COURSE PREPARATION MATERIALS

Core VI Live:

Finalization of Physiologic Rehabilitation Case

Important Risk Management Packet Included

LVI Global
1401 Hillshire Drive, Ste 200
Las Vegas, NV 89134
www.lviglobal.com
888.584.3237

Risk Management

The items below must be completed and faxed or mailed to LVI Global prior to case approval.

- ☐ Student Information Form
- ☐ Agreement for the Dentist Participant
- ☐ Release of Liability Form
- ☐ Information Verification
- ☐ Patient Informed Consent
- ☐ Patient Education Form Regarding Full Mouth Reconstruction
- ☐ Records Release & Consent
- ☐ Documentation of Work Done at Home (please answer every element of question # 3)
- ☐ Medical History
- ☐ Periodontal Evaluation
- ☐ LVI S.M.I.L.E.S. Evaluation Form (optional)
- ☐ Musculoskeletal – Occlusal Signs Exam Form (optional)
- ☐ Case Approval Worksheet, FULLY completed
- ☐ A set of models mounted to the Physiologic bite (see specific requirements on page 5)
- ☐ Digital photographs (see 'Core V & Core VI Live Required Photographs' sheet attached)
- ☐ Full mouth radiographs OR Panorex plus Bitewings in digital format (see 'Core V & Core VI Live Required Photographs' sheet attached)
- ☐ Tomograms in Natural CO and Orthotic (see specific requirements on page 5)
- ☐ Have an original certification of licensure sent from your state board to: LVI Global
  Attention: Core VI 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.
- ☐ BioPAK scans Rest/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 and instructor. We advise that you not make any travel plans until the case is officially approved by Core VI Live Course Director, Dr. Heidi Dickerson.

Models:

Please send a set of models mounted in the Physiologic position of the case you plan to bring to the course at LVI Global. Take your impressions with a polyvinyl siloxane material, not alginate. Pour your models up in stone (i.e.: yellow, green, and pink). Please label the models with your name as well as your patient's name. Your case must be approved before your lab can begin your wax-up, so send your case information to LVI as soon as possible. Your

laboratory will require a separate set of polyvinyl impressions and a Physiologic bite transfer to fabricate your diagnostic wax-up.

Please mail your models & completed case approval worksheet to:

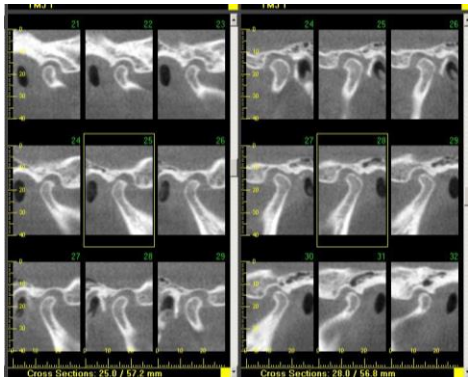
LVI Global
ATTN: Core VI Live (Course Session Date and Your Name) C/O Risk Management
1401 Hillshire Dr. Suite 200, Las Vegas, NV 89134

Tomograms/CBCT:

Please see example of an acceptable tomogram – they must be sent to LVI no later than 4 weeks prior to the course start date. If you are unable to get tomograms in your area, you can have them taken at LVI. The fee is $395 and must be paid for by credit card from the doctor only. We cannot accept payment directly from your patient. Please contact Risk Management (riskmanagement@lviglobal.com) at least 4 weeks before the course to schedule an appointment or for more information.

Tomograms MUST be taken of your patient in two positions:

- Existing CO
- In physiologic position using any of the following; tens or K7 bite registration, fixed or removable orthotic.



Other Important Information:

- An LVI Esthetic Preparation Komet Bur Kit will be 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.
- 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.
- If your patient has implants you must bring all the necessary supplies to treat the implant

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 or letter of good standing. 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

Student Information Form

Please complete this form and mail or email: riskmanagement@lviglobal.com
LVI Global • 1401 Hillshire Dr. Ste 200 • Las Vegas, NV 89134 • Phone (888)584-3237

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
- ☐ Intermediate esthetic dentist
- ☐ Experienced 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

Please complete this form and mail or email: riskmanagement@lviglobal.com
LVI • 1401 Hillshire Dr. Ste 200 • Las Vegas, NV 89134 • (888)584-3237

I, _____, am a participant in a continuing dental education program, Core VI 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 _____ 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.
Patient's Name

My current liability insurance coverage is with:

Name of Insurance Company _____

Please Print Dr.'s Name _____

Doctor's Signature _____

Date _____

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

Release of Liability Form

Please complete this form and mail or email: riskmanagement@lviglobal.com
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Release of Liability Agreement

I am participating in the LVI Course, Core VI 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

Please complete this form and mail or email: riskmanagement@lviglobal.com
LVI • 1401 Hillshire Dr. Ste 200 • Las Vegas, NV 89134 • (888)584-3237

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 VI Live: Finalization of Physiologic Rehabilitation Case

Patient Name_____

Nature of Treatment to be Rendered: Functional/Esthetic / Restorative treatment of the dentition to include 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:

_____
Signature *Date*

_____
Printed Name

WITNESS:

_____
Witness *Date*

_____
Printed Name

Patient Education Form Regarding Core VI Live

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

LVI Global • 1401 Hillshire Dr. Ste 200 • Las Vegas, NV 89134 • Fax (702)341-0983

As a patient of Dr. _____, I _____ understand the following information regarding my treatment in the CORE VI Live Course at LVI on _____, 20__.

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

I understand that for a period of time prior to the first visit of the Core VI Live Course at LVI, I will be placed in an orthotic repositioning device(s) on the lower and/or upper teeth to establish and maintain my neuromuscular occlusal position. At the first appointment for Core VI Live at LVI the device(s) will be removed; the upper and lower teeth will be prepared and temporary restorations will be placed on the upper and lower dentition. At the final appointment for the Core VI Live at LVI, approximately one month later, the permanent restorations will be placed on the upper and lower dentition. Between the two appointments, I will be contacted by my doctor from his/her office to ascertain my comfort and the health of the dentition.

I do understand that although final restorations will be placed, there will be some required refinements to these restorations after cementation. To properly complete the occlusal changes my doctor will begin in this course, neuromuscular science will be used and will always need to be considered in order to protect the restorations and established occlusion that will be placed by my doctor in the for the Core VI Live Course at 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, and submit a copy with the risk documentation prior to the course.*

Records Release & Consent Form

Please complete this form and mail or email: riskmanagement@lviglobal.com
LVI • 1401 Hillshire Dr. Ste 200 • Las Vegas, NV 89134 • (888)584-3237

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, 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: _____

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:** (Please 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. (please include dates)

_____

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

_____

******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 preformed (**including detail**).

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I hereby verify and confirm that _____ 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.
Patient's Name

Participating Doctor's Signature _____

Printed Name _____

Prep Date
BP ____/____
P____
Seat Date
BP____/____
P____

MEDICAL HISTORY

Patient Name:_____ DOB:_____

Sex: _____ Height: _____Weight: _____

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

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)

PERIODONTAL EVALUATION FORM

Please indicate on the charts below and in writing any concerns regarding the periodontal health of the patient and treatment required before and/or during the case treatment plan for this patient. Please document if the patient's periodontal health requires no special attention.

_____

_____

_____

_____

_____

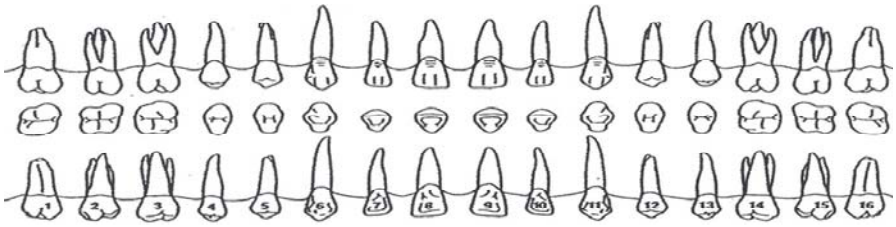
PERIODONTAL CHARTING RECORD

Name: _____ Medical Alert: _____

Date:

	Mobility																
	Probe 3																
	Probe 2																
	Probe 1																

Buccal

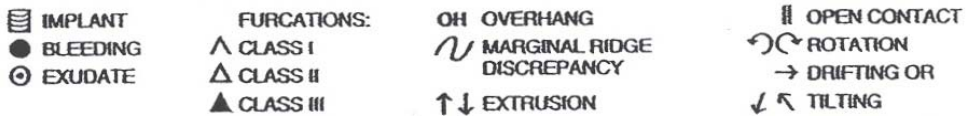


Lingual

Date:

	Probe 1																
	Probe 2																
	Probe 3																

LEGENDS:

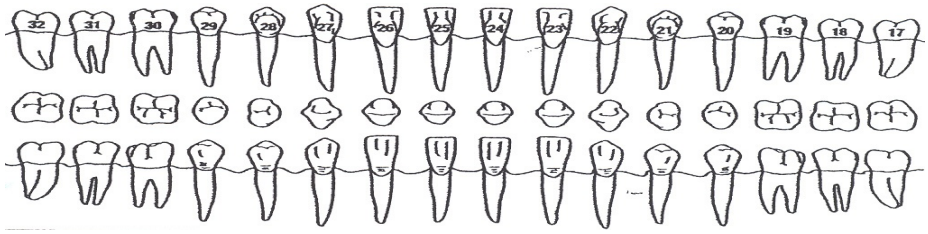


Date:

	Probe 3																
	Probe 2																
	Probe 1																

Lingual

Buccal



Date:

	Probe 1																
	Probe 2																
	Probe 3																
	Mobility																

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: _____

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_____

Core VI Live Case Approval Worksheet

Important Note: You must return this worksheet with your models for case approval.

Models must be mounted to the Physiologic position.

Please do not leave any part of this form blank.

Dr.		Patient:
Central Width of tooth #		*If the upper centrals have crowns, please use lower width guidelines*
Central Length of tooth #		Type of current orthotic: removable ☐ fixed upper ☐ fixed lower ☐
Existing Vertical from tooth # to #		Total time in current orthotic:
LVI Golden Vertical		Total time in Phase 1:
Vertical in Current Orthotic		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 VI Live? 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.):

_____

_____

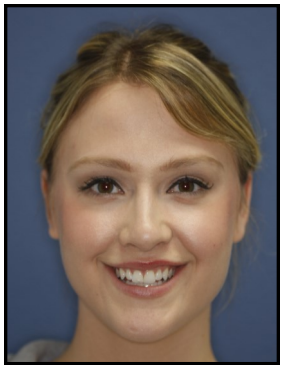
_____

LVI Vertical Index:

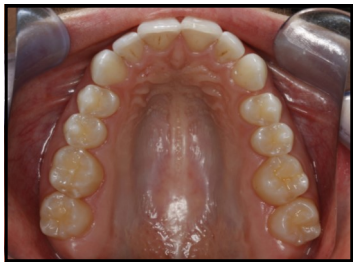
Central Width	**Ideal Length**	**Golden Vertical**
7 mm	9 mm	14.5 mm
7.5 mm	9.75 mm	15.75 mm
8 mm	10.5 mm	17 mm
8.5 mm	11 mm	17.75 mm
9 mm	11.5 mm	18.5 mm
9.5 mm	12.25 mm	20 mm
10 mm	13 mm	21 mm
10.5 mm	13.5 mm	22 mm

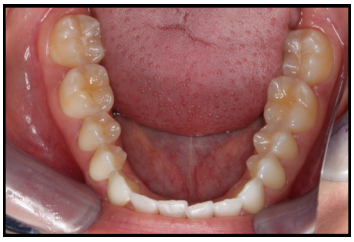
CORE V & VI Live REQUIRED PHOTO-

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

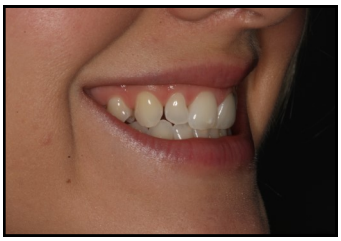


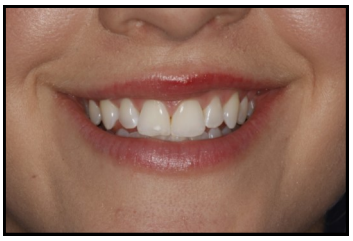
Full Face Smile

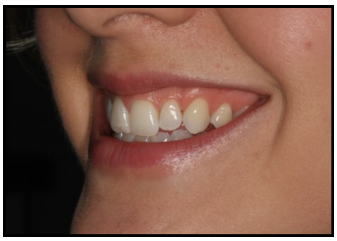




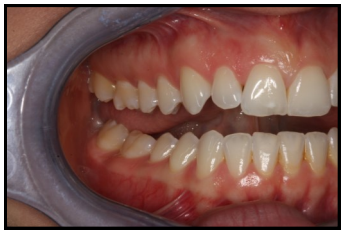
Occlusal (Upper and Lower)

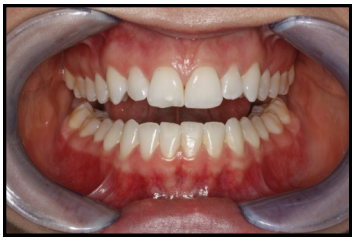


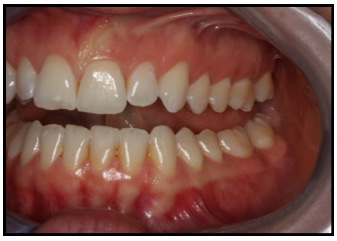




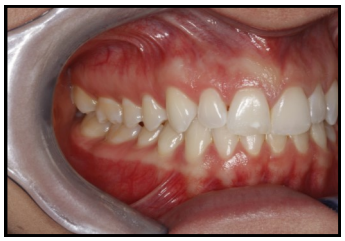
Up-close Smile — Right lateral view, Anterior, Left lateral view

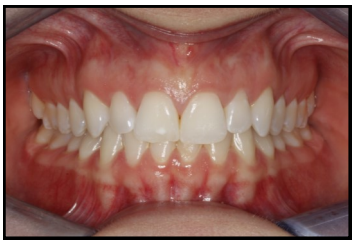


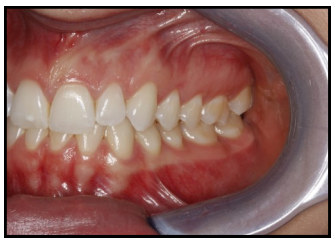




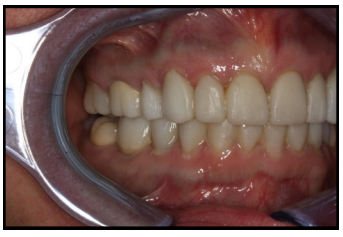
Retracted Slightly Open — Right, Anterior, Left

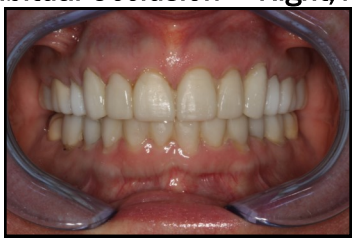


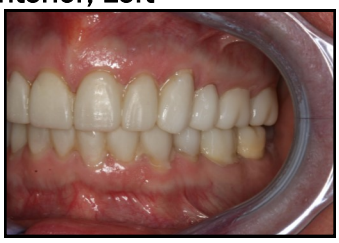




Retracted Habitual Occlusion — Right, Anterior, Left







Retracted Physiologic 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.

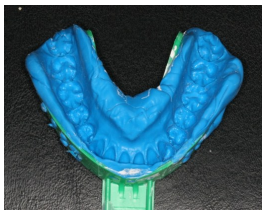
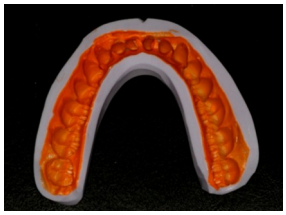
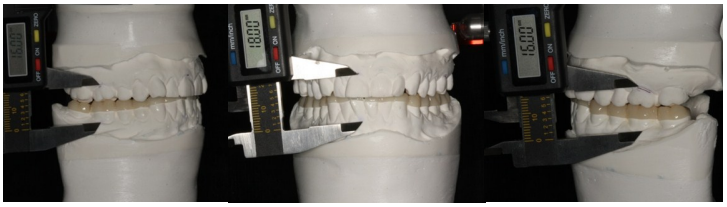
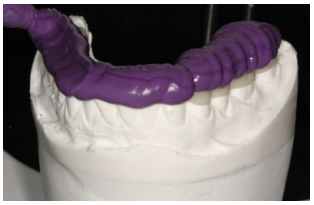
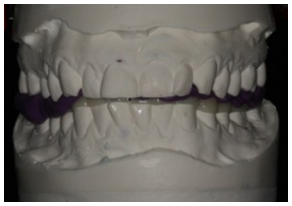
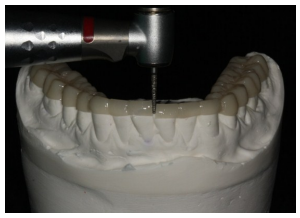
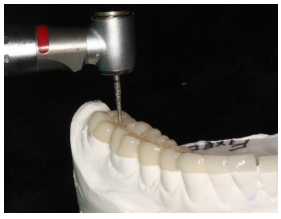
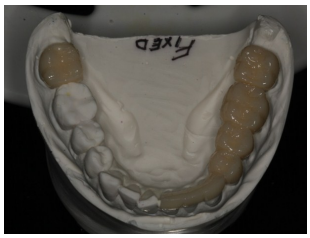
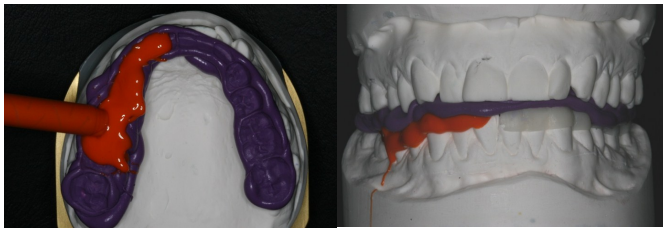
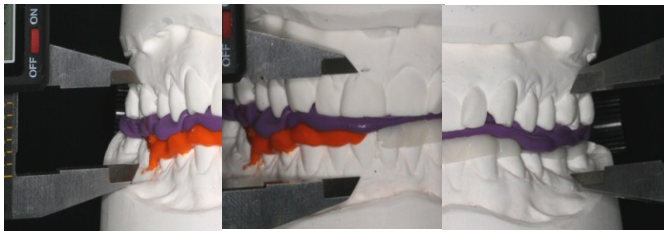
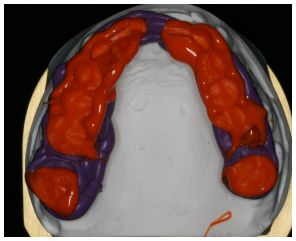
Musculoskeletal - Occlusal Signs Exam Form

NAME_____DATE_____AGE_____

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

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. Verify 3 verticals.
5) Using a model of their natural dentition as guide, section fixed orthotic from mesial of central incisor to mesial of 2nd 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.
7) Section fixed on the other side until the mesial of 2nd 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 verti-cals.
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.
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 & sym-metry bite.
12) Using the new stent, fabricate a new fixed orthotic. Verify 3 verticals.
13) Send to LVI trained lab:

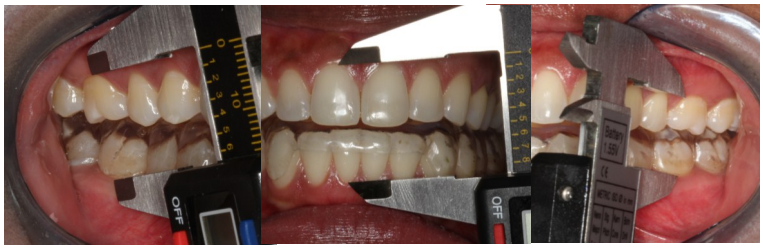












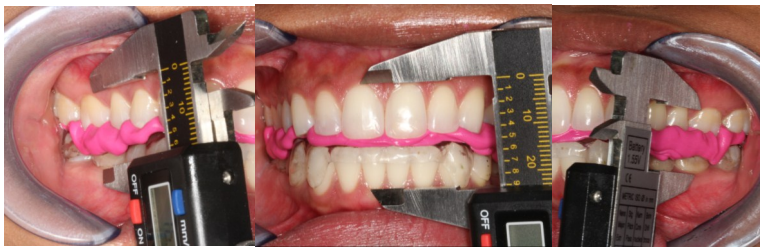
- ◊ 1 completely relined Bite transfer
- ◊ Upper (include HIP)/Lower PVS impressions
- ◊ Symmetry bite
- ◊ Full face photo of symmetry bite on patient
- ◊ Bite Management sheet
- ◊ Smile Design evaluation

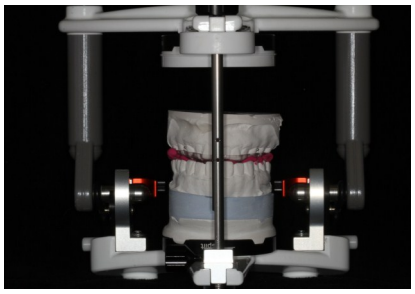
Removable Orthotic Bite Transfer

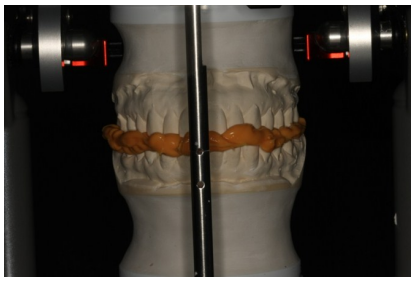
1) Take upper & lower PVS impressions of the natural dentition and pour up models
2) Mount upper to HIP on Stratos prior to Bite transfer appointment
3) At appointment, TENS patient for an hour so they are on their neuromuscular trajectory
4) Verify 3 verticals in removable orthotic—Right/ Anterior/Left
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:

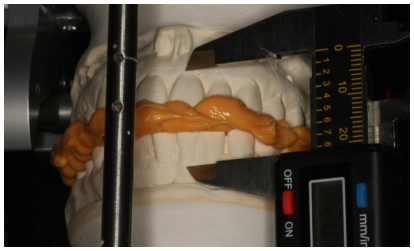
- ◊ Mounted models
- ◊ 1 Bite transfer
- ◊ Upper (include HIP)/Lower PVS impressions
- ◊ Symmetry bite
- ◊ Full face photo of symmetry bite on patient
- ◊ Bite Management sheet
- ◊ Smile Design evaluation

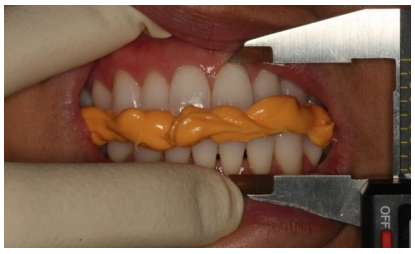












Assistants

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, 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.

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.

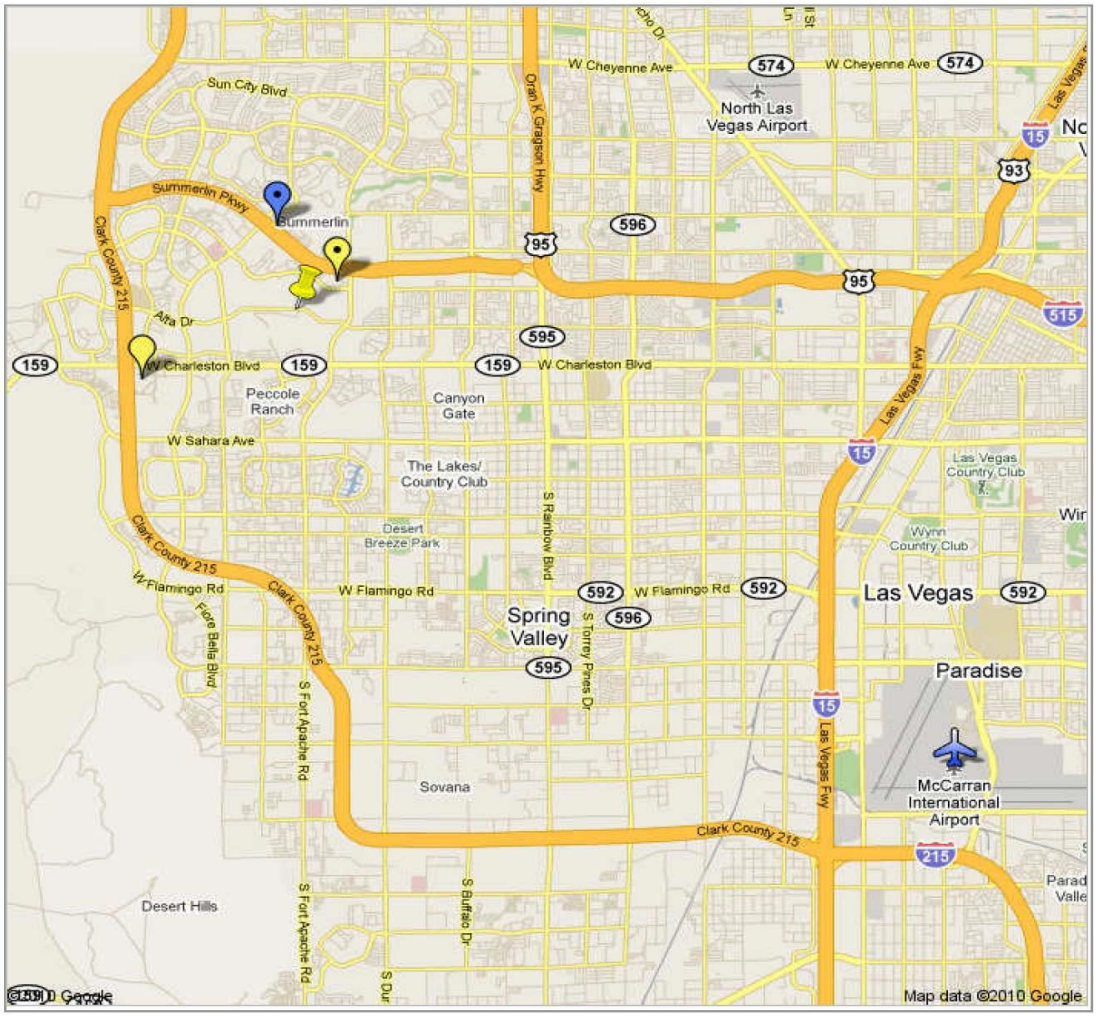
Travel Information

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

IT IS HIGHLY RECOMMENDED THAT YOU BOOK YOU HOTEL AS SOON AS POSSIBLE.

30 DAYS OUT LVI'S ROOM BLOCK WILL BE RELEASED SO ROOMS MAY NOT BE AVAILABLE

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:

- Prepare the entire case in one sitting, impress and temporize in the new position that you have scientifically determined to be the best for your patient.
- Seat restorations for a full case in only one appointment with predictability and ease using the tried and proven techniques taught at LVI.
- Utilize scientific coronoplasty techniques to finish the case to maximum efficiency and function. Then you will see it proven using scientific instrumentation.
- Implement this complex procedure in your practice
- Accurately equilibrate a case for maximum function.