - What type Cancer? \_\_\_\_\_
  - How was it treated? \_\_\_\_\_

If you have any other medical conditions please consult with the Clinical  
Director prior to participating.

By signing below, you understand the contraindications and have no  
medical restrictions. Participation is optional at all times.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_



## Core V Live Case Approval Worksheet

**\*\*Important Note: You must return this worksheet with your models and NM bite for case approval.**

**Please do not leave any part of this form blank.**

Dr.				Patient:	
Existing Verticals (list tooth #'s for Right, Anterior, and Left)	R #	A #	L #	If the upper centrals have crowns, please use lower width guidelines	
Central Length of tooth #			Total time in current orthotic:		
Central Width of tooth #					
LVI Golden Vertical			Total time in Phase 1:		
Verticals in Orthotic (list tooth #'s for Right, Anterior, and Left)	R #	A #			
				Bite Transfer (circle one): Y Date _____ N If yes, please give details below in question 4.	

1. Do you own (please circle one) : K7 BioPak Neither
2. Do you plan to restore the lower arch in Core VII? Y N
3. Do you plan to restore any implants? Y N

If yes, please give tooth numbers & treatment plan for each below:

4. Please provide any other information pertaining to the case or the patient's symptoms (patient headaches relieved after wearing orthotic, etc.):

**LVI Vertical Index:**

Central Width	Ideal Length	Golden Vertical
7 mm	9 mm	14.5 mm
7.5 mm	9.75 mm	15.75 mm
8 mm	10.5 mm	17 mm
8.5 mm	11 mm	17.75 mm
9 mm	11.5 mm	18.5 mm
9.5 mm	12.25 mm	20 mm
10 mm	13 mm	21 mm
10.5 mm	13.5 mm	22 mm



# MUSCULOSKELETAL - OCCLUSAL SIGNS EXAM FORM

NAME \_\_\_\_\_

DATE \_\_\_\_\_

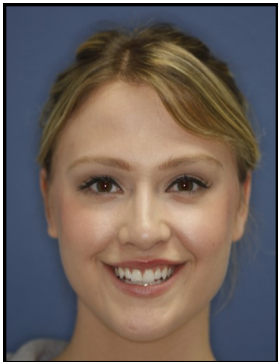
AGE \_\_\_\_\_

SYMPTOMS	SIGNS (intra-oral)
1 <input type="checkbox"/> Headaches	1 <input type="checkbox"/> Crowded Lower Anteriors
2 <input type="checkbox"/> TMJ Pain	2 <input type="checkbox"/> Wear of Lower Anterior Teeth
3 <input type="checkbox"/> TMJ Noise	3 <input type="checkbox"/> Lingual Inclination of Lower Anterior Teeth
4 <input type="checkbox"/> Limited Opening	4 <input type="checkbox"/> Lingual Inclination of Upper Anteriors (Div. II Occlusion)
5 <input type="checkbox"/> Ear Congestion	5 <input type="checkbox"/> Bicuspid Drop Off
6 <input type="checkbox"/> Vertigo (Dizziness)	6 <input type="checkbox"/> Depressed Curve of Spee
7 <input type="checkbox"/> Tinnitus (Ringing in Ears)	7 <input type="checkbox"/> Lingually Tipped Lower Posteriors
8 <input type="checkbox"/> Dysphagia (Difficulty Swallowing)	8 <input type="checkbox"/> Narrow Mandibular Arch
9 <input type="checkbox"/> Loose Teeth	9 <input type="checkbox"/> Narrow Maxillary Arch (High Palatal Vault)
10 <input type="checkbox"/> Clenching/Bruxing	10 <input type="checkbox"/> Midline Discrepancy
11 <input type="checkbox"/> Facial Pain (Nonspecific)	11 <input type="checkbox"/> Malrelated Dental Arches
12 <input type="checkbox"/> Tender, Sensitive Teeth (Percussion)	12 <input type="checkbox"/> Tooth Mobility
13 <input type="checkbox"/> Difficulty Chewing	13 <input type="checkbox"/> Flared Upper Anterior Teeth
14 <input type="checkbox"/> Cervical Pain	14 <input type="checkbox"/> Facets
15 <input type="checkbox"/> Postural Problems	15 <input type="checkbox"/> Cervical Erosion (Notching of Gingival)
16 <input type="checkbox"/> Paresthesia of Fingertips (Tingling)	16 <input type="checkbox"/> Locked Upper Buccal Cusps
17 <input type="checkbox"/> Thermal Sensitivity (Hot & Cold)	17 <input type="checkbox"/> Fractured Cusps (Particularly CI. 1 & II Non-Functional Cusps)
18 <input type="checkbox"/> Trigeminal Neuralgia	18 <input type="checkbox"/> Chipped Anterior Teeth
19 <input type="checkbox"/> Bells Palsy	19 <input type="checkbox"/> Loss of Molars
20 <input type="checkbox"/> Nervousness/Insomnia	20 <input type="checkbox"/> Open Interproximal Contacts
	21 <input type="checkbox"/> Unexplained Gingival Inflammation and Hypertrophy
<b>SIGNS (extra-oral)</b>	22 <input type="checkbox"/> Crossbite
1 <input type="checkbox"/> Facial Asymmetry Bilateral/V	23 <input type="checkbox"/> Anterior Open Bite
2 <input type="checkbox"/> Short Lower Third of Face	24 <input type="checkbox"/> Anterior Tongue Thrust
3 <input type="checkbox"/> Chilitis	25 <input type="checkbox"/> Lateral Tongue Thrust
4 <input type="checkbox"/> Abnormal Lip Posture	26 <input type="checkbox"/> Scalloping of Lateral Border of Tongue
5 <input type="checkbox"/> Deep Mentalis Crease	
6 <input type="checkbox"/> Dished-Out or Flat Labial Profile	
7 <input type="checkbox"/> Facial Edema	
8 <input type="checkbox"/> Mandibular Torticollis	
9 <input type="checkbox"/> Cervical Torticollis	
10 <input type="checkbox"/> Forward Head Posture (Lordosis)	
11 <input type="checkbox"/> Elongated Lower Face(Steep Mandibular Angle)	
12 <input type="checkbox"/> Speech Abnormalities	



## CORE V Live REQUIRED PHOTOGRAPHS

You must submit the following photographs of your patient in digital format:



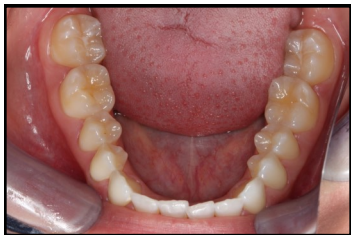
Full Face Smile



Up-close Smile — Right lateral view, Anterior, Left lateral view



Retracted Slightly Open — Right, Anterior, Left



Occlusal (Upper and Lower)



Retracted Habitual Occlusion — Right, Anterior, Left



Retract Occlusion in Fixed Orthotic — Right, Anterior, Left

\*Please DO NOT send prints or original photographs to LVI.

\*All materials sent in for submission must be duplicates.

\*If you will require radiographs during the course please bring extra copies with you.

### Upload all required photos & x-rays:

- Before beginning, RENAME each individual picture you are uploading BEFORE UPLOAD so that the name of the doctor attending and the course name is included in the filename. For example, each picture should be "John Smith Core II 01.jpg", "John Smith Core II 02.jpg", etc.
- Using your Web browser, go to <https://www.hightail.com/u/LVIRiskManagement>
- Type in your email
- In the subject field type the course name and date and your name For example, Core II March/April 2011 John Smith
- Upload only your PROPERLY NAMED photos
- If you have any issues call Programs at 702-341-7978.



# Course Change and Cancellation Policy

Registration fees are non-refundable and must be exercised within two years. LVI Global, LLC ("LVI") reserves the right to cancel courses 30 days prior to the scheduled date of a course or activity. Should LVI cancel a course or activity, LVI will apply the full value of any deposits and fees related to said course or activity to future LVI course or activities. Should LVI cancel a course or activity, you may also have the option of having the deposits returned to you. Fees remain non-refundable but, may be reapplied to another course or activity. LVI will not be responsible for any other fees, costs or consequential damages associated with canceling this LVI course or activity. For courses requiring a live-patient, the treating Doctor must bring a patient of record. During courses conducted at LVI, I understand that photographs or video may be taken of me for educational and marketing purposes. I hold harmless LVI for any liability resulting from this production. I waive any right to inspect the finished production as well as advertising materials in conjunction with these photographs. I understand that I may receive marketing materials as a result of my attendance.

## **Change/Cancellation/Postponement Policy:**

- A change, cancellation or postponement of course date is not complete without your required signature and date.

## **The following do not apply if moving from TBD status to date selection**

- If change, cancellation, or postponement is received 60-90 days prior to registered course, 25% of the course fee will be forfeited.
- If change, cancellation, or postponement is received within 60 days, 50% of the course fee will be forfeited.
- If change, cancellation, or postponement is received less than 30 days prior to your registered class, 100% of the course fee will be forfeited.



# Travel Information

Please note travel expenses are not included in your tuition. Visit the [LVI Global website](#) for the most up to date travel information.



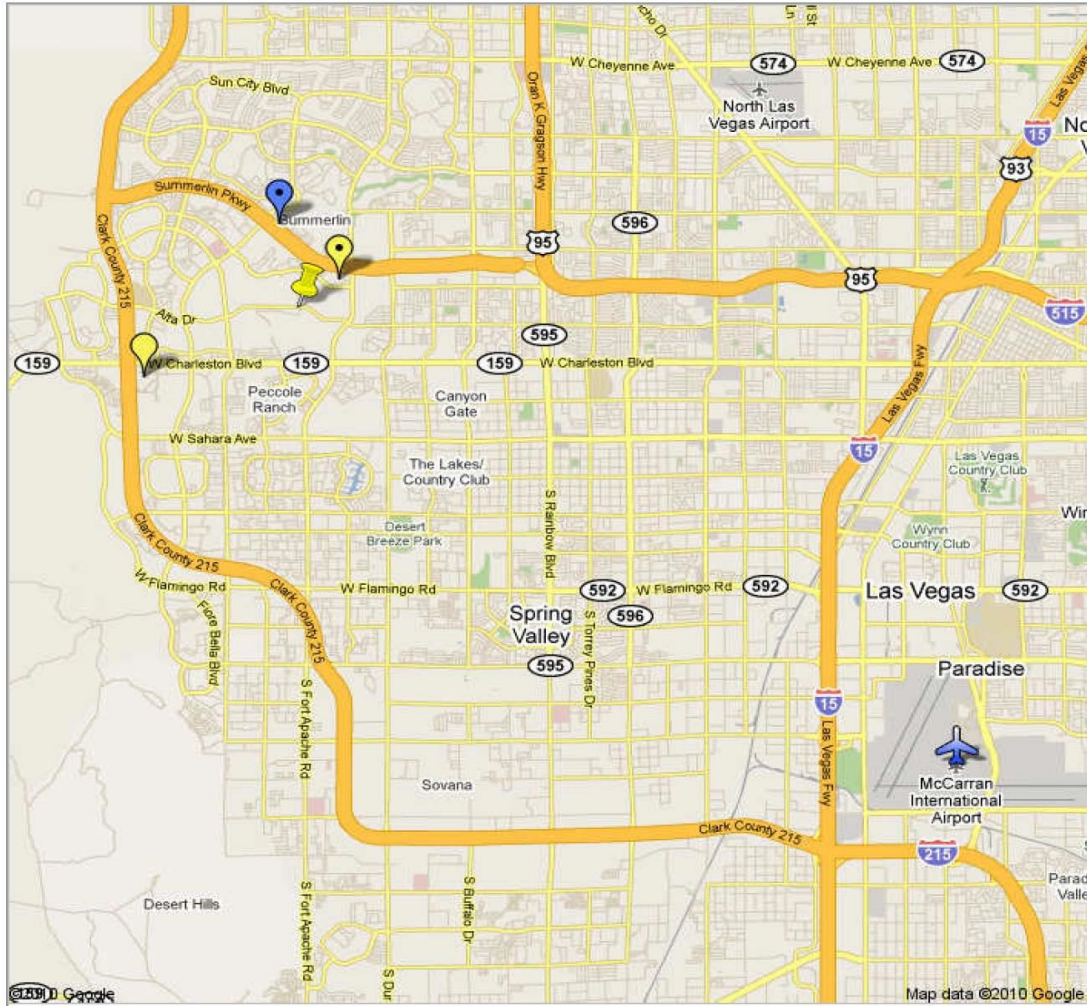


# Assistants

It is mandatory that participants bring an assistant to the program unless auditing. You can register your assistant as a “clinic only” team member; however, it is highly recommended that you register them for the Dynamic Team Concepts course. As a full participating registrant your assistant will have access to lectures, meals and other activities that the Clinic Only assistants are prohibited from attending. Dynamic Team attendees are introduced to clinical and practice procedures that will enable them to not only appreciate their role much but share in the a learning experience that is custom designed to parallel the program in which you are attending. Previous Dynamic Team program attendees report that participating in the Dynamic Team program enhances their comprehension the skills and techniques learned by the doctor offering a quicker transition of the skills learned when returning home. This is also true for the rest of your team. Historically, Doctors who are accompanied by their entire office Team start faster and find that it is easier on their return to the practice. Your team will return inspired, committed to this high value dentistry and are able to communicate its value to your patients.



# Maps and Directions



LVI



Red Rock Casino, Resort and Spa



Suncoast Hotel and Casino



McCarran Airport



JW Marriott Las Vegas Resort Spa

**Click on the links below to view and print maps and directions to the specified locations.**

[McCarran Airport to LVI](#)

[McCarran Airport to JW Marriott Resort and Spa](#)

[McCarran Airport to Suncoast Hotel and Casino](#)

[McCarran Airport to Red Rock Casino, Resort and Spa](#)

[JW Marriott Resort and Spa to LVI](#)

[Suncoast Hotel and Casino to LVI](#)

[Red Rock Casino, Resort and Spa to LVI](#)



# Frequently Asked Questions

## What is the weather like in Las Vegas?

In the winter months temperatures range from 15-60°. In spring the weather is nice with highs between 70-80°. Summer months are hot, highs up to 110°, with nice warm summer nights. In the fall it cools down with temperatures back around 70-80 degrees.

## What should I wear when I come to LVI?

Business casual. We tend to keep the building cold so you might want to bring a light sweater.

## What should I wear if I am treating a patient in the clinic?

Just as you would in your office, appropriate Clinical Attire is expected at LVI. Attire should conform to OSHA/CDC guidelines and regulations, and should include protection like closed toed shoes for all of the team in the clinical setting.

## Is food served at LVI?

A continental breakfast is served at 7:00 each morning and lunch is provided each afternoon. Snacks are also available throughout the day.

## How far is the Las Vegas Strip from LVI?

Approximately 12 miles. It could take up to 30 minutes with traffic.

## Do you provide transportation to LVI?

LVI provides transportation *only* from The Red Rock Hotel and JW Marriot Hotel. Check with the Bell Stand for pick up times on course days.

## Where do I check-in when I first arrive at LVI?

For every course you attend at LVI, you must check-in on the first day in the **Hillwood Building (Building with the purple rotunda)**. You will be directed to breakfast at registration.



# CE Information

## How many CE hours can I expect to receive from this course?

After completing this program, you will receive a CE form of the appropriate AGD approved continuing education credit hours. These credits represent the lecture and participation portion of the course.

## When will I receive my CE credits?

Your CE form will be presented along with your attendance medallion and/or letter. Please keep a copy of this form in your office records.

## Does LVI submit my CE credits for me?

We will submit your CE credits to the AGD if you provide us with your AGD number. It is your responsibility to keep the CE form indicating your credits on file in your office and, if necessary submit your CE hours to the appropriate organization(s) (i.e.: your state/territory, etc.).

## What happens if I lose my CE letter?

Once you receive your CE form, hold on to your originals and send copies when submitting your organizations. If your original letters are misplaced, LVI must charge a \$30.00, per course, processing fee for necessary research. Replacement CE letters can take up to 3 weeks to receive.

## Educational Objectives:

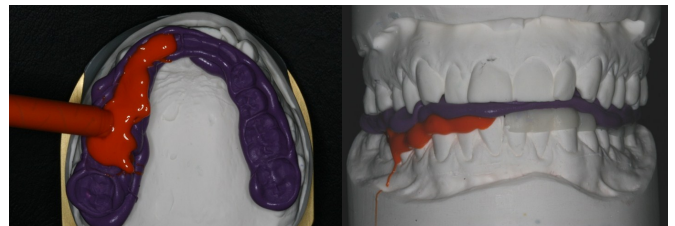
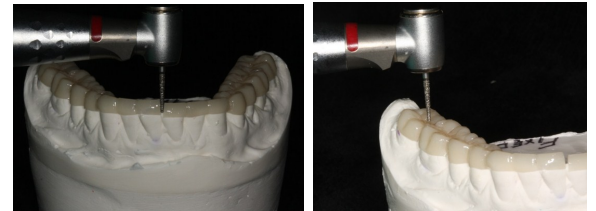
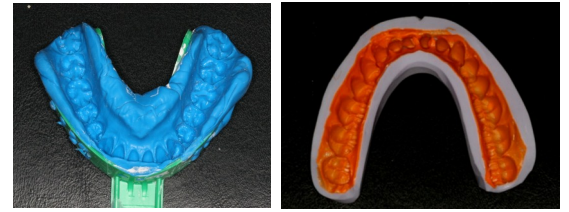
The educational objectives for this course are for the participants to be able to:

- Manage difficult cases such as bruxers, restoration of vertical dimension, and restoring severely dark teeth.
- Understand and address problems associated with a need for occlusal stabilization.
- Define and utilize techniques for subtle porcelain contouring and chairside customization before and after final placement.
- Understand management principles, case presentation skills in addition to good diagnosis and treatment planning
- Identify appropriate marketing case presentation skills in addition to good diagnosis and treatment planning.
- Educate our staff and patients about the power of Physiologic dentistry.



## Fixed Orthotic Bite Transfer

- 1) Prior to bite transfer appointment, take impression of fixed in patient's mouth, pour up model, and make a new Sil-tech stent to fabricate a new fixed orthotic.
- 2) At appointment, TENS patient for an hour to ensure they are on their neuromuscular trajectory.
- 3) Verify 3 verticals (Right/Anterior/Left) in the patient's mouth.
- 4) Place bite reg over the fixed orthotic in the patient's mouth. Have patient close into bite reg. This is the NM CO bite. Repeat to have a 2<sup>nd</sup> CO bite. Verify 3 verticals.
- 5) Using a model of their natural dentition as guide, section fixed orthotic from mesial of central incisor to mesial of 2<sup>nd</sup> molar (or whatever tooth is your "distal stop").
- 6) Remove fixed orthotic. Place NM CO bite reg back into patient's mouth on the upper arch. Reline CO bite reg in the area of the sectioned orthotic. Have the patient close. Verify 3 verticals. Repeat with 2<sup>nd</sup> CO bite reg.
- 7) Section fixed on the other side until the mesial of 2<sup>nd</sup> molar (or whatever tooth is your "distal stop"). Remove orthotic.
- 8) Reline NM CO bite reg—avoid overlapping the bite reg with any previously relined segment. Have patient close. Verify 3 verticals. Repeat with 2<sup>nd</sup> CO bite reg.
- 9) Remove last posterior stops of the fixed orthotic. Reline NM CO bite reg (avoid overlapping) and have patient close. This is the completely relined fixed orthotic Bite Transfer. Should have 2 (1 for Dr and 1 for the Lab).
- 10) Verify 3 verticals—R/Ant/L. Verticals should be the same as when fixed orthotic was in.
- 11) Take Upper (include HIP)/Lower PVS impressions & symmetry bite.
- 12) Using the new stent, fabricate a new fixed orthotic. Verify 3 verticals.
- 13) Send to LVI trained lab:
  - ◇ 1 completely relined Bite transfer
  - ◇ Upper (include HIP)/Lower PVS impressions
  - ◇ Symmetry bite
  - ◇ Full face photo of symmetry bite on patient
  - ◇ Bite Management sheet
  - ◇ Smile Design evaluation



# LVI S.M.I.L.E.S. Evaluation Form

Patients Name \_\_\_\_\_ Date \_\_\_\_\_

## S. - Size and golden proportion.

Width of centrals \_\_\_\_\_ Length of Centrals \_\_\_\_\_ W/L Ratio \_\_\_\_\_ (75%-80%)

Golden Proportion \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (1.6/ 1 / .6)

Centrals Latrals Cuspids

Correct to proper dimensions if possible

Yes  No



## M. - Midline and Canting

Is the midline correct?

Yes

No how far off \_\_\_\_\_ R/L

Is the smile canted?

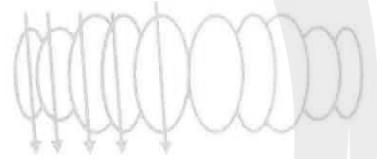
Yes

No



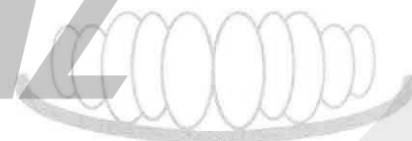
## I. - Axial Inclination

- The teeth are properly mesially inclined
- Mesial / distal incline which needs correction
- Leave teeth as is, even though not properly inclined



## L. - Lip Line vs. Incisal Edge of Teeth

- Incisal edges properly follows lip line
- Reverse smile line
- Deficiency (describe) \_\_\_\_\_



## E. - Extra hard tissue guidelines

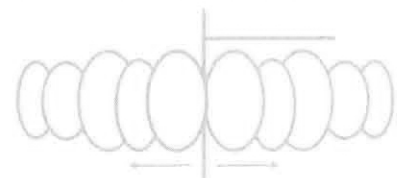
- Contact points proper (gingival migration posteriorly)
- Gradation of teeth proper
- Arch form proper

Corrections necessary \_\_\_\_\_



## S. - Soft Tissue Conditions

- Good Gingival Symmetry / Correction \_\_\_\_\_
- Good Height and Contour / Correction \_\_\_\_\_
- Gingival Zenith Correct / Correction \_\_\_\_\_





## Removable Orthotic Bite Transfer

- 1) Take upper & lower PVS impressions of the natural dentition and pour up models
- 2) Mount upper to HIP on Stratos prior to Bite transfer appointment
- 3) At appointment, TENS patient for an hour so they are on their neuromuscular trajectory
- 4) Verify 3 verticals in removable orthotic—Right/Anterior/Left
- 5) Place bite registration over removable orthotic and have patient slowly close into bite registration. Orthotic should feel stable in the bite. Verify that verticals are the same.
- 6) Remove the orthotic/bite reg from the patient's mouth. Place it on the mandibular model. Before mounting to upper, hand articulate the lower to the upper to verify that the 3 verticals are the same as in the patient's mouth. Mount lower to upper HIP model using the orthotic/bite reg.
- 7) Once mounting is set, remove the orthotic/bite reg, and verify 3 verticals—R/Ant/L.
- 8) Using the mounted models, place bite reg on lower model and close the Stratos into the bite reg. Verify 3 verticals. This is the removable orthotic Bite Transfer. (Make 2 bite transfers-1 for Dr and 1 for lab)
- 9) Verify Bite Transfer(s) in the patient's mouth—R/Ant/L. All measurements should be the same as when you first started.
- 10) Return removable orthotic to patient
- 11) Send the following to an LVI trained lab:
  - ◇ Mounted models
  - ◇ 1 Bite transfer
  - ◇ Upper (include HIP)/Lower PVS impressions
  - ◇ Symmetry bite
  - ◇ Full face photo of symmetry bite on patient
  - ◇ Bite Management sheet
  - ◇ Smile Design evaluation

