Imagine a new patient has just walked into your practice for the first time. They’re not sure what to expect, and they’re not exactly sure what might be going on in their mouth.

Best-case scenario: A patient comes in for a routine checkup and he or she is out the door in 30 minutes with no problems.

Worst-case scenario: A patient comes in and that routine checkup turns into a root canal and the need for a crown. Now, that 30-minute visit has become two additional, lengthy appointments: One to prepare the tooth and another to return and have the lab-created crown placed.

But these days, things are looking up for our patient. While he or she may still need that root canal and eventual crown, if the doctor is equipped to create chairside restorations, the patient can get everything done in just one visit.

Using CAD/CAM equipment, the process starts with the doctor taking an intraoral scan of the affected tooth or teeth. The resulting digital file is then sent to a local computer where either the doctor or a member of staff uses specialized software to design the restoration. Finally, the restoration is transferred to an on-site mill (and then some finishing steps) where the restoration transforms from a virtual existence to a completed and ready-to-use restoration.

With or without a lab
Restorations—including crowns, inlays and onlays—can be manufactured for use anywhere in the mouth, but the most common restorations are posterior crowns.

“Most users have routinely used CAD/CAM to manufacture monolithic all-ceramic single unit posterior restorations such as e.max and/or zirconia (Zirlux/BruxZir) materials,” John Cox, Vice President of Technology Sales at Henry Schein says ...

See chairside, page 36
What you do in your office helps create a healthier planet.

We’re all familiar with the concept of “Going Green” as a way to safeguard our natural resources— and using environmentally-friendly products from the Henry Schein Global Reflections Flyer is a great way to be part of this important cause. A portion of the proceeds from every purchase made through this special program will be donated to nonprofit organizations that strive to make our world a better place.

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What's now possible with chairside CAD/CAM.

**IS SAME-DAY DENTISTRY RIGHT FOR YOU?**

What our experts are excited about in 2017 And why you should be excited, too!

Dr. Nash shows a new method to more efficiently place a cemented implant crown

**TECHNIQUE:**

Digital impressions for better implants

**EDITORS' CHOICE**

**Why 2017 might be a new “Golden Age”**

Dentistry is a beautiful field. I am in the business of giving people smiles, new beginnings, second chances, a clean slate. It is a privilege afforded to very few.

But in the hidden angles of those perfectly proportioned embrasure spaces, there is also a world of growth, of opportunity, of business. Those two worlds, the one of science and esthetics and health and the one comprised of finances and facts, do not have to be at war with each other. They can complement each other. When run the right way, a dental business can become an avenue to helping countless more people, patients and staff alike.

I set out in the world of dentistry with a business background to unite these long estranged enemies. Business management and healthcare, when coupled in their optimal forms, can become a superpower, a force which breaks the barriers of access to care, quality of care, and patient experience.

When a practice has the right systems in place and the right resources, running a business can go from being an impediment to a facilitator of better dentistry. ...
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Better strength, esthetics with this composite

Kerr’s new Harmonize™ is described as a next-generation composite infused with Adaptive Response Technology (ART). ART is a nanoparticle filler network formulated to help you achieve lifelike restorations with more ease and simplicity than ever. With better blending capabilities and enhanced structural integrity, the ART of Harmonize is said to provide your restorations with exceptional strength and esthetics. The ART filler system in Harmonize diffuses and reflects light in a similar way as human enamel, for an enhanced chameleon effect. Careful control of the size and shape of the ART filler system permits high loading for optimal strength. Enhanced nano-scale filler particle network has improved mechanical properties and is more reactive with resin for more efficient polymerization. Adaptive viscosity is said to offer easier handling and the material’s filler network features high loading and a spherical shape to minimize stickiness while also incorporating a rheological modifier. This provides adaptive viscosity: It’s softer while sculpting, making it easy to shape the composite. When sculpting is complete, the viscosity increases, which prevents the material from slumping.

Kerr Corp.
800-KERR-123
KerrHarmonize.com
CIRCLE RS #3

Diode laser features super pulse technology for more precise, enhanced tissue cutting

The Epic Pro, which reportedly offers the most laser power of any diode laser in dentistry, is the first product to be introduced resulting from BIOLASE’s strategic development agreement with Ipg Photonics. The newest addition to the Epic family of dental soft-tissue lasers, Epic Pro features several new innovations that are industry-firsts: A new super pulse technology for more precise, enhanced laser tissue cutting; real-time automatic power control to enhance speed and consistency when performing surgery; and pre-initiated, bendable, disposable tips with new smart tip technology to ensure tip performance and quality.

BIOLASE
888-424-6527
biolase.com
CIRCLE RS #4

Digital integrated implant solution improves planning, confidence

Carestream Dental has introduced CS Solutions for Implants, a digital integrated implant solution that is said to support more confident diagnoses, improved treatment planning, better patient/referral communication and greater confidence when placing implants. Prosthetically driven implant planning starts by combining the data sets from a digital impression taken by either the CS 3500 or CS 3600 intraoral scanner and a CBCT scan by either the CS 8100 3D extraoral scanner and a CBCT scan by the CS 9300 system. The two scans are reportedly automatically aligned in CS 3D Imaging software to create a virtual set-up with little to no manipulation from the doctor. Next, a new Prosthetic-Driven Implant Planning module of CS 3D Imaging allows doctors to virtually plan the crown and implant on the same screen to ensure that the implant is positioned according to the ideal future restoration. Doctors add the crown to the combined scanner/CBCT datasets and place the implant from a library featuring more than 60 manufacturers. They can also create their own implants and manage their own library.

Carestream Dental
800-944-6365
carestreamdental.com
CIRCLE RS #5
IS SAME DAY DENTISTRY RIGHT FOR YOU?
What’s now possible with chairside CAD/CAM
This month’s cover story takes a close look at how chairside CAM/CAM technology has changed the way you perform dentistry, as well as the expectations of your patients by Robert Elsenpeter

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68 Solve a clinical challenge | The Canary System detects caries around the margins of amalgam restorations. by Dr. Stephen Abrams
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CAV27-0715-2 Rev. 2
Dr. Erinne Kennedy
Dr. Erinne Kennedy completed her undergraduate studies at The Ohio State University before earning her degree from Nova Southeastern University College of Dental Medicine in 2009. After completing an Advanced Education in General Dentistry at the University of Colorado, Dr. Kennedy practiced private practice in Colorado. Proficient in CEREC dental technology, with a focus on things that provide better care and better experiences for patients. He blogs about technology and life at blog.denite.com.

Dr. Jason Watts
Dr. Jason Watts is a graduate of Nova Southeastern University College of Dental Medicine. Dr. Watts is a contributing editor to igniteDDS, and the lead author for the Wisdom Tooth Blog (MedproDentalBlog.com). He is a dental consultant for Medpro Dental Matpractice and has a private practice in Cape Coral, Florida.

Dr. Tara Griffin, DMD
Dr. Tara Griffin is a 1994 graduate of Millikin University and received her Doctor of Dental Medicine degree from the University of Kentucky College of Dentistry. She completed her general practice residency at the Hampton Veterans Affairs Medical Center, and maintained a private group practice in Illinois for several years, with a focus on comprehensive restorative dentistry and treatment of TMJ disorders and sleep apnea. Dr. Griffin currently practices in Florida.

Dr. Emily Hobart
Dr. Emily Hobart graduated from Midwestern University Glendale, Arizona in 2015. During her time in dental school she was very involved with the American Student Dental Association (ASDA), serving as the chapter president for two years and District 10 trustee for one year. A native of Ontario, Canada, Dr. Hobart grew up in the Phoenix area. She currently practices in Columbia, South Carolina.

Dr. David Rice, DDS
Dr. David Rice is the founder of igniteDDS, the nation’s largest student and new dentist community. Dr. Rice travels the world speaking, writing and connecting today’s top young dentists with successful dental practices. He maintains a restorative and implant practice in East Amherst, New York. Dr. Rice received his DDS degree from the State University of New York at Buffalo in 1994, and completed his residency at the Allegheny General Hospital in Pittsburgh in 1995.

Dr. John Flucke
John Flucke, DDS, is Chief Dental Editor and Technology Editor for Dental Products Report and dentistry’s “Technology Evangelist.” He practices in Lee’s Summit, Missouri, and has followed his passions for both dentistry and technology to become a respected speaker and clinical tester of the latest in dental technology, with a focus on things that provide better care and better experiences for patients. He blogs about technology and life at blog.denite.com.

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Dr. Amisha Singh
Dr. Amisha Singh is a Denver native and loves living in Colorado. While in dental school, she was the founder of the first diversity oriented, nationally based organization at the school and she currently serves the University of Colorado Department of Diversity and Inclusion as an alumni contributor. She is a member of the ADA, CDA and MSC and serves on the CDA New Dentist Committee as Social Chair. She is also a blogger/writer, speaker and is the AVID Healthcare Liaison for Denver Public Schools.

Our Mission Statement
Dental Products Report—known for its trusted new product information—delivers a sharp focus on high-tech innovations and their implementation as well as how cutting-edge technologies are transforming practices. DPR helps dentists future-proof their practices and position themselves to deliver the best dentistry possible to benefit both their patients and their practices. We are committed to delivering unbiased, quality content.
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The top 8 most embarrassing dentist/patient situations

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TOP 5
CHANGES TO CHAIRSIDE
PROCEDURES

01 Work with or without a lab

Chairside is an appealing option for those who wish to invest the
time and money in a same-day dentistry solution. However, there
may still be cases when the doctor wants to use a laboratory.

02 Mill your own posterior fixed restorations

If you’ve got the ability to mill in your office, most of the time you could be
doing all of your posterior fixed restorations, according to Dr. John Flucke.

03 Understanding the ROI

The prospect of owning a chairside system comes with a hefty price
tag—most systems cost in excess of $100,000. In order for the expense
to make sense, the practice must do a certain number of chairside
cases each month. But remember, cost can be measured by metrics
other than dollars and cents. One ability afforded by chairside is the
capability for dentists to satisfy their patient’s wants and needs.

04 New methods to communicate

Using a lab in conjunction with one’s chairside efforts underscores
the need for solid communication. Happily, manufacturers
provide tools that can help bolster those connections.

05 Better accuracy, diagnostics

With the expanding potential delivered by a digital workflow, improved
information can only help with improved treatments. Diagnostically, the idea
of capturing, keeping digital records and being able to look at your mouth
over time will be able to provide much more information long-term, and it’s
always better when the clinician can show things like the recession.

For more details on this topic, make sure to read this month’s cover story.

WORK WITH OR WITHOUT A LAB

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MILL YOUR OWN POSTERIOR FIXED RESTORATIONS

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THE POWER OF TECHNOLOGICAL CHANGE

Continued from cover ... I set out in the field to eradicate the Monday Blues.

Older dentists speak of the Golden Age of Dentistry and reminisce about times when fee for service patients and gold foils dominated. This may not be the Golden Era any longer, but that does not make this time any less precious. Times may have changed with regards to insurances and reimbursements, but we have gained so much with technological advances. We have shifted from the Golden Era to the Age of Technology.

Growth happens outside of one’s comfort zone and that is exceedingly true for practices. The jump from paper charts, processed films and traditional impressions may be a rough transition, but it is a transition that pays off in spades. The resources offered in practice management, appointment reminders, patient reward systems and chairside patient education are changing the way dentistry is done.

Any dentist who has struggled with case acceptance should know the magic of an intraoral camera. A crack in enamel or an amalgam which encompasses three cusps is hard to argue with in its fully pixilated glory. A dentist who has had problems with appointment failure rates can change their life easily and affordably with a service that combines reminding patients and reviewing their experience at the office. Technology can make life easier, practices more profitable, and the care we provide better.

Growth in dentistry has not just been limited to technology and the standard of care. We now know the toll 30 to 40 years of dentistry can take on a human’s skeleton and muscle structure. We can be more proactive with our own care. The simple shift in widespread use of loupes has transitioned the way we work and the work we do. Lightweight magnification has enhanced the topography of our preparations as well as saved our backs.

The ability to globally connect with fellow clinicians has afforded us the opportunity to build a worldwide community. We are no longer sole dentists working within our four walls. As we build connections, our education and our motivation has the potential to skyrocket. We should care for ourselves with the same diligence and passion with which we care for our patients. Longevity, health and mental resiliency for a practitioner mean a longer, healthier career which translates into helping countless more people.

Is it inarguable that dentistry has transformed within the past 50 years at a record breaking pace. Materials, techniques and even the practices themselves have changed so quickly and so significantly that they barely represent their beginnings. But, with this change has come an incredible amount of opportunity. In this world, we have the ability to change not only the smiles and lives of our patients, but the world we practice in as a whole. That is a humbling opportunity.

[Dr. Amisha Signh]
DPR Editorial Advisory Board
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* Stanley F. Malamed – Handbook of local anesthesia – 6th Ed

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One practitioner shares how ClearCorrect easily and efficiently helped one patient become more confident in his smile. by Dr. Matthew R. Parker DMD

http://bit.ly/2eCT34G

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Log on to DentalProductsReport.com for up-to-date product news and our exclusive content
TempCanal™ Enhanced
Pulpdent’s newest calcium hydroxide product, TempCanal Enhanced, features pH > 12 and disinfects canals and prevents flare-ups, making it ideal for routine use between visits and for extended treatment of complicated cases. The simple-to-use material is said to flow easily through 27-gauge x 25 mm, 2-side-vent, endo irrigation needles. The non-setting, non-drying formula will not clog the needle and is easily removed with file and irrigation. The 2-side-vent, closed-end needle controls placement and ensures uniform coating of canal walls, while also preventing extrusion beyond the apex. The paste will not dry out in the syringe. TempCanal™ Enhanced is packaged in standard 1.2 mL and 3 mL luer lock syringes for convenient one-hand operation.

Pulpdent Corp.
617-926-6666 | pulpdent.com
CIRCLE RS #16

OraCoat® XyliGel®
OraCoat, a division of OraHealth Corp., a leader in the breakthrough technology of oral adhering discs, recently launched a new version of OraCoat® XyliGel®. Formulated with all-natural ingredients, XyliGel coats the mouth with 17% xylitol and oral lubricant to help relieve the symptoms of xerostomia (dry mouth) for those who have very low levels of saliva or prefer to use a gel.

OraCoat
877-672 6541 | oracoat.com
CIRCLE RS #18

Brasseler USA is pleased to unveil the new NL4500 handpiece. Featuring a unique 45° angle head design that allows for maximum visibility and posterior access, it is ideal for treating impacted molars. Equally important is the special triple port design that delivers a water stream, not a mist, directly to the tip of the bur. The NL4500 is designed to deliver a powerful 21 watts of power, features ceramic ball bearings and a push button head, all in a lightweight design.

Brasseler USA
800-841-4522 | BrasselerUSA.com
CIRCLE RS #17

Vista Dental Products introduces the world’s only Dripless Syringe™. These patent-pending syringes feature anti-drip technology, reportedly greatly reducing the risk of bleach stains, damage to skin, eyes and oral mucosa, and cost no more than a standard irrigating syringe. The syringes feature a unique color-coded plunger to quickly identify NaOCl, and color-coded ring for improved visibility in magnified fields. They are available in untipped and pre-tipped 6 cc and 12 cc syringes.

Vista Dental Products
877-418-4782 | vista-dental.com
CIRCLE RS #19
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Progressive Orthodontic Seminars is an ADA CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry. Progressive Orthodontic Seminars designates each day of seminar for 8 hours of continuing education credits.
EXPAREL

Pacira Pharmaceuticals recently announced new data regarding the benefit of EXPAREL® (bupivacaine liposome injectable suspension) for patients undergoing third molar (wisdom teeth) extraction, marking the official launch of the product to the oral surgeon community. EXPAREL is a local analgesic that provides prolonged non-opioid postsurgical pain control. As many battle the opioid addiction crisis, there is a particular opportunity to offer opioid alternatives to treat postsurgical pain in oral surgery patients.

Pacira Pharmaceuticals, Inc.
973-254-3587 | EXPAREL.com
CIRCLE RS #21

Wrigley’s Orbit® Prophy Paste and Gum packs

Young Dental and Wrigley have introduced Wrigley’s Orbit® Prophy Paste and Gum packs. This first-of-its-kind product lets patients experience the signature flavors of Orbit gum both during and after dental appointments. Each co-pack contains a single-dose cup of Orbit-flavored prophy paste in the brand’s Bubblemint™, Spearmint and Peppermint flavors, and a piece of corresponding Orbit sugar-free gum. The new Orbit Prophy Paste has a smooth, rich consistency that effectively removes stains and easily rinses away.

Young Dental
800-325-1881 | youngdental.com/orbit
CIRCLE RS #22

Planmeca Evolution Dental consoles

Planmeca offers a solution to a problem facing many practices: how to help clinicians work more efficiently in the footprint of their existing office. Connected technology, and efficient environments combined with clever organization are the answer – and Planmeca Evolution Dental consoles provide the solution. The line of Evolution Consoles including the Evolution 12 O’Clock, Evolution Central Island Console, and Evolution Side Console all feature quick and easy integration of modern technology. Offering Ethernet and 3.0 USB connections, PlanScan® (digital scanner) integration, CPU storage, LED lighting, and medical grade duplex GFCI outlets, these digital, and up-to-the-minute enhancements aid the clinician’s workflow and information processing. Evolution console features are unmatched by standard dental cabinetry.

Planmeca
630-529-2300 | planmeca.com
CIRCLE RS #23

2-piece Zirconia Implant

With more than 10 years of clinical experience, Z-Systems is proud to announce their 2-piece Zirconia Implant. The z5c was introduced to fulfill the needs of an aesthetic, healthy and safe alternative in modern implant dentistry, and reportedly only the real tooth is more natural. This is currently the only FDA-approved 2-piece Zirconia Implant available in North America.

Z-Systems North America
877-874-9407 | zsystemusa.com
CIRCLE RS #24
As one of the first practices in the US to offer Icon®, a resin infiltrant, Affiliated Pediatric Dentistry & Orthodontics started tracking every patient and surface they treated. After three years, they presented their findings* at the American Association of Pediatric Dentistry Annual Session and within the September, 2015 issue of Dental Products Report. The study showed an astounding 98% success rate of arresting interproximal enamel lesions in permanent teeth. Used to treat post-ortho and other cariogenic white spots as well, Icon offers an aesthetic alternative to surgical intervention, stopping the progression of early carious lesions without drilling, anesthetics or unnecessary loss of healthy tooth structure. Resin infiltration is now recognized under the CDT code D2990. Get great results and grateful patients with the revolutionary Icon resin infiltrant.

Start arresting early caries today at drilling-no-thanks.com.

* Neither Affiliated Pediatric Dentistry & Orthodontics or any of their employees were compensated for the study.
**PRODUCT WATCH**

**Alginplus**
Major®, a brand division of American Tooth Industries, presents a new extra-high precision alginate for impressions. Alginplus has an enriched formula for enhanced detail reproduction and a color chromatic phase indicator formulated for easy and precise results regardless of water temperature and hardness. It is fast setting, hypoallergenic, cadmium and lead free, gluten free, and does not contain red dye number 5 or animal protein.

*American Tooth Industries*
800-235-4639  | americantooth.com
CIRCLE RS #26

**Casi 3C and Casi 3L**
Cosmedent’s Casi is an innovative double-ended composite sculpting instrument designed to follow the curvature of natural tooth structure. Its built-in convexity and anatomical curvature gives the Casi an advantage for anatomical shaping. The larger end is for sculpting and shaping the central and canines, the smaller end for laterals and lower anterior teeth. This lightweight and easy-to-use instrument comes in a titanium-coated finish.

*Cosmedent, Inc.*
800-621-6729  | Cosmedent.com
CIRCLE RS #27

**ABF Waxes**
ABF Waxes, available in the U.S. through Sterngold, are said to be characterized by their unique composition that guarantees exceptional properties during use. These waxes make it possible to create the esthetics that will provide your wax-up with character. There’s a light version to ensure basic coloring and a dark version to generate typical shade in the fissures. In the liquid stage these waxes still remain opaque. It can be easily used for any type of modeling, in particular for the construction of occlusal surfaces, coronal walls and armatures.

*Sterngold Dental, LLC*
800-531-2685  | sterngold.com
CIRCLE RS #28

**Exspider™ Rapid Expansor Ortho Screw**
Exspider™ Fan-Type Rapid Expansor Ortho Screw by Leone® is now available in a mini size; 7mm. Made entirely of biomedical stainless steel, the expanding arms are laser-welded to the screw body with laser-engraved directional arrows. This mini-sized Exspider screw allows widening of the single anterior sector of the maxillary arch while still maintaining expansion at the molar level.

*Leone America*, a division of American Tooth Industries
800-235-4639  | info@leoneamerica.com
CIRCLE RS #29
NEW! FROM GREAT LAKES

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PROBLEM SOLVED...
A vastly different & supremely comfortable splint

The Rhea™ Occlusal Appliance combines the accuracy of a laboratory-made splint with the ease of a boil and bite appliance. However, the appliance is fabricated with material unlike any other heat-softening material on the market. Rather than simply softening to temporarily engage undercuts, the Rhea will:

- re-form to subtle differences in the patient’s dentition
- compensate for slight variances in impressions, and
- compensate for deformities caused by plaster expansion

Patient feedback indicates that the Rhea is the “most comfortable” splint they’ve ever worn.

The Rhea is custom-formed to original models, and as a result, chairside seating is only necessary to fine tune fit and compensate for minor variations. A low profile, soft/hard multi-layer and smooth low-friction surface makes the Rhea extremely comfortable to wear.

Rhea Occlusal Appliances:
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Get the details! Call our Splint Specialist today: 1.800.828.7626 or visit RheaSplints.com

Email: info@greatlakesortho.com | 716.871.1161 (Worldwide)

Interested? Circle Product Card No. 30
A close look at how the new NobelZygoma implants were developed

Nobel Biocare’s Robert Bañez, along with a pair of clinicians, tell DPR what makes this implant system so special.

[ compiled by Stan Goff ]

Last fall Nobel Biocare released the NobelZygoma implants, designed to anchor in zygomatic bone and provide high primary stability for Immediate Function. The product launch was featured on the cover of the August 2016 issue of Dental Products Report.

Here, Robert Bañez, Global Head of Product Management, Implants at Nobel Biocare, shares the story of how this product came about. Also, a pair of clinicians tell us how they use NobelZygoma implants and what they like best about the results.

How did this product come about?

Bañez: Nobel Biocare has long been at the forefront of treatment for edentulous patients and has offered zygomatic implants for 25 years. We work with an ethos of continuous improvement, so it was natural for us to look at how we could build on our already proven products in this area.

In our dialogue with some of the world’s leading experts in zygomatic implant placement, it became clear that there was interest in more implant options as well as adjustments to help ensure primary stability for Immediate Function.

The need for more zygomatic implant options was also supported by published research, which has highlighted the significant anatomic variations in patients undergoing zygomatic implant treatment.1

Taking all this into account, our internal experts set to work on the development and thorough testing of a new zygomatic implant solution. NobelZygoma was the result.

How long was the process, and what makes this product special?

Bañez: At Nobel Biocare we do not believe in innovation for innovation’s sake. The existing Brånemark System Zygoma implant options had seen 25 years of clinical success, so a key challenge was identifying the right improvements in order to make a significant impact on treatment results.

The development process for NobelZygoma took several years, with a significant period of evaluation by experienced zygomatic implant experts prior to the official launch.
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Their feedback was extremely positive from the beginning.

A significant change to the design compared with our previously available zygomatic implant options is the tapered apex, which has been introduced to further help ensure high primary stability.

In addition, while the Brånemark System Zygoma implants have a fully threaded surface, parts of the NobelZygoma surface are left unthreaded, which many clinicians prefer.

We also introduced two new implant lengths, 32.5 mm and 37.5 mm, to further help the surgeon account for variations in bone anatomy among patients. The total range of available lengths for NobelZygoma ranges from 30 mm to 52.5 mm.

Keeping things straightforward and cost-effective for dental professionals was also an important consideration. As a result, the surgical and prosthetic components for NobelZygoma remain the same as for the Brånemark System Zygoma.

What are you most proud of?

BAÑEZ: We are extremely proud of Nobel Biocare’s heritage in zygomatic implants, and that we could further build on this success with NobelZygoma.

Patients who are being treated with a zygomatic approach are those with severe maxillary resorption. This means that the potential for improvement in quality of life is huge. These patients may have sought help several times and perhaps even been told there are no other options for them before zygomatic implants offer hope of a possible solution.

The whole team behind NobelZygoma is also proud to play a role in helping these patients improve their day-to-day lives with a fixed restoration. We’ve also pleased that we can continue to keep Nobel Biocare at the forefront of treatment for edentulous and soon-to-be edentulous patients.

And of course, it is gratifying to hear experts in the zygomatic concept such as Paulo Malo and Dr. Rubén Davó speak highly of NobelZygoma and the results they are achieving for their patients with this new option. It’s this kind of feedback that motivates the team here at Nobel Biocare to come to work each day and keep innovating to help our customers and their patients.

How have you spread the word to clinicians and why should clinicians consider using this product?

NobelZygoma was officially launched to dental professionals and press at our Global Symposium in New York in June 2016 and received a very positive response. Alongside the traditional marketing efforts to highlight the benefits of the implant, some of the well-known clinicians that are regularly using NobelZygoma have been sharing their treatment results at industry events.

At the 2016 EAO Congress in Paris, for example, renowned clinician Dr. Paulo Malo presented some of his experiences with NobelZygoma at the Nobel Biocare innovation forum. At the same event, Dr. Rubén Davó, a pioneer of zygomatic implant placement, presented a study that he and his team had conducted using NobelZygoma implants. For the 33 implants placed, Dr. Davó and his team observed a 100-percent success rate over a period of at least six months.

Here is some of the feedback from prominent clinicians who are using NobelZygoma implants:

PROF. PAULO MALO
LISBON, PORTUGAL

“The design features of the new NobelZygoma implant allow me to offer even better treatment solutions to my patients in a more effective way: the new apex shape gives me enhanced bicortical anchorage in zygomatic bone.”

REFERENCES
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*MMA - Methyl Methacrylate

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Election Years Are Inevitably Uncertain...

The Dentist’s 2017 Practice Protection Report

REVEALS HOW YOU CAN: Stay In Control, Become Bulletproof, and Thrive In Any Economy...

THE ECONOMY IS UNCERTAIN. YOUR PRACTICE DOESN’T HAVE TO BE.

FREE RESOURCES AVAILABLE INSIDE:
The Ultimate Cash Flow Crash Course for Dentists
2017 IS THE YEAR OF Uncertainty AND Unpredictability IN DENTISTRY.

Gone are the days when...
• Competition was rare
• People couldn’t easily access (often inaccurate) online reviews
• Patients were compliant and the internet didn’t make everyone an overnight “expert”

We have to face it. The ADA tells us dentistry hasn’t fully recovered from the recession. While you’ve been busy working more and very likely earning less, the dental profession has been rocked by seismic waves — and the ground you’re standing on has shifted.

You need to take action and protect your practice, and your future. … But how?

You’re a high achiever committed to helping people improve their lives. That’s why you chose a career in dentistry. And you’re an excellent dentist. You stay up to date on new treatments, new technologies and new equipment, have a deep respect for science and enjoy being a medical professional.

But, did you anticipate running a practice would be a struggle? Or did you imagine leaving the stress of dental school behind you — and once you became a dentist it would be smooth sailing.

You knew you’d work hard — of course.

But you expected to enjoy the kind of cash flow that allows for the “perks” in life — driving the car you choose, a home you love, enjoying vacations and putting away for your family’s future.

You anticipated the feeling of pride every time you opened the door to your state-of-the-art office, reminding you of your accomplishments and the freedom and flexibility of being in charge.

How on earth did the difficulty of running a practice evade you? You might have heard some grumbling, but you were eager. Excited. Ready.

Dental school didn’t prepare you for business management, staff issues, marketing, equipment maintenance, bills and taxes.

Your cash flow challenges are particularly frustrating, because you don’t understand why some months are robust and others can be completely unnerving.

No one gave you a crystal ball to foresee the ever-changing economy. And, after a volatile election year, it’s impossible to know what’s next. And now, there’s...
YOUR REALITY: DENTISTRY ISN’T CHANGING.
IT’S ALREADY CHANGED.

Today, patients choose health practitioners based on criteria you don’t even understand.

Some days it feels like your day-to-day isn’t about dentistry. It’s about business development and management, marketing and meetings. Not what you signed up for.

You long to spend your days doing what you do best. Treating patients. Having the extra energy to study new developments in dentistry and expand your knowledge.

As hard as you’re working you would think the money would be pouring in. But it’s not. Some months it seems more like a few coins dropping in a large, empty bucket. Plunk. Plunk. Plunk.

You tell yourself you just need to keep taking care of your patients and your practice will grow, and it’ll be less of a grind every day.

Still, you wonder…

Why Doesn’t the Income You Bring in Match the Intensity and Commitment You Dedicate to Your Work?

Let’s address the elephant in the room. Whether you love or hate management — to be successful as a dentist in your own practice, you have to be successful at business.

It’s not easy. They don’t teach you business skills in dental school. If your success was determined solely by your professional abilities, your coffers would be full, your days would be so much simpler, and cash would flow like a river after a flood.

But, your success is not determined by your professional abilities, you’ve felt that, haven’t you?

Trends in dentistry support what you’re seeing. According to the ADA:

• Fewer adults are seeking regular dental care
• Prospective patients view oral health as a luxury, not a necessity
• More new dentists than ever are graduating each year

“The best way to predict the future is to create it.”

- PETER DRUCKER

Still, you wonder…

Why Doesn’t the Income You Bring in Match the Intensity and Commitment You Dedicate to Your Work?
And, get this. Dentistry Today reports that:
Only 7% of dentists felt they were well-prepared from a business standpoint to own a dental practice after graduation, but 46% own a practice within a year.

It’s clear — the vast majority of dentists feel ill-equipped to run their practices, yet you show up, give it your all and hope for the best.

Even the ADA has begun to recognize the huge disconnect dentists are dealing with. The wide gap between the clinical practice you trained for and the entrepreneurship you’ve taken on.

A 2015 ADA survey of stress and job satisfaction revealed that 86% of dentists felt stressed, and 37% described their stress as high or very high. The factors contributing to their stress?

See the graph below.

Sound familiar? Chances are, you’re living and breathing this reality every day. Notice the stressors are business related... Except this next one, which is key.

Your balance is out of whack because the business side is demanding. There’s so much more to do than treat patients. It can be mind-boggling. Truly.

It’s why so many dentists look at me like a deer in the headlights when I ask questions like:

- What’s the lifetime value of a patient in your practice?
- What percentage of your budget goes to staffing?
- How much are you spending on marketing every month?
- What kind of return is it bringing you?

Maybe these questions make you uncomfortable too, because you don’t have all the answers — and think you should.
Look, you didn’t get an MBA — you went to dental school. You happen to have chosen a profession where some days you feel like you need both to be successful.

None of Us Know the Future. In a Rocky Election Year, We’re More in the Dark than Ever...

We don’t know what the economy will look like with a new administration. Will patients be panicked about health care and holding back?

What about taxes? Will social security take a hit? The national mood is equally uncertain.

We can’t know what the new administration will bring, how our economy will fare or how the general public — your patients — will react. When people feel uncertain, they tend not to spend. They opt instead, to cut out what they perceive as unneeded expenses, and they wait, and watch.

Your best defense? Create predictable cash flow, and put your future in your control.

AND, A NEW ADMINISTRATION ISN’T THE ONLY CHANGE YOU’RE FACING

More than ever before, patients are prioritizing their health care choices and oral health is NOT at the top of most lists. That’s why it’s more important than ever you give new patients a reason to choose YOUR practice.

Savvy consumers have the power — and the information they need to choose healthcare providers. Choice is a just a click or phone call away.

This means your patients are defining the success of your practice!
THERE ARE SOLUTIONS TO THE PROBLEMS PLAGUING THE DENTAL PROFESSION

By taking charge of the aspects of your business within your control, you can see more new patients coming through your doors every month. You’ll control your cash flow and experience the security of knowing your practice is on solid ground — and growing — no matter what else is going on in the world around you.

According to the ADA, over the last decade, most practices are experiencing patient attrition. They predict you could lose as many as one third of your patients before the decade is over.

Can We Talk About Business and Profits?

Financial projections. Business planning. Cash Flow. It’s a safe bet those weren’t 101 classes you ever took. How could you? They were never offered.

Let me simplify your practice income equation:

YOUR INCOME = Billing Per Patient \times Number of Patients You See
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Let’s say your average patient spends $750 in a calendar year and you have 1500 patients. Your practice income (not profit) would be $1,125,000.

To maintain that income, the ratio of patients to billing must stay proportionate. Or, if one decreases, the other must increase to keep pace. How you work the equation can make or break your future.

{Do You Want to Settle for Maintaining? Or Do You Want to Realize Your Ambitions, and Achieve Your Financial and Lifestyle Goals?}

Let’s look at another simple equation. If you want to make more money in your practice, there are three obvious choices:

- Perform more procedures
- Spend less money
- See more new patients

The first option requires your existing patients somehow, suddenly, need more dental work. Unless you add a new specialty or service (which will likely come at an expense you’ll have to offset before you add profit), the dollars spent per patient stays more or less fixed. Sure, some patients will need more in a given year, but that factors in as well. And, it’s a possibility, not a plan.

Spending less money is always appealing, but with rising costs and staff salaries, it’s not the most reasonable place to look for more tangible profit.

New patients, however? Bingo.

Getting new patients might feel like the area of your practice you can least control.

Whatever you spend on marketing and advertising — from a big budget to as little as possible, it’s very likely no one in your office knows what your advertising and marketing dollars are returning to your practice.

Marketing expenses of any size can be validated, if they can be proven to bring in new patients, which controls your cash flow, and relieves your stress. You probably don’t need to spend more, you need to understand more, because...

{Chances Are You’re Turning New Patients And Cash Flow Boosting Opportunities Away Every Day, and You Don’t Even Know It!}

The good news is that there’s an effective way to have prospective patients choose you.
And that is critically important, because new patients are what will transform your practice’s cash flow from ho-hum to hell yeah!

Why? Because new patients help you control – and manage your cash flow. Here’s the skinny. You assumed the risk of running a practice, and the reward – cash flow – is what gives you freedom. If you reliably know what you will earn, your stress level plummets. Predictability is reassuring (and possible to attain when you understand cash flow).

You put your heart and soul into your practice – you deserve commensurate rewards, so you can live well, compensate staff according to their contributions and actually plan your future!

If you’ve ever paid yourself last, or given up a paycheck because the bills couldn’t wait, conquering cash flow will be life changing.

Most dentists manage their cash flow by reacting rather than planning. Our new (and free) resource, The Ultimate Cash Flow Crash Course: Preparing for 2017, boils down the dental essentials you need to conquer your cash flow instead of it controlling you.

TO RECEIVE YOUR COPY OF THE ULTIMATE CASH FLOW CRASH COURSE: PREPARING FOR 2017 SIMPLY FILL OUT THE CARD ENCLOSED ON PAGE 6 OR VISIT WWW.MYCASHFLOWCOURSE.COM.
In 2017, Choose to Replace Chaos with Consistent Cash Flow

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» How to speak your prospective patient’s language by understanding the question they’re really asking so you can...  
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P.S. — On top of 2017 being economically and politically unpredictable, you still face an ongoing battle with patient attrition! You CAN’T AFFORD to let your cash flow continue to suffer... Or your income will decline drastically in the years to come!

DentistryIQ.com reports the average practice may lose as much as 10% of its patient base through normal attrition! This means if you aren’t actively focused on steadily increasing your new patients, your cash flow and income will hit catastrophic lows as your patient attrition compounds in the next 3–5 years.

No hardworking and ethical doctor should have to suffer with declining income, patient attrition, or stagnant cash flow... Reserve the free Ultimate Cash Flow Crash Course today by returning the card enclosed on Page 6, or by visiting www.MyCashFlowCourse.com.
Be prepared for 2017! Protect your practice with a CASH FLOW boost... Reserve your Crash Course while it’s still available.

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Although tooth whitening is establishing itself as a popular dental treatment, several factors must be considered when selecting the ideal whitening solution. The factors include patient lifestyle, tooth discoloration, compliance ability and tooth sensitivity. With the ever-increasing patient demands for whitening options (increased comfort, convenience, effectiveness, etc.), dental manufacturers have created an array of whitening systems to meet these requests. As a result, dentists must determine the appropriate whitening solution that also matches the patient's lifestyle and desired results, in combination with their clinical situation and overall oral health. With many factors to consider, selecting a whitening treatment can be challenging and overwhelming.

Introduced in the 1800s, in-office whitening was the primary choice for dentist-prescribed tooth whitening.1 However, the development of home-applied tray bleaching in the 1980s changed the field of tooth whitening dramatically.2 Unlike in-office treatments that require dental professionals to perform the procedure, at-home whitening is dentist dispersed and individually applied, significantly reducing the cost. With at-home whitening, patients are now able to whiten their teeth, following their dentist's instructions, at their own convenience.

Today, most dentists still offer these two types of whitening treatments, although with advancements in research the whitening materials have significantly evolved. In-office whitening uses a powerful bleaching agent (e.g. hydrogen peroxide, carbamide peroxide, sodium percarbonate peroxide) to effectively whiten teeth in a single office visit. While using the same potent bleaching material, at-home whitening contains a lower concentration of the active ingredient to whiten teeth.2 When supervised by a dentist, at-home or in-office peroxide bleaching has been shown to be safe and effective.3

Another challenge in determining the appropriate whitening treatment plan is choosing the ideal whitening gel. Carbamide peroxide is the most common active ingredient in whitening materials, dissociating into hydrogen peroxide and urea.4 It is ideal for at-home whitening because of its slow breakdown during oxidation. Unlike hydrogen peroxide—which releases its whitening power almost instantly—carbamide peroxide releases about 50 percent of its whitening power in the first two hours and can remain active for up to eight hours.5 Therefore, the duration of exposure time and bleaching agent concentration directly affect the diffusion of hydrogen peroxide through the dentine and the efficacy of the whitening.

ABOUT THE REVIEW
With the combination of the world’s leaders in their field, Contemporary Product Solutions’ dexterous, knowledgeable and experienced leadership team maintains a sharp eye for emerging products in the field of general and restorative dentistry by providing a “Total Office” perspective of clinical information and application, incorporating photographs and videos to assist chairside procedures for better patient results. CPS (cpsmagazine.com) will continue to evaluate one product at a time with professionalism, integrity and a commitment to excellence.

Customized take-home whitening with Opalescence
An evaluation of Opalescence, a whitening system from Ultradent Products. [Shannon Pace Brinker, CDD, CDA, Contemporary Product Solutions]

Opalescence PF
For use with customized take-home whitening trays, Opalescence PF offers many options for patients. With its easy syringe delivery, Opalescence PF is said to be easily customizable for each patient’s individual situation. The gel contains 20 percent water to prevent dehydration, and the sticky, viscous formula helps keep the gel and tray in place. With four concentrations and three flavors, patients can completely customize their whitening experience.

Ultradent Products
888-230-1420 | ultradent.com
CIRCLE RS #35
Why professional supervision matters
During the initial whitening consult, dentists should complete a thorough oral examination and evaluation with pre-operative photographs. With this information the dentist can monitor the tissues (hard and soft) throughout treatment to ensure the patient responds ideally to the whitening gel and no damaging effects occur, such as tooth demineralization or gingival irritation.

After the initial assessment, determining the types of discolorations will help identify the appropriate whitening solution. With three classifications—intrinsic, extrinsic or internalized—tooth stains vary in their ease of removal. Extrinsic stains are localized on the tooth surface or within the pellicle layer by reaction between sugars and amino acids, or acquired from other external elements. Intrinsic stains, such as those from tetracycline or fluorosis, are found within the dentine, and result from systemic or pulpal origin. They are the most difficult type of stains to remove. Similarly, internalized stains are also located in the dentine, but result from extrinsic stains entering the dentine via tooth defects, such as cracks on the tooth surface.

Although in-office treatment is ideal for a variety of tooth discolorations, darker stains (e.g. dark yellow and black teeth or stains from tetracycline and fluorosis) can be challenging to whiten, requiring more than one bleaching application. Used in conjunction with in-office treatment, at-home whitening can provide the ideal supplement to treat tougher stains.

At-home whitening is also effective as a standalone treatment and a practical alternative to in-office whitening. Effective at treating most discolorations, at-home whitening is still under dental supervision and monitoring. At-home whitening provides a cost-effective solution for those who can’t afford in-office treatment or for those who prefer the convenience of whitening at home. Dentist-dispensed at-home whitening minimizes risks involved in whitening such as uneven results, enamel damage or hypersensitivity, because the systems are supplied by dentists, who can diagnose any problems or special needs, plan the appropriate treatment and fabricate the customized tray used to apply the whitening gel.

Challenges with at-home whitening
While ideal for patients who desire to whiten their teeth on their own schedule, complications still occur with dentist-dispensed at-home whitening. Problems with patient compliance can arise due to discomfort and inconvenience. Poorly fitted trays can inhibit proper application of the whitening gel to the tooth surface, reducing the effectiveness of the hydrogen peroxide. Patients can have difficulty applying the material, especially if the gel is too thin. During whitening, some patients report discomfort as the tray moves or gel migrates out of the tray and onto gingival tissues. The discomfort can be exacerbated if the taste of the gel is unappealing.

Patients may also complain of increased sensitivity during and after whitening treatments. This side effect may be caused by changes of fluid in the dentinal tubules. Specifically, too much fluid moves out of the teeth during whitening, causing dehydration that leads to oral pain. Some whitening gels add water to their solution to ensure proper hydration. The addition of fluoride and potassium nitrate has also been shown to reduce tooth sensitivity. The application of fluoride also makes the teeth less susceptible to caries, and leads to fewer hazardous effects on the enamel mineral content.

Further, as hydrogen peroxide degrades throughout the whitening process, it can create a more acidic environment that leads to potential tooth structure damage. Some whitening gels have an initial acidic pH, which can further favor demineralization of tooth enamel. Lower pH environments can lead to increased tooth sensitivity, gingival irritation,
and bacteria growth. Adding buffers to the whitening gel ensures a basic or neutral pH.

The right solution for different patients
Ultradent Products has developed a system of at-home whitening treatments, Opalescence PF, that is cost-effective and reduces sensitivity and discomfort. Its unique formula allows for complete customization. With four different carbamide peroxide concentrations, dentists can tailor whitening treatments to an individual’s expectations, extent and type of tooth discoloration, and likelihood of compliance.

When determining the treatment plan for at-home whitening, dentists consider concentration, duration, application and desired results based on the patient’s type and extent of tooth discoloration. Opalescence PF is ideal for at-home treatments because of its versatility and customization depending on the patient’s desired results and clinical condition. Available in four carbamide peroxide concentrations (10, 15, 20 and 35 percent), Opalescence PF requires wear times ranging from 30 minutes to overnight. Opalescence PF is effective in removing discolorations due to congenital, systemic, pharmacologic and traumatic factors, as well as those resulting from fluorosis and tetracycline. The lower doses are suitable for patients who want to wear the whitening trays overnight or who demonstrate extra sensitive teeth. Higher concentrations are more appropriate for quicker results and those patients who have less availability to apply the whitening gel and wear the whitening tray. Dental professionals can therefore customize whitening treatments in terms of both concentration and duration to fit a patient’s schedule, lifestyle, and degree of tooth discoloration.

In addition to versatility, Opalescence PF provides practical solutions to many of the common complications associated with whitening and at-home treatments. The safe and effective whitening gels include potassium nitrate and fluoride to reduce sensitivity and strengthen enamel. The gel also contains 20 percent water to prevent dehydration. Opalescence PF also contains buffers to maintain a neutral pH, thereby preventing an acidic environment and damage to the tooth structure.

Using a customized whitening tray, the Opalescence PF system promotes even application of the whitening gel and continuous contact between the gel and tooth structure throughout treatment. An easy syringe delivery improves the efficiency for loading the tray. The sticky, viscous formula helps keep the gel and tray in place, preventing the solution from migrating during treatment, thereby improving patient comfort, which helps patient compliance. Opalescence PF is also available in three flavors—mint, melon and regular—improving taste and comfort.

Conclusion
With Opalescence PF, dentists can provide their patients with a proven whitening solution for at-home treatment. Effective in treating even the toughest of stains and discolored teeth, patients can complete the whitening treatments safely and efficiently following the dentist prescribed plan at their own convenience. The ideal tool to customize whitening treatments for all types of patients to fit their lifestyle, and with customized tray application and a thick, viscous gel, Opalescence PF is designed to reduce sensitivity, enhance comfort and improve patient compliance.
As a dental hygienist for over 40 years, I like to think I have seen a lot of improvement with products that I use. Of course, I learned the basics of instrumentation and got the opportunity to use an ultrasonic scaler only once, maybe twice while in school.

One of the products that wasn’t around when I was in school was the air polisher. After graduating, I just happened to work in an office that had one. That was exciting, but no one seemed to know exactly how it worked or why anyone wanted to use it. The first time I used it, it was a disaster and I found there was definitely a learning curve. Quite a few patients learned to hate it (or me) based on the “sandblasting” they got from my inability to control the spray. Maybe some of you have had similar experiences. Even when I got somewhat familiar with the use, my patients complained: “my gums are sore,” “it takes my make-up off,” “it’s just too messy.” Long story short, I only used it on those who requested it. It took time to clean up, and my busy schedule did not allow for any extra time for cleaning up the salty, powdery residue that seemed to settle everywhere.

Fast forward to 2015. I was invited to learn about, observe and use the new Air-Flow® technology by Hu-Friedy. I was skeptical about seeing a product I thought I would never use. Well, I was wrong because it was amazing! I’ve always supported the premise that biofilm was the root of all evil, and this air polisher removes it, both supra- and subgingivally. It polishes the teeth, removes stain, can be used effectively for implant maintenance, restorative materials, and orthodontics, all with little trauma to the patient or clinician. The air/water pressure/powder stream is controlled and is delivered in a warm spray. Instead of sodium bicarbonate, the powder is glycine. As you might know, glycine is a non-essential, biocompatible amino acid and much smaller in particle size than sodium bicarbonate. This system was designed for comfort. When I was introduced to the Air-Flow, I was both clinician and patient. As the clinician, it was exceptionally user friendly, and as the patient, it was so gentle and the powder was fine and even slightly sweet. I even got my tongue cleaned and it was painless. Your patients will love it: it’s cleaner, gentler and faster. Efficient biofilm management with air polishing is time saved, which gives the clinician freedom to treat the patient in a comprehensive manner.

Now, you will need to make a decision and choose the option best suited to your practice. There are several choices. You can choose the handheld portable, the Air-Flow Handy 3.0 PREMIUM, which is small, lightweight and connects to your unit. It is easy to hold and fairly balanced. You can use two attachments: one for supragingival plaque removal and one for biofilm removal in the sulcus. If you are one who

**AIR-FLOW® Handy 3.0 PREMIUM**

Designed to be used with the Hu-Friedy EMS AIR-FLOW PERIO powder (made from glycine), the Handy 3.0 PREMIUM reportedly has the versatility to easily, efficiently and effectively remove harmful biofilm from both supragingival and subgingival areas of the tooth. It includes two handpiece attachments for supragingival (PLUS) and subgingival (PERIO) applications with one handy unit.

Hu-Friedy Mfg. Co.
800-483-7433 | hu-friedy.com
CIRCLE RS #37

“Efficient biofilm management with air polishing is time saved.”

A hygienist shares how Air-Flow® technology made her a believer in the benefits of air polishers. [by Lynn Russell, RDH, MEd]
doesn’t want to be constrained in my
dental hygiene treatment, I would
definitely go for this unit.

Beyond the portable choices, there
are also the stand alone models: Air-
Flow S1 or the Air-Flow S2. Both
units have supragingival biofilm and
stain removal, while the S2 is a com-
bination unit also featuring Piezon
technology. My personal preference
is the Air-Flow Master or the Air-
Flow Master Piezon®. The Master is
equipped with two handpieces and
powder chambers that offers the
ability to easily switch from Classic
to Perio powders, allowing you to
be prepared for any patient in your
chair. For those patients that perhaps
require additional scaling, the Mas-
ter Piezon® may be your best option.

The numbers back me up. 200
periodontal pockets were treated
with the Air-Flow and there was a
1.22 mm reduction in pocket depth
in a short time of four-to-six months.
Hand instrumentation to remove
subgingival biofilm takes anywhere
from 30 seconds to one minute per
pocket. The air polisher with glycine
takes five seconds of exposure to dis-
rupt and remove the biofilm.1,2 You
don’t have to be a mathematician to
figure out the time savings.

In its position paper,* the ADHA
highlights a study by Galloway and
Pashley (1986) that demonstrated
the air polisher can cause clinically
significant loss of tooth structure
when used excessively and should
therefore not be used on exposed
cementum or dentin.3 In addition,
ADHA cites Woodall’s 1993 text-
book recommendation that states
“air polishers should be avoided
around most types of restorative
materials due to the possibility
of scratching, eroding, pitting or
margin leakage.”1,2 This, however,
would not be true for the glycine
powder.

So, if you are looking for an
efficient and time-saving alterna-
tive, superior biofilm management,
increased comfort, a higher level of
care and a state-of-the-art alterna-
tive technology, I personally rec-


dommend these Air-Flow® Products.

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* The American Dental Hygien-
ists’ Association 2010 Position on
Polishing Procedures lists the fol-
lowing as contraindications for air
polishing procedures using sodium
bicarbonate:

Patients with restricted sodium
diets, respiratory, renal, or
metabolic disease, with infectious
disease, children, diuretics or long-
term steroid therapy, and with
titanium implants.
Using education, Invisalign in practice
Putting fundamental Invisalign training, education into practice for greater success.

PHILLIP TALLEY, DDS
PEACHTREE CORNERS, GA

Incorporating new treatment options into the dental practice brings with it workflow, team duty delegation and marketing implications. New treatments require team members to understand how to use any hardware and software involved, as well as how to integrate what needs to be done into the existing overall scheduling and flow of the practice.

For these reasons, team training and support become significantly important when adding new treatments to the practice’s service mix, including Invisalign. Without complete team involvement in the education and implementation processes, the practice could fall short of achieving its goals.

With Invisalign, however, involvement and empowerment is assured from the very beginning when dentists and their team (i.e., dental assistants, hygienists, treatment coordinators) attend the Invisalign Fundamentals training program. A two-part introductory program for new Invisalign general practitioners, this essential education involves a dentist-only session in one room and a team-only session in another. In this way, each member of the practice gains relevant knowledge and experience at the same time, from the beginning. As a result, the practice can hit the ground running and begin treating patients as soon as they return to the office.

Hit the ground running
After my team and I attended the Invisalign Fundamentals training program, I immediately contacted my local Invisalign representative—Dan Kossak—to schedule a meeting. At that time, we determined appropriate Invisalign case fees, received some additional pointers on scheduling and reviewed patient record requirements. We also identified key “to-do” activities for the next 90 days, including marketing initiatives. Additionally, my team and I practiced our consultations and the hand-offs that were taught in the team course.

Specifically, the half-day live course format focused on clinical education and hands-on training for treating the wide range of patients who might be candidates for Invisalign. We learned how to identify ideal Invisalign case types, and use the Invisalign software to virtually set up planned cases. My team also learned relevant case submission procedures and undertook their own practical hands-on exercises. From getting the word out to existing and new patients about our Invisalign treatment to talking about malocclusion issues with patients, and from digital photography to impression techniques, the four training team members from Contemporary Product Solutions and representatives from their partners (3M, Shofu, Solutionreach and CareCredit) covered everything to better prepare us for incorporating all aspects of the Invisalign process into our day-to-day operations.

Additionally and equally important, my entire team met with me to discuss their individual candidacy for Invisalign treatment, since all of them returned from training and told me they wanted to be a patient. I knew that I would receive three discounted cases, so if needed, my team members would go into Invisalign first. This would not only benefit them, but also help with marketing Invisalign to my patients. Nothing demonstrates a practice’s belief and confidence in a treatment better than team members who have completed or are undergoing it themselves and can provide a first-hand experience perspective.

Implementing team roles and responsibilities
Because of the training we received, my team and I have been able to properly identify Invisalign cases, make appropriate scheduling and planning decisions, and keep our goals on
The education and training we received was paramount to ensuring that the entire team bought into the Invisalign concept and was clear about their roles and responsibilities in the process to ensure an efficient workflow and synergy.

In our practice, the conversation starts with our hygienist, who completes a bite analysis, looks at how the patient’s teeth fit together and helps them see and understand their type of bite using digital photos and the straight talk brochure. My role, with the help of my dental assistant, is to gather proper records, approve the dental simulation and explain to the patient how Invisalign can help achieve this for them. Then, it’s the scheduling coordinator’s responsibility to determine how to make Invisalign affordable for the patient through financing or other financial considerations.

Overall, it’s about first finding out what the patient values and what they want to change about their smile. We then communicate with the patient how Invisalign can help them. This makes the scheduling coordinator’s job much easier from a financial perspective in terms of finding a payment option that the patient is comfortable choosing, whether this involves financing, insurance or a combination of both.

Following up with in-practice training
After having some time getting Invisalign incorporated into our practice we decided to take it one step further and have Shannon Brinker, CDA and her CPS team of trainers come into our practice to do a in-practice training to review all of the basics and specifics for initiating and completing an Invisalign case.

We reviewed the best ways to conduct a consultation, how to close cases with CareCredit and did additional training on digital photography. They also recommended spending time with my hygienist to actually see them working and communicating one-on-one in regards to malocclusion.

Additionally, in-office visits and one-on-ones with our Invisalign representative has further helped to bolster our confidence, efficiency and comfort level in treating orthodontic cases that can benefit our patients in terms of esthetics, enhanced oral hygiene, and safeguarding periodontal health.

Conclusion
In my experience, attending the Invisalign Fundamentals training program with my team has been instrumental to our successful integration, marketing and delivery of this value treatment. What contributed to the value of this program was that it addressed the whole team’s perspective, due to the expertise of the CPS trainers (e.g., treatment coordinators, dental assistants, hygienists), all of whom combined real-world experience with the highest level of ahead-of-the-curve education to ensure our successful Invisalign integration.

By attending this program at the same time, meeting in-office with our sales representative, having a second in-practice training and treating team first, our practice was able to better integrate all aspects of the Invisalign process into our day-to-day workflow. Not only do I look at malocclusion differently—which I believe has made me a more comprehensive dentist—but the Invisalign training and ability to offer this treatment has also elevated my team to a higher level of clinical excellence.
WHAT OUR EXPERTS ARE EXCITED ABOUT IN 2017

DPR spoke with several experts in our industry about what they are excited for in the dental industry in 2017. More on page 46.

[ WEB EXCLUSIVES ]

ADDITIONAL CONTENT ONLINE

6 ways to find—and purge—social media deadbeats
Dead weight on your social media accounts won’t help your business succeed. It’s time for a purge. By Michael Ventriello
http://bit.ly/2f1aK1P

Top 3 laser procedures you can put into your practice right now
Dr. Chris Walinski lets you know what you can and should be performing with your dental lasers. By Dr. Chris Walinski
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Is Disney the future of digital dentistry?
Not content with theme parks and movies, Disney is now moving into the world of dentistry. By Nicholas Hamm
http://bit.ly/2hPnoSn

[ IN THIS SECTION ]

TECH UPDATES
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We’re only going to become more reliant on dental software in the future, so the time to start training is now.

TECHNOLOGY EVANGELIST
WHY BACKING UP IS SO CRITICAL
Dr. John Flucke explains why backing up your data could be the difference between practice success and practice disaster.

DIGITAL MARKETING
MOBILE WEBSITES AND THE DENTAL PRACTICE
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Log on to DentalProductsReport.com for up-to-date product news and our exclusive content
Understanding the real impact of digital impressions

A look at how one prosthodontist is using the technology to save time and to attract patients to his practice.

[ by Renee Knight ]

After three years of researching the technology and his options, Dr. Robert Berg invested in an intraoral scanner. He chose the 3Shape TRIOS® 3 because of the cost savings it would bring to his practice, its ease of use and its accuracy—and so far he’s been happy with the results. Here’s a look at what the 3Shape TRIOS 3 has done for his prosthodontic practice over the last year.

What has been the return on your investment?

I look at return on investment in two ways. The first is how the scanner saves me money. Part of that is saving on impression material. I have purchased 90-percent less impression material in my first year of use. It also saves me a ton of chair time and helps me save on lab bills. Crowns are fabricated digitally through CAD/CAM rather than by conventional methods. This keeps the production costs down for the lab and translates into lower lab bills.

The other ROI is how I utilize the system for restorative dentistry, orthodontics and implants. If I can apply it to multiple disciplines in dentistry, rather than for just restorative, then I’m way ahead of the game. I use it every day for all the different types of procedures that I do.

How do patients react to the technology?

Patients are really impressed with the technology. Beyond that, they don’t have to worry about gagging on gooey impression material any more. It enhances the patient experience and is actually building my practice. If one patient tells her husband “Dr. Berg made my crowns without having to take impressions with the goop, instead he used cool technology that is painless, odorless, tasteless and comfortable,” chances are her husband will want me to do his next crown.

Patients can’t believe how quick and efficient the process is. If patients have a digital impression made once they’re never going back to a conventional impression. There’s no more anxiety or fear of gagging or pulling a loose tooth out in an impression because we can now capture impressions without making contact with the teeth.

It also saves both me and my patients time. Since I’ve incorporated the 3Shape TRIOS 3 into my practice, I’ve reduced my patient visits by approximately 35 percent. I used to give myself an hour and a half for these appointments. Now I give myself an hour and I still usually find I have 20 minutes to spare. It also takes me about half the time to actually place the crown at the insertion visit.

How has the 3Shape TRIOS 3 improved final outcomes?

Communication with the lab is improved and the speed in which I have restorations returned to me is also drastically improved. I don’t have a milling machine in the office. I am scan only. Within five minutes of making the impression, the lab has the scan and is already putting it into production. It used to take me two to three weeks to get crowns back. Now I’m getting them in three days. That means patients are in provisional restorations for much less time.

The quality of the final restoration and the fit is much more precise. There’s less room for interpretation of where the margins are. You have the data right in front of you in real time. So if you can’t see a margin, you can recapture the scan in a matter of seconds. It’s real-time clinical validation.

The 3Shape TRIOS 3 is definitely more efficient in terms of the cost and time of the actual procedure. It’s definitely more accurate. The restoration fits better than the conventional fabricated restorations, and I know I’m going to get it right every time because I can validate my work chair-side before the impression is ever sent to the lab.

There’s also no more storing casts in my office. I now store them digitally. This makes it easier to communicate with labs and other specialists. We can merge the data from the intra-oral scan with CBCT and treatment with all members of the team without having the patient present.

Why would you encourage other dentists to invest in an intraoral scanner like the 3Shape TRIOS 3?

It’s going to make them more productive. It’s going to save them laboratory fees. I’ve lowered lab costs in single unit crowns by two thirds, just by switching to digital impressioning. I now spend about 90 percent less in a year on impression material. Those savings alone help dentists recoup that initial investment very quickly.

The 3Shape TRIOS 3 scans in full color, and shade measurement is accurate. I use the HD camera all the time. It’s like having an intraoral camera. And patient education is huge. When patients can’t perceive they have a problem they won’t accept treatment. The 3D images from the 3Shape TRIOS 3 make it easier for me to communicate the nature of the problem to them visually. Before the 3Shape TRIOS 3 I used a hand mirror and adjusted the light to try to show patients what was happening in their mouths. Now I can take a scan and put it up in color on the screen for them to see.

The ease of use is great and the learning curve is much simpler than people would think. Scan once and you’re a novice, scan twice and you’re an expert. That’s how easy scanning is for us. My assistant does 90 percent of my scanning.
WHAT CAN CHAIRSIDE DENTISTRY DO FOR YOU?  
[By Robert Elsenpeter, contributing writer]
CHAIRSIDE DENTISTRY HAS LONG PROMISED THE REALITY OF “SAME-DAY” TREATMENT FOR PATIENTS. BUT WHAT’S POSSIBLE NOW? WHAT DO DIGITAL TOOLS LIKE CAD/CAM ALLOW DENTISTS TO DO? WHAT STILL NEEDS TO BE SENT TO A LAB? AND WHAT WILL CHAIRSIDE DENTISTRY DO FOR YOUR BOTTOM LINE AND YOUR PATIENT CARE?

Continued from cover... “There are now some situations where you can make full-arch mouthguards for bruxism,” adds Dr. John Flucke, DDS, Technology Editor for Dental Products Report. “There are some systems that can potentially do bridges.”

Don Bell, Director of Marketing, CAD/CAM, at Ivoclar Vivadent, observes that most clinicians start small and then graduate to more complex cases.

“I think for new owners, single unit cases—like posterior crowns without complications—are in-office,” he says. “Other types are sent to a lab. However, many offices evolve quickly and do most restorations in-office.”

There’s no hard-and-fast rule as to whom, in the practice, designs chairside restorations. Dr. David Rice, a general dentist in Amherst, New York and founder of IgniteDDS.com, has used a CEREC system for 13 years, creating as many as two chairside cases per day. He and his staff share in restoration design duties.

“Because we have used the technology for so long, they’re extremely well-trained, so they do most of the design,” Dr. Rice says. “The times that I do the design are the patients that, maybe they just need the doctor to be in the room, and they need a little extra TLC. So it’s not the technology and limitations, it’s more about the patient and education.”

Chairside is an appealing option for those who wish to invest the time and money in a same-day dentistry solution. However, there may still be cases when the doctor wants to use a laboratory. Current chairside limitations include both the systems’ capabilities, the doctor and which technology he or she decides to use.

“It’s based on the technologies they select,” Dr. Rice says. “Some technologies are better than others and have a more broad spectrum of treatment. Providers’ experience levels and skillsets with the technology dramatically can change the frequency with which they need a laboratory or they can handle things on their own.”

“If you’ve got the ability to mill in your office, most of the time you could be doing all of your posterior fixed restorations,” Dr. Flucke says. “Especially now, given how easy it is to capture, as quick as it is, and as accurate as these milling units have become. Premolars and molars could be done chairside with no problems at all.

And if you want to do the anteriors, you certainly can, the only caveat is that does take more time, because then it involves the artistic part of this, because you have to stain and glaze the materials to make them look really, really good. Some people enjoy doing that, other people would rather turn that over and let the lab do it.”

Costs
As one might expect, the prospect of owning a chairside system comes with a hefty price tag—most systems cost in excess of $100,000. In order for the expense to make sense, the practice must do a certain number of chairside cases each month.

“You buy it like you would buy a car,” Dr. Rice says. “Even though it’s, maybe, $150,000 for the ability to mill something chairside, people make payments on that. So I’ve always looked at it and said, ‘If your payment is $1,000 per month, and your lab bill is $100 per tooth, as soon as you’ve done 10 teeth, you’re even with your purchase cost.’ The savings is that it costs me about $30 dollars a tooth to mill a restoration in my practice. In my situation, my lab is very expensive, because we pay for very high-end esthetics. So in my case, our lab bills are typically $250 dollars per tooth, and then when I use CEREC, it’s $30 dollars a tooth. So it’s a massive savings.”

Cost can be measured by metrics other than dollars and cents.

“Time is the only thing you can’t buy,” Dr. Gary Severance, DDS, Planmeca University, says. “It’s priceless. If you bring all the values into play, and not just the ROI, you’re changing the whole philosophy of dentistry; when somebody that used to take two or three appointments to come back and see you—and you took two or three appointments to get something done—and you can do in one appointment, now you’ve changed the whole spectrum of the perception of dentistry.

“You’ve eliminated what patients may not like, which is temporaries, the additional injections, and taking off work and coming back to do it. You changed a whole perception of dentistry.”

“It is time-consuming for the dentist,” Jason Atwood, CDT, Senior Digital Solutions Advisor, Core3d-centres adds. “Chairside options are about the convenience. Sometimes the patient needs same-day results, and the dentist has to have an option to provide such. However, it would not be productive for the average practice to do all of their lab work this way. A dentist’s time is best spent seeing patients, not designing, milling and finishing crowns.”

Another ability afforded by chairside is the capability for dentists to satisfy their patient’s wants and needs.

“It’s the ability to never say ‘No’ to a patient,” Dr. Severance explains. “When they call the office and they say, ‘I have this tooth that broke and I need it fixed before I can go to a wedding,’ in the past we have to call in favors from the laboratory, and take all that into account. If you have a solution in your office, you can say ‘Yes’ to every patient’s request. Just being able to say ‘Yes’ will maintain a lot of your patient bases, and we know when somebody has the same day restoration completed, they won’t go back to the old way.”

Being able to save time and say...
same-day esthetics are no longer a dream—they are possible with the latest in chairside technology (Photo courtesy of Dr. David Rice, Founder/Chief igniter igniteDDS).

This may all sound like the lab is being shut out of the restoration workflow, but even while doctors are able to offer more in-house services there is still a place and a need for labs.”

“...”Yes” to patients makes chairside a premium service and one that puts more money in your pocket.

“I’ve always felt that, especially in the beginning, it might cost a little more, but what the patient is paying for is the ability to treat a tooth in one appointment rather than two,” Dr. Rice says. “They’re paying for a practice’s investment in technology.”

“There is a certain premium that you can assign to the technology because you’re not requiring them to come back and take off work or find a babysitter, or any of the other things that come with the dental appointment,” Dr. Flucke observes. “I have a friend who says, ‘Sometimes in dentistry, I don’t charge patients for what I have to do, I charge them for what I don’t have to do.’ He says that as a little bit of a joke, but I do think there’s something to that.”

The lab’s role
This may all sound like the lab is being shut out of the restoration workflow, but even while doctors are able to offer more in-house services, there is still a place and a need for labs. Labs might find themselves handling any one of the steps in the restoration creation process.

“It continues to evolve,” Dr. Severance says. “With more open systems, the laboratories can actually login and help the design. There are some laboratories that offer design services. The unique thing about dentistry is that every office is very unique on their procedures. If they are a crown and bridge office that’s doing a lot of work and working very fast, it may be more efficient for them to scan, then either send to the lab for immediate design, which could then send it back to the office to be milled, or the laboratory could login and design some of the cases directly there, and then the assistant—who they’re cutting another case—could simply load a block in the mill. Or they can finish the case completely for a quick turnaround.”

And being that resource for their doctors is a successful business model.

“What we find, typically, is it is the laboratories that embrace and are able to assist at the office in providing crown and bridge are the most successful,” Dr. Severance says. “I always say it is a team sport. Not only is it the team members on the other side of the chair that become experts on scanning or designing or finishing restorations, but the laboratory is part of that team as well. Now laboratory technicians have the beautiful, artistic ability, treatment planning, are able to look at the big picture in many cases and are also experts on handling materials. They can actually train the chairside assistants to do a lot of the staining and glazing.”

“A lab has so much talent and value to contribute to a dental office,” Bell says. “I think it’s how the value gets delivered to the office and how it’s integrated into the workflow of a dental office with in-office capabilities.”

The most prevalent way labs tend to be involved in chairside cases is through case design.

“Some dentists send the file to a lab partner who designs, and sends back the file to the office where it can be milled chairside,” Cox says. “The characterization of the crowns in this scenario is still very demanding when dealing with anterior restorations. We see this design service growing in the future as labs work to remain close partners to dental offices that have in-office mills.”

“Remote designing is becoming more and more popular,” Artwood notes. “There are many labs that both offer and use this type of service. This is a viable option for a practice that wants to utilize technicians that specialize in digital design. Especially if they do not have a qualified person on hand, or would rather pay a small fee instead of spending the extra time.”

As cases become more complex, the lab could be pulled in for their knowledge.

“When [cases] get up to multiples, smile designs or comprehensive care, the laboratories’ expertise is brought in, quite a bit,” Dr. Severance says. “It’s really up the spectrum from using the laboratory for specific cases, and it’s up to the office’s competence and feeling of accomplishment for these procedures.”

When a practice decides to use a lab is a choice for the practice to make.

“There’s no hard-and-fast rule,” Dr. Severance says. “There used to be a black-and-white line. It’s pretty gray now. When you need it, use the laboratory. It doesn’t, economically, makes sense for a dentist to take away from the chair time and sit and design a six-unit, smile design while the laboratory and/or dental assistant could do it much easier.”

“We involve the lab when it is a highly, highly esthetic case,” Dr. Rice says. “When I have somebody who wants perfection, and then I feel that working with a ceramist who has that skill set helps me deliver the very best dentistry.”

Communication
Using a lab in conjunction with one’s chairside efforts underscores the need for solid communication. Happily, manufacturers provide tools that can help bolster those connections.

Dentsply Sirona, for example, offers its Sirona Connect portal, which allows patient scan data to be transmitted from the dentist to the laboratory. If necessary, the two parties can collaborate on the case via the portal.

“Through digital impressioning, there is much more communication between the doctor and the laboratory, in a digital way,” Norbert Ulmer, Director of Laboratory CAD/CAM at Dentsply Sirona Dental, says. “Nowadays, professionals can apply technology based on the situation at hand and the indication at hand. For instance, if a doctor who is set up for single-visit chairside...
The ability for doctors to create same-day restorations shouldn't concern labs that they will be shuttered. In a broad sense, there will always be a need for labs. “The lab can provide a wider range of restorative options, especially to a smaller practice,” Atwood says. “Chairside options require an investment. Not just in dollars, but in time as well. In addition to the purchase costs, maintenance costs, consumables costs, etc. There is also time that has to be spent training/learning how to use the technology. Time spent doing the work in-house. Time that the practice spends not seeing patients. It becomes a decision of what is more cost-effective at that point. A lab can provide skill, technology and products for a fee; instead of an investment. There is value in providing that service.”

The ability of labs to bring their expertise to doctors using chairside underscores the continuing need for lab services.

“What we see happening a lot is that CEREC dentists are perfectly capable of doing certain cases in-office,” Ulmer says. “But because of certain situations in their office that day, ‘you know, I’m much better off sending this to my laboratory, because I trust my laboratory.’ While initially, laboratories were worried about the dentist investing into single-visit chairside dentistry, new relationships have formed. These relationships are built on the same attributes as traditional relationships, meaning they are based on the expertise that the laboratory brings to the office. The doctors are reaching out to the laboratories to ask for direction, to ask for advice, to ask for their expertise. These laboratories are embracing the CEREC office and are helping the doctor with their knowledge, experience and technology. They typically manage to form much closer dentist-laboratory relationships than the laboratories that are shying away from the CEREC office, because they feel that they share knowledge, they might lose the account. It’s typically the opposite.”

Labs are still able to provide a level of service that chairside dentistry cannot.

“The quality of a chairside option will never surpass what you can get from a lab,” Atwood says. “I have worked with dozens of different products and machines, large and small. It is my observation that the larger industrial mills yield a superior finished product. When you put this type of technology in the hands of a lab technician who does this everyday versus a practice that does this infrequently with lesser machinery, there is a gap in quality.”

Esthetics are particularly well delivered by laboratories.

“A doctor is going to want have somebody with the artistry and eyes of a really good lab technician to do that, as opposed to either trying to do that themselves or have staff do it,” Dr. Flucke says. “There is going to be a market for the dental labs, I just don’t know if it will be as big a market as it is now. I don’t think you can ever replace the human element. You can try really hard, but when it really comes down to art, could a machine create the Mona Lisa? I think that there’s always going to be a human element involved in it.”

While labs need not worry about becoming dinosaurs, they must also evolve with the times, realizing that some doctors do embrace chairside, and should adjust their business practices accordingly.

“We are living in modern and competitive times,” Ulmer observes. “Anybody who is not willing to adapt to the change of the times should be scared. But anybody who is willing to provide the expertise and the service that his clientele needs and is looking for, actually is looking at great times, because the level of care is increasing, patients are spending more money on dentistry. Doctors are primarily not laboratories. They are looking at the dental team to supply their office with the restorative work that they need, and they’re doing it with the best service providers.”

“It’s one of those things where, as labs go more digital themselves, there’s always going to be a market for some people that, for whatever reason, don’t want to be involved with the whole chairside category,” Dr. Flucke says. “You are going to find some people, because of the cost of the technology, because of the way they practice, maybe because of the way the fees are structured, they have to see a lot of patients in the day, so they don’t have the time to sit down and do the designing. I think there’s always going to be a market for laboratories.”

Ulmer observes that now is a pivotal time for labs and laboratories, because are a lot of laboratories that are changing. “I don’t think ‘afraid’ is the right word,” Bell says. “Are [labs] open to changing, evolving? If yes, the capabilities and skillset will be delivered and utilized. If no, if a lab wants a stream of dentists sending cases consistently to the lab for fabrication and fees from 10 years ago, then that lab should be afraid.”

dentistry, he may choose to do everything in a single visit, and that works out fine. But there may be reasons, based on either the material that he wants to choose, based on the schedule that he has that day or based on the expertise required for the specific case at hand, and he may choose to reach out to his laboratory to leverage their expertise and their technology for his dental team. Through Sirona Connect, dentists can send the scans to their laboratory and the laboratory can take that scan, design a case and send it right back to the doctor so that the doctor can then mill that in-office, with the patient still in the chair.”

Doctors and laboratories might use CAD/CAM components from different vendors. But as long as the pieces are compatible with each other, communication can still proceed.

“If they have a more complicated procedure, with an open system, like ours, you can immediately drop it off at the laboratory, virtually, or drop it off with the surgeon, or drop it off with the perio,” Dr. Severance says. “It’s a much more efficient way to communicate back and forth. Once you go digital, you can choose who does what, when. The big thing about having everybody communicate virtually is not waiting days to send impressions for models to pour up. It can be as immediate as you want.”

The future of chairside

With CAD/CAM, doctors are able to do astounding things, things that were the stuff of science fiction just a couple of decades ago. Looking five or 10 years into the future, CAD/CAM promises to deliver even more extraordinary features.

“One of the coolest parts of dentistry is the evolution,” Dr. Rice believes. “When I first went chairside, it was single, posterior crowns, and today we do crowns, we do quadrant dentistry, whether it’s a crown or partial crown, like an inlay or an onlay. We can treat bridges. We can treat dental implants, where we can fabricate not only the crown but also the abutment. When it comes to incorporating a lab, we can also do orthodontics with Invisalign or ClearCorrect. We can do sleep appliances or occlusal guards. It keeps expanding and expanding. I would say in the next five years, we’ll be able to do just about every dental procedure digitally, if a dentist
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Chairside advancements will also lead to the best materials for each case and for each patient.

“[I expect] data-driven material selection, treatment planning, shade and translucency selection and custom fabricated restorations delivered in one visit and in total harmony with the patient's biomechanics,” Bell says.

Beyond utilizing chairside technologies for the sole purpose of creating restorations, Dr. Severance expects those tools to be used daily, in different capacities.

“Our mission statement is, ‘Every time a patient sits down, a scanner gets picked up,’ ” Dr. Severance says. “If you go to the dentist now, they'll do an oral cancer exam, they'll look in hygiene and maybe take study models. In the future, and certainly I don’t think anybody is there yet, but we’re all shooting for that, but when you sit down for your first visit, instead of us looking in the mouth, maybe we’ll immediately take a scan of your mouth. And now we can see in color, we can immediately look on screen, can see things and capture that record. And then we save that. In six months, when you come back, you sit down in the chair, we pick up the scanner and scan you, and now the computer compares. What did your mouth look like six months ago and what does it look like today? And show me the differences, because in any medical profession, we essentially look for changes—if your teeth rotated a bit, if there is recession that moved up. We do that, visually, now or with models. But a computer can monitor change, and the computer could point out, ‘Your recession was 3 mm now it’s 4 mm.’

What’s going on? Well, this tooth rotated. Or this tooth moved.”

The goal, he says, is to make scanning a proactive part of patient care, rather than a reactive response to a problem.

“Diagnostically, this idea of capturing, keeping digital records and being able to look at your mouth over time will be able to provide much more information long-term, and it’s always better when the clinician can show the recession,” Dr. Severance says. “They can tell you, ‘Yeah, you’re losing a little gum here.’ But if they can show you the change in time, you now, immediately own that problem and see it directly, versus a memory from the last time I checked it.”

Cost can be a major hurdle, but once doctors realize the value that chairside equipment provides to his or her practice, the cost goes down.

“Leveraging our strong relationships with both dentists and labs, Henry Schein Dental connects dentists to our network of labs—in coordination with our lab business, Zahn Dental—to help streamline digital workflows,” Cox says. “We work with our technology suppliers to offer a variety of chairside solutions for oral health professionals—through Henry Schein Connect Dental, the company’s digital platform—as well as three digital impression scanners from Planmeca, 3Shape and 3M. Whether the practice is ready to move to chairside CAD/CAM or 3D printers are not yet used for restorations. Currently, they are used to create models or surgical guides. But in the near future, they could sit on a desktop in the clinic as part of a chairside solution.

“I think the next thing you’ll see is 3D printing,” Dr. Flucke says. “There’s such an interest in that and there’s so much development in that.”

Materials and services
Chairside dentistry is only possible because of technological innovations; advancements will come from manufacturers in terms of technology, materials and services.

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simply wants to start by taking digital impressions, we have a variety of open-architecture, digital solutions to help customers make the right choices to meet their unique needs, while helping ensure these technologies work together seamlessly.”

Expect materials to improve, both in terms of esthetics and strength. “We’ve always had ‘pretty,’” Dr. Rice says. “But now we have ‘pretty’ and ‘strength,’ so there’s almost no tooth in the patient’s mouth that we can’t restore with chairside. What I look forward to is a continual evolution in that balance between strength and beauty. (IPS) e.max is about as perfect as you can get, but every time I think that, somebody comes out with something better.”

In some cases, labs maybe needed to handle materials that doctors are not able to manufacture themselves. “There are more and more doctors that are investing into fast zirconia sintering furnaces,” Ulmer says. “But not all of them have them today, so if they wanted to prescribe an all-zirconium oxide restoration, and they cannot fast sinter, it doesn’t make sense to do the restoration in a single visit, so they would do this through the laboratory.”

The future of the workflow
Chairside dentistry is an exciting proposition for many clinicians, but it may also cause trepidation for doctors and labs. As technology marches forward, dental and lab professionals can learn from those who have already been there.

Ulmer advises laboratories, “The nature of the game has not changed. It’s just that we are dealing with a different environment and a different dynamic. The nature of the game is still being the expert and the service provider for the doctor, and helping him to succeed with his or her dentistry.”

For clinicians, Dr. Rice advises embracing a system that allows growth. “Even if the cost seems prohibitive, I would always choose the system that allows me to at least grow into milling my own teeth and didn’t handcuff me into only being a scanning device,” Dr. Rice says. “Because at some point you’re going to get really great at scanning, but you’re going to realize that you’re going to want to do this process from start finish, and I hate when people spend $20,000 thinking they’re going to save money, and then two years later, they have to spend an additional $150,000. If you’re going to go for it, I would say go for it. It’s worth it.”

Dr. Rice says that the best advice he can pass along is the same advice he got from others. “They said ‘Yes’ to technology,” he observes. “They overcame those fears. They took the leap of faith, and every single one of those people—and I’m a good example of it—found out that it was so much more powerful, not only to deliver great dentistry but to be a practice builder. It’s an amazing marketing advantage, in addition to being an amazing clinical tool.”

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WHAT OUR EXPERTS ARE EXCITED ABOUT IN 2017
—and you should be too!
AS WE SAY GOODBYE TO THE YEAR 2016, WE TALKED TO SOME OF OUR EXPERTS ABOUT WHAT THEY ARE EXCITED ABOUT FOR 2017. FROM NEW TECHNOLOGY TO NEW WAYS TO APPROACH HYGIENE, WHAT THEY TOLD US WILL PROBABLY EXCITE YOU, TOO.

Here is what the experts had to say:

**DR. MARK HYMAN:**
**LIBERATING DENTISTS TO PRACTICE UNENCUMBERED WITH AFFORDABLE INTRAORAL CAMERAS**

Dr. Mark Hyman, full-time private-practice clinician, educator at University of North Carolina, Chapel Hill, and national and international speaker, considers the quality of your dental photography the gateway to practice success in 2017. He invested in Digi-Doc intraoral cameras for all eight operatories in his Greensboro, North Carolina, practice. He also takes before, during and after photos of his procedures.

“In this competitive, turbulent, litigious time we live in, our friends in the insurance industry might turn around and say, ‘Where was the decay? You did unnecessary work. You did too many crowns. You did too many build ups.’ If you have photos of the before, during and after … it’s ball game, mic drop, end of story,” says Dr. Hyman.

He shows patients their photos on an LCD monitor, usually without saying anything else. “We don’t have to beg patients to accept care. We just put a big color photo of their tooth on an LCD monitor in front of them and shut up.”

Dr. Hyman credits the convenience of today’s intraoral camera for giving dentists the freedom to practice how they want, without limitations placed both externally and internally.

“That’s what I want for my dental colleagues in 2017: Liberation. Liberation from the insurance companies and from our limiting beliefs as to what patients will or won’t say yes to,” Dr. Hyman explains.

Best of all, it’s a relatively small investment. Dr. Hyman remembers his first intraoral camera from 1991. It cost $17,900 and came with a cart so you could drag it from room to room. By contrast, his Digi-Docs are much smaller and cost less than $5,000 each. They pay for not only themselves, but also other expensive technology in the practice.

“This investment can lead to everything else. You want to buy a CBCT machine? They’re expensive, right? If you only add an extra $500 per day, and figure most doctors work 200 days a year, then you have an extra $500 a day times 200 days and bang! That’s a $100,000 increase in twelve months,” Dr. Hyman explains. “So you earn a cone beam or a CEREC machine just using that concept of convenient photography.”

However, Dr. Hyman says that even $500 is a low estimate. He estimates he and his team add at least $2,000 a day. Even reducing that number by half, clinicians could add $1,000,000 to their practice over five years, just by investing $5,000.

“Those are numbers people can get excited about,” he says. “This is not hard to do.”

**DR. JOHN FLUCKE:**
**EMBRACING EXPANDED FUNCTIONS OF YOUR TEAM AND EMERGING SCIENCES**

Dr. John Flucke, a general dentist in Lee’s Summit, Missouri, is excited about including the team more in 2017. Keeping your lines of communication open with your people allows them to help you with their fullest abilities.

“Dentists tend to be hands-on and think, ‘If I don’t touch it, then it’s not right,’ or ‘If I don’t touch it, I’m not comfortable.’ You don’t always need to do that,” he says.

Dr. Flucke practices in Missouri, a state with expanded function. He allows everybody to do as much as they legally can, because it’s more fun for them and a lot of what they can do makes his life easier.

“Everything just rolls better when you include the team. And I love that. The people that work for me love being able to help and use their skills,” he says.

The assistants can cement crowns and adjust occlusion out of the mouth in Missouri. When there are prosthetics to cement, Dr. Flucke ensures everything looks perfect; his assistant does the cementation and the cleanup.

“That saves a bunch of time for me because while it’s done, I’m doing something different. I am not even in the room. It makes things go so much better. The schedule is more available to patients because they are not looking for times when I have all that time in my schedule.”

However, Dr. Flucke believes dentists should expand their functions, specifically for implants. Implants weren’t part of the regular curriculum when Dr. Flucke went to dental school. However, today they are. Because he didn’t train on them, he doesn’t place implants and he knows a lot of other dentists his age are in the same boat. He recommends becoming familiar with them and more comfortable with them.

“Even if you don’t place implants,
you need to educate yourself about them, because the science is undergoing a lot of dramatic changes,” he said. “Younger doctors have placed them in dental school. To them, it’s second nature. For people like me that aren’t doing it, you still need to stay on the edge as far as learning about them, because they’re becoming more commonplace.”

“Having that ability to do guided impact surgery at your fingertips as a general dentist changes your entire practice,” she explains. “I thought when we became CEREC our practice changed. But when we purchased our cone beam, it’s crazy the way it opened us up to do guided implant surgery.”

Hunter encourages both clinicians and their assistants to get out of their comfort zone in 2017 and quit feeling apprehensive about new technology.

“When you reach higher and get out of that comfort zone, you’re forced to learn the technology and what it can do. From that comes success. It’s making you do something that you might not otherwise have done. I love it for that reason alone,” Hunter said. “If you are in an area where there are a lot of dentists and you don’t have the proper technology or the ability to design and place implants right there in the office, you are going to be left in the dust.”

Also, the integration creates a complete impression system. Dr. Chi uses it for most types of cases, from single units in the office to the more complicated cases he sends to the lab. He uses it for complex esthetic cases, as well as Invisalign cases. He credits the ability to scan the upper and lower arch very quickly.

“From that standpoint, it’s a great all-around impression system if you want to do same-day or if you want to do traditional dentistry and still use a digital impression system,” Dr. Chi says of the 3Shape technology.

Dr. Chi likes how the 3Shape system works even on complex cases. He explains that all the digital impression technologies have difficulties getting an accurate impression of the whole area. “With this one, it simplifies that process,” he said.

Also, the integration creates a complete impression system. Dr. Chi uses it for most types of cases, from single units in the office to the more complicated cases he sends to the lab. He uses it for complex esthetic cases, as well as Invisalign cases. He credits the ability to scan the upper and lower arch very quickly.

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“Some of the other CAD/CAM software can also do that, but it’s pretty easy the way 3Shape has it set up,” Dr. Chi says.

Hygienist explains.

That’s because hygienists love their instruments sharp and ergonomic. Vavrosky is intrigued by Scandinavian company LM Dental, and their new LM Ergo Sense Sharp Diamond Sharpen line. They require no sharpening and have a wide handle which improves ergonomics. One of her favorite features, however, was the RFID chip technology.

“You can have a chip inserted into them, utilizing RFID technology, and it can tell you how often it’s been used, if it’s clean, the maintenance, all these things after you hook it up to your computer. It’s a built-in dental tracking system,” she says. It can also tell you where they are, a feature that might have more significance in a large group practice where several dental professionals are using instruments.

Another reason Vavrosky thinks the LM Instruments are a game changer is that they provide improved ergonomics. The wide handles protect the hygienist’s hands.

“If you have too small of a handle you squeeze more. It has to do with pinch pressure. When handles are wider, it reduces muscle fatigue, which reduces the chance of muscular-skeletal injury. Plus, with them being silicone, supposedly it also helps with tactile sensitivity.”

One of the biggest challenges hygienists have is finding time to sharpen instruments. Not only is the schedule usually tight, but the sound is also awful. Vavrosky describes it like “fingernails on a chalkboard.” She jokes that you could sharpen them right next to the patient, but was confident it would scare them right out of the operatory.

“But sharp instruments are vital. If they are sharp, your scaling is more efficient and thorough,” Vavrosky says. “It sounds horrible, too, but when a patient cancels, we shouldn’t get excited for that. We should be like, ‘Oh no! They aren’t getting their treatment.’ But really, it’s like, ‘Oh good! I have time to sharpen my instruments.’”

“"When you reach higher and get out of that comfort zone, you’re forced to learn the technology and what it can do. From that comes success. It’s making you do something you might not otherwise have done.”"
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“...I like the flexibility that it provides.”

How the EyeZoom™ Mini helped one practitioner be more effective in providing care. [by D.J. Wanberg]

HOW DID DR. DANIEL MCKINNEY, owner of McKinney Dental in Madison, Wisconsin, get introduced to the EyeZoom™ Mini? It turns out that his practice and the company that makes the EyeZoom™ Mini are neighbors. Orascoptic is located in Middleton which is a northwest suburb of Madison where Dr. McKinney has his practice.

“I have been using Orascoptic products almost since I started in dentistry,” he says. “I hadn’t heard anything about it (EyeZoom™ Mini) and a rep for the company gave me a call and asked if I was interested in evaluating the production and to have an opportunity to be a spokesman for it.”

A dentist needs many things to provide a high quality of care, and magnification to see parts of a mouth or tiny objects during procedures is critical.

The EyeZoom™ Mini is the second loupe to be launched under the EyeZoom™ name. It features a two-step magnification technology that allows the user to switch between 2.5x and 3.5x.

I think the EyeZoom Mini would help general dentists to be more effective in providing quality care because of the number of times we can switch magnification.”

The working distance and declination angle are customized to each user.

“I like the flexibility that it provides. You have the opportunity to go back and forth between magnifications. It allows me to be more thorough and provide a high level of quality in what I do,” Dr. McKinney says.

The product has patent-pending technology and was co-engineered with Konica Minolta. The company website page on the EyeZoom™ Mini states that it provides dentists top clarity and high-definition resolution.

“I would encourage dentists to look into Orascoptic products. I think the EyeZoom™ Mini would help general dentists to be more effective in providing quality care because of the number of times we can switch magnification,” the Wisconsin dentist says. “They should look into seeing if it fits their style of practice.”

The optical systems on the EyeZoom™ Mini are made with Grade A fine annealed glass lenses fused with anti-scratch and anti-reflective coatings. All carrier lenses are made with High Index polycarbonate material.

“You can flip back and forth between a detail-oriented view or a macro look at things. I like the magnification adjustments,” Dr. McKinney says. ●
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An improved way to deal with broken appointments

How a new update to Dentrix Ascend can help manage missing patients.

[ by Robert Elsenpeter ]

Dentrix Ascend recently rolled out an update to its practice management application. Since Ascend is cloud-based, practices that use it already have access to its new features.

Jill Nesbitt, MBA, is the founder of Dental Practice Coaching and has 20 years experience managing group practices. We asked her about the Ascend update and how practices can get the most out of its new features.

What is new in the update? What will practices see that wasn't there before?
The focus of this update was, really, on broken appointments, to give us more information and to do something, automated, that makes things a lot nicer.

You can enter a reason when somebody cancels. If they call in and say, “Well, we've got to go to this, that or the other,” or “Somebody's got the flu,” you can enter a reason and then it will track that for you.

I always like it when things are done automatically for me, and I don’t have to enter any information, so one of the things I really like is that as soon as you break the appointment, it documents the date and the time. It will also track how much notice they gave you. One of the things teams will find when they start using this is that because of those two pieces—automatically documenting the time that they called in and letting us put in the reason—now when you go back, you can say, “Who are my chronic patients who seem to keep canceling on me?” And you have a list of all the appointments, the reasons and how much notice they gave.

Jokingly, you can say, “If grandma died three times, maybe something is going on that is suspect as to why they keep canceling their appointment.” That lets the team make better decisions about scheduling and when and where they want to offer an appointment.

Is there a larger philosophy behind the Dentrix Ascend update?
Even though this is very specific to broken appointments, what it lets you do is better manage scheduling. As we know, everything really revolves around how well we can manage our book. So we can manage the appointments and offer the right people the right times, and that may mean, “Now I know who my chronic abusers are and/or what their stories are.” Maybe somebody is truly just very ill. We can manage it, overall, better, which means we’ll have less wasted time.

You can tie that directly to productivity and finances. So this is a really thoughtful improvement. It's...
You are responsible for managing the schedule, not just turning around and rebooking someone over and over who chronically doesn’t show up. That wrecks it for somebody else who actually needs to come in.”

simple and very intuitive. There’s not a lot of training that you need. As soon as you click “Break” it pops right up: “Reason for missed.” So it’s really easy for a new team member. You don’t need to walk someone through it, as long as you tell him or her, “Put in the reason that they tell you.”

One of the things that I see the most is that so many of my offices really struggle to get a good broken appointment system. They mix up the idea of, “The customer is always right” or “The customer always comes first.” Well, that may very well be true, but you are responsible for managing the schedule, not just turning around and rebooking someone over and over who chronically doesn’t show up. That wrecks it for somebody else who actually needs to come in.

Does Dentrix Ascend take any action based on those broken appointments, or is it simply a notification tool for the team?

What it does is you can set up, automatically, when an appointment status goes to “Broken” or “No-show,” and it’ll automatically send an email or a text message to that patient to say, “We missed you.” And you can customize that communication by “Broken” or “No-show”, to automatically go out to the patient to say, “We need to get you rescheduled” or “We missed you today.” Who knows? If you get it within an hour, maybe that patient calls and says, “Oh my gosh, I completely forgot. Is there anything else today?” And maybe we can work you into the schedule later on if somebody else misses his or her appointment.

It ties in. On one side, what this does is it gives us more information, but on the communication side, it also tries to fix the problem.

Is any additional training needed or is it all fairly straightforward?

There’s really no training. What I would encourage offices to do is use this as an opportunity to have a staff meeting and talk about, “What’s our approach? What if we do start to see appointments canceled three times? Four times? Five times? What’s going to be our guideline?” I think that would be the better opportunity. The software is working for them and giving them better tools, and how are they going to use those tools to manage their practice more effectively?

Since Dentrix Ascend is a cloud-based system and subscribers already have access to these new features, what advice do you have for practices who may come across these features for the first time?

What I like is that they are really small tweaks. Even if no one ever said a word to you, one of the things that Ascend will do, as soon as a new release is updated, the next time everyone logs in, it’ll give you a pop-up window that says, “New updates available.” And you can click a little button to learn more, and it’ll walk you through exactly what all the new updates are.

But let’s say that when Suzy logs in at the front desk, and she’s running a little bit late and already hustling with her day, she doesn’t have time, and she just closes out of that window. Even if, later on, she is following the guidelines, and someone calls to cancel their appointment, she clicks “Broken,” the next thing she is going to see is that reason for missing. She can very easily type that it. The only thing might be is just to tell her, “We want you to fill that information in.” It’s literally so straightforward.

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Are dental schools providing adequate software preparedness?

We're only going to be more reliant on dental software in the future, so the time to start training is now. [by Mike Uretz]

Dental software is quickly becoming the lifeblood of any practice or group. All aspects of clinical, administrative and financial operations are becoming more dependent on software technology. Next generation, state-of-the-art practice management and claims processing systems, sophisticated clinical software including electronic health records, electronic referral management, integrated imaging, demand for patient web access, governmental mandates for interoperability of patient records, and increased HIPAA reporting and liability are just a few of the dental software driven changes facing today’s dental practices.

However, the fact remains that many dental schools do a poor job of preparing students to deal with the increasingly complex world of dental software that a graduating dentist will have to deal with for years to come.

I have seen numerous instances where a new graduate joins an existing dental group and is expected to select new software technology. Some groups assume that the recent graduate, being brought up in a tech-literate world, has the skills needed to lead evaluation and selection of new software.

And when it comes to dental software for a graduate acquiring an existing “old-school” practice or building a new practice, the skills needed to be successful become much more daunting. Not only do they need to have the skills to evaluate and select the right software, but they now need to deal with the details of purchase, acquisition and implementation.

Each year I’m invited by a top dental school to give seminars to their graduating dental students on “next-generation” dental software technology. I was recently approached by an attendee after delivering one of my dental software workshops.

“I went to school for years to learn how to provide quality clinical patient care,” he said. “No one prepared me for having to deal with software vendors and technology companies.”

Some graduates won’t think about preparing to select, purchase and implement dental software until it’s too late. Whether you plan on starting your own practice, or joining an existing practice, dental software vendors will try to earn your business. And if you’re not prepared to make this decision, the vendors will have the upper hand.

So, what should dental schools be teaching students to prepare them for this journey, and what’s the recipe for dental software success? In many years of helping practices and groups with their software acquisition and purchase, I’ve found that it boils down to three main things:

1. Choosing the right software and vendor that meets practice management and clinical needs and is able to grow as your practice grows
2. Negotiating the best price possible, along with an iron-clad contract that gives you as much protection as possible
3. Making sure you have a solid implementation plan, managing this plan and holding your vendor accountable along the way

A well-structured vendor demonstration is key

A good start for a dental school would be to think about incorporating education on conducting organized vendor demonstrations into their curriculum. This is very low-hanging fruit. The biggest mistakes in software evaluation and selection are often made with these vendor demonstrations. Instead of the practice or group exercising control over the demonstration, the vendors are left to run the show, spending more time than necessary showing features that might not be your priority, and not showing features that are critical to your practice. The cliché, “the inmates are running the asylum” comes to mind here.

This scenario can be prevented by going into a vendor demo with clear objectives, a set time frame, a list of the clinical encounter and practice management scenarios that you typically see, and precise knowledge of what’s important to you and what you want to see demonstrated.

In addition to addressing your issues and concerns, vendors should also exhibit certain “soft skills,” such as the ability to understand practice or group needs and demonstrate these in the software, a desire to engage attendees by asking questions, and a willingness to think outside the box and deviate from their prepared scripts.

Conversely, a group or practice should be wary of those vendors who exhibit “red flag” behaviors, such as one sided conversations, or discussion of solutions before they understand actual needs and requirements. You’ll know this is happening if you feel that the vendor is exclusively in “sell mode.” The liberal use of technical jargon to impress or confuse is a red flag. Also, watch out for vendors who make promises about future features, as these might not materialize (the reason such features are known as vaporware). If the vendor exhibits these behaviors, politely excuse yourself.

Will dental schools get there?

I am encouraged with the growing number of students that contact me regarding learning about the ins-and-outs of dental software as well as dental schools recognizing that the “nuts-and-bolts” of dental software and IT education are important in dental education. After all, we are becoming a more technical world, and understanding how to evaluate, select and purchase the best software possible is a growing necessity in providing the best patient care and efficient operations.

ABOUT THE AUTHOR

Mike Uretz is a nationally-recognized dental software, IT and Electronic Health Records (EHR) expert. He is the founder of DentalSoftwareAdvisor.com and DentalSoftwareCompare.com as well as the Dental EHR Editor for Dental Products Report. As a leading industry consultant and educator, Uretz has helped both individual and group practices evaluate and select software vendors and solutions, structure and negotiate vendor contracts, and provide vendor management. He also has assisted practices with obtaining state subsidy payments through the EHR Incentive Program. Mike can be reached at mikeu@dentalsoftwareadvisor.com or 425-434-7102.
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WHEN YOU LIVE IN A DIGITAL WORLD, you become dependent on your technology. Think about it. Probably 10 or maybe 15 years ago having a mobile phone was a luxury or perhaps a hassle, but either way it wasn’t that important. Nowadays you get a mile or so away from home and realize you left your phone on the kitchen table and you will turn around to go back and get it. That’s not a bad thing. At one time the “horseless carriage” was considered new technology and now we can’t get along without it.

Why should I back up?  
The following statistics were gathered from various sources including the Boston Computing Network* and while some of the information is old, you can still see the disasters that can be created when a crash happens. I have no reason to believe these statistics have gotten any better over time.
- Six percent of all PCs will suffer an episode of data loss in any given year. Given the number of PCs used in U.S. businesses in 1998, that translates to approximately 4.6 million data loss episodes. At a conservative estimate, data loss cost U.S. businesses $11.8 billion in 1998.
- 30 percent of all businesses that have a major fire go out of business within a year. 70 percent fail within five years.
- 31 percent of PC users have lost all of their files due to events beyond their control.
- 34 percent of companies fail to test their tape backups, and of those that do, 77 percent have found tape backup failures.
- 60 percent of companies that lose their data will shut down within six months of the disaster.
- 93 percent of companies that lost their data center for 10 days or more due to a disaster filed for bankruptcy within one year of the disaster. 50 percent of businesses that found themselves without data management for this same time period filed for bankruptcy immediately.
- American business lost more than $7.6 billion as a result of viruses during first six months of 1999.
- Companies that aren’t able to resume operations within 10 days (of a disaster hit) are not likely to survive.
- Every week 140,000 hard drives crash in the United States.
- Simple drive recovery can cost upwards of $7,500 and success is not guaranteed.

Why backing up is critical  
Backing up your data could be the difference between practice success and practice disaster.

Of course the thing that is difficult about technology is suddenly not having it. Just like turning around to go get your phone, we’ve all become so dependent on technology that when we don’t have access to it, things tend to grind to a halt.

Trust me on this one, if you are truly dependent on technology, you’ll do anything you can to avoid being without it. That’s why this month’s Technology Evangelist column will focus on backing up your data and making sure it is safe... just in case of a disaster.

What I want to give you in this article is a basic understanding as well as a menu for how to ensure your data can be retrieved in case things go sideways... and life can always go sideways.

Now before we get started, let me confess that I’m a bit of an outlier. My motto has always been if having two of something is good, then having six of something is three times as good. So with that in mind, remember that I’m the king of overkill. Your mileage may vary. However, I will tell you this. In backup strategies, redundancy is important. It is critical to have at least one more backup than you think that you will need! Of course the part that makes this interesting is how do you know how many you truly will need? That’s the reason I tend to lean toward more instead of less. I refer to the backup process as being “the backup chain” and the more links it has, the better it is.

What do I back up?
Basically you need to back up anything that you don’t want to lose. While that may seem a bit flip, there are things on some of your computers that you probably can afford to do without. For instance, on my

Dr. John Flucke
Hard drives fail. It’s a fact of life. I can guarantee you that. What I can’t tell you is when the failure will happen. Because of that, it’s much better to be prepared for hard drive failure... before it happens rather than after.”

Because of that, I don’t keep any pictures of any value in the Pictures folder of my desktop, and that means I don’t care if that folder is backed up or not.

If you happen to have a lot of correspondence that you’d like to save, then backing up the Documents folder is probably a smart thing to do.

My advice is to make a list of things you do not want to lose and make sure that those folders are part of your backup strategy. Take your time and make sure to include everything you need. As far as backing up your dental office info, the easiest way to find out what critical files need to be backed up regularly is to call your software company and ask them. They will not want you to lose your data, and you will be happy to explain to them which files and folders are critical to backup. A quick call to their support line should be all you need to do. Just make sure to take notes and write down the critical components they recommend.

The same rule applies to your radiographs and other images if they are not part of your practice management software. If you are using a separate program to take and store images, make sure you call them and get their recommendations as well.

How do I back up?
The process is actually pretty simple and shouldn’t take a particularly long time. First, go to Google and search on the term “replicator backup.” You will find a few programs in this search and they all work well. My personal preference is one called “Karen’s Replicator.” The program is easy to use. You simply install it on a computer, and you run the program and check the boxes next to the folders (even on the network) you want to back up. Once this is done, you check the boxes on the folders where you want each backup to go.

The first time the program runs it will move all the data being backed up to your empty backup folders. The second time it runs, it will compare each file on the source with the file on the backup and only backup files that are new or have changed. This is the joy of a replicator: It doesn’t move every file every backup. It only moves ones that didn’t already exist on the backup. This means I can do a total backup on my system (which is currently around half a terabyte) in about 30 minutes.

Where do I back up?
There are lots of small portable backup drives out there. They all work well. I happen to prefer My Passport drives made by Western Digital. They are small, reliable, and affordable. I have one for each day of the week (redundancy). I run the backups at the end of the day and I leave them with me. I personally feel that the office backup is much too important to have in anyone’s possession than the doctor.

There are other portable drives that are much more durable such as the ioSafe portable. This heavy duty portable drive will withstand a 20-foot drop, immersion in water up to 30 inches for three days, and being crushed with 5,000 pounds. A 500 gb model is available for $650. These things are pretty much indestructible.

Once I’m at home, I take the drive out of my bag and store it in my home office. Then I take the next drive in the rotation and put it in my bag for the next day. This means that I have at least three backups off site at any one time and one with me in the office. Having off-site backups is critical in case of a critical disaster that destroys the office and its contents.

However, you can also set your replicator program to run when you are not in the office and to back up at night to other computers or NAS (network attached storage devices). A NAS that I am particularly fond of is the Drobo 5N. I wrote about this device last month in my Top 5 Test Drives article, but here is a little bit of info on it:

Drobo makes a variety of external hard drives for backing up and/or storing your data. However, they do it with a unique twist. Drobo devices contain multiple hard drives (like a server) and store your information redundantly on all of the drives (once again, like a server). The unique problem that Drobo solves is if one of the hard drives fails, it can be easily replaced.

What about online backups?
One of the questions I’m frequently asked is “can’t I just have an online backup?” Online backups are a good idea and can be one (or multiple if you have more than one) links in the backup chain. However, I also like the idea of having a physical backup that I can get my hands on in an emergency. Downloading gigabytes of data can take a long time and even if the online company will send you your data on a hard drive, you still have the downtime of having it shipped in overnight. A physical backup could bring you back considerably faster.

Also, I prefer online backups provided by dental companies for the simple reason that they have a vested interest in keeping you in business and will do everything they can to get your data to you as fast as possible.

Hybrid backups
One of the best ideas is what I refer to as the hybrid backup because it uses both a local backup as well as a cloud based online one as well. This hybrid system is currently being supplied by a company called DDSRescue.

This type of backup uses a small DDSRescue computer on your network. Some files are run on your server and the network box can communicate and backup all needed data from the server and stores it on the box. This data is also uploaded to the cloud in a HIPAA compliant manner to provide online backup.

The DDSRescue device performs a backup in my office once an hour saving multiple backups throughout the day. These backups are stored both locally and in the cloud.

This is the easiest system to use because it requires no intervention by doctor or staff. Once the DDSRescue team configures the device, it will perform all its functions automatically and autonomously. Check them out at http://ddrescue.com/

Wrapping up
Hard drives fail. It is a fact of life. I can guarantee you that. What I can’t tell you is when the failure will happen. Because of that, it is much better to be prepared for hard drive failure and/or data loss before it happens rather than after.

Following the information above should help you avoid a long term data disaster. I’ve lost drives over the years, learn from my mistakes.

“A Boston Computing Group reference available on dentalproductsreport.com.”

ABOUT THE AUTHOR
John Flucke, DDS, is Chief Dental Editor and Technology Editor for Dental Products Report and dentistry’s “Technology Evangelist.” He practices in Lee’s Summit, Missouri, and has followed his passions for both dentistry and technology to become a respected speaker and clinical tester of the latest in dental technology, with a focus on things that provide better care and better experiences for patients. He blogs about technology and life at blog.denticle.com.
Mobile websites and the dental practice

The internet has gone mobile, and it’s critical that your dental practice website does also.

[ curated by Dr. Lou Shuman with Cory Roletto, MBA, cofounder of WEO Media ]

Each month, Dr. Lou Shuman consults with a dental digital marketing specialist to discuss the latest developments in social media trends, SEO strategies, website optimization, online reputation management and more. This month, Dr. Shuman consults with Cory Roletto, MBA, cofounder of WEO Media, about the importance of mobile websites.

**Why are mobile websites important?**

Most people realize mobile devices have become an integrated part of our lives in a very short period of time. According to ComScore and Morgan Stanley Research, the number of mobile users surpassed desktop users around 2014. Although mobile devices and desktop computers connect to the same internet, the experiences are very different. Beyond the apparent screen size difference, when people are using mobile devices they tend to have shorter attention spans, and are looking for different information. Optimizing the mobile experience is essential to marketing conversion and increasingly important on even being found in search. On April 21, 2015, commonly referred to as Mobile Armageddon, Google started separating its search ranking algorithm into two distinct desktop and mobile algorithms. They also started marking websites as “mobile friendly” and included this criterion.
on mobile search rankings, setting the de-facto standard. In May 2016 Google rolled out an update to further boost the benefits of being mobile friendly.

Is there more than one type of mobile website?
Yes, most people know about two (dedicated and responsive) but there are actually five methods for rendering a mobile website.

1. Dedicated mobile websites (also called “mobile-optimized” sites): Dedicated mobile sites have design elements specifically designed for interaction and to the size of mobile devices. They are totally separate designs from the desktop website version and often have independent functionality. Because of this, dedicated mobile can be fine-tuned for user experience and conversion rates compared to responsive designs. On the downside, they require separate maintenance and updating.

2. Responsive websites: Responsive websites respond to the viewers’ screen size by rearranging and/or eliminating elements of the website as the screen size gets smaller. Responsive designs are more difficult to build, but once up and running updates and maintenance are done in one place.

3. Adaptive mobile websites: Adaptive mobile websites are sites that change the website design depending on screen size. With adaptive designs you can optimize for any size screen you want and can provide the ultimate user experience. But these types of websites are very hard to maintain. Depending on the number of “cut” point, screen sizes you are targeting, you may end of maintaining several different websites.

4. Applications (apps): An app is a program specifically designed to run on a particular mobile operating system, such as Apple’s iOS or Google’s Android. Apps can have added functionality well beyond a normal website, but can be expensive to build and maintain.

5. Accelerated Mobile Pages (AMP): AMP is a new open source initiative spearheaded by Google and the primary driver is to decrease page load times and increase reliability on mobile websites. Similar to “mobile friendly”, AMP websites may get an additional rank boost and if your website is an AMP website you will see it marked as such in Google webmaster tools. This indicates a significant effort by Google to promote AMP. AMP websites are dedicated mobile sites (discussed above) using AMP HTML and the AMP JS library. This may limit site functionality, but enables faster rendering of pages.

Which type of mobile site is best for a dental office?
The proverbial answer is, it depends. Most dental offices do not want to spend a small fortune creating a mobile website and do not want to spend much time maintaining and updating it. These two parameters rule out Adaptive and Application. AMP is still very new on the block and not supported by CMS systems which means building the website from the ground up which significantly adds to cost and maintenance. Therefore, we recommend either a responsive or dedicated website(s). Dedicated sites have the advantage of optimizing design and content, responsive provides a full website and easier updates. So, it comes down to a matter of preference and the office’s goal.

I have heard responsive sites are better for SEO, is that true?
No. I cringe every time I hear a consultant say responsive design is better for search engine optimization (SEO), In fact, according to Google responsive design is neither better nor worse for SEO. This myth is further disproved as most mobile websites do not use an m subdomain. Dedicated mobile sites built today use the same website address (URL) as the desktop version. They do this by using device detection or media calls which determine on the fly which website (the mobile or desktop) to render on your device.

Is responsive design better for tablets such as iPads?
It can be. It depends on the robustness of the responsive implementation. We build both responsive and dedicated websites, depending on the dental offices goals and preferences. Through building over 1,000 websites of various types we have learned that using device detection to render the full desktop website on a tablet provides a similar user experience as responsive websites. •

Conclusion
There are many types of mobile websites. Choose the one that best fits your dental office’s needs. If you need help deciding which type of mobile site to build, contact Cory Roletto for advice. Your dental office’s unique goals and preferences will determine which type of mobile site is best. After all, a mobile website is in the practitioner’s office to help improve their practice, not to detract from it.

ABOUT CORY ROLETTO
Cory Roletto is partner and cofounder of the dental marketing firm WEO Media where he leads the operations team. He holds an MBA and BS in Chemical Engineering from the University of Washington. He is the recipient of several awards in marketing and engineering, an investor in start-up companies and an executive board member of Northwest Kidney Kids, (www.nwkidneykids.org), a regional non-profit charity.

ABOUT DR. LOU SHUMAN
Dr. Lou Shuman is a long-time contributor to Dental Products Report and a member of the DPR editorial board. He is president and CEO of Cellerant Consultant Group. He is also the Chairman of the Technology Advisory Board at WEO Media, a Venture-in-Residence at Harvard’s Innovation Lab, and founded a dental-education internet company.

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EFFECTIVELY PLACE A CEMENTED IMPLANT CROWN

Dr. Ross Nash explores a better way to deal with placing cemented implant crowns. You’ll see a step-by-step method to solve this all-too-common problem. More on page 66.

[WEB EXCLUSIVES]

Creating an immediate load denture using digital tools

How one lab and dentist team created an amazing result using an all-digital process. By Tra’ Chambers, Owner of Express Dental Laboratory, and Dr. Steven Park.

http://bit.ly/2d00tWi

ADDITIONAL CONTENT ONLINE

The top 5 how-tos of 2016

We took a look at the most popular how-to articles from the year that was. Compiled by Ryan Hamm

http://bit.ly/2hWEWLQ

How to jump start your cosmetic dentistry practice

It’s time to take another look at direct veneer technology. By Dr. Harvey Silverman, Founder of the Silverman Institute of Cosmetic Dentistry.

http://bit.ly/2h3nDEB

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[IN THIS SECTION]

ERGONOMICS

EXERCISE THAT CAN WORSEN DENTISTS’ HEALTH

Why your exercise routine may be the most damaging part of your lifestyle.

TECHNIQUE

USE DIGITAL IMPRESSIONS FOR BETTER IMPLANTS

Explore how using newer impression technology streamlines the restorative workflow.

TECHNIQUE

HOW TO SOLVE A COMMON CLINICAL CHALLENGE

Using The Canary System to detect caries around amalgam restorations.
EXERCISE THAT CAN WORSEN DENTISTS’ HEALTH

Your exercise routine may be the most damaging part of your lifestyle.

Crossfit, P90X, Pilates, gym machines: exercise regimens are good for you, right? Wrong! Due to dentist’s predisposition to unique muscle imbalances, certain exercises and gym machines should not only be modified, but eliminated altogether.

Unfortunately, most healthcare professionals do not realize this, and they give dental professionals the same exercises they give everyone else who walks in their door. This can throw dentists into the “vicious pain cycle.”

The delivery of dental care requires excellent endurance of the shoulder girdle, rotator cuff and core stabilization muscles for safe shoulder movement and working posture (Fig. 1a-in blue). These stabilizing muscles tend to fatigue quickly with forward head, rounded back and elevated arm postures—all commonly seen among dental operators. When these muscles fatigue, other muscles compensate and become overworked, tight and oftentimes painfully ischemic (Fig. 1b-in red).

There are many gym machines that can worsen this imbalance in dentists. One example is the shoulder abduction machine (Fig. 2), which can over-strengthen the deltoid and supraspinatus muscles. These muscles already tend to be tight in dentists due to frequent lifting of the arms away from the sides of the body. This imbalance can cause improper movement at the shoulder joint, possibly resulting in painful impingement of the rotator cuff tendon and a myriad of other shoulder dysfunctions. Instead, specific rotator cuff stabilizing muscles should be targeted in the dental professional’s exercise program.

P90X and Crossfit are both fitness crazes that feature a brief 20-30 minute intense circuit-type workout. The downside of these regimens is that if you aren’t properly conditioned, you fatigue quickly, which leads to poor form and poor stability, which in turn then leads to injury—frequently of tendons. Dentists should modify or eliminate many of the exercises in these regimens.

The upright row (Fig. 3) is one example of a P90X exercise that dentists should consider removing altogether from their routine. While this may be fine for the general public, dental professionals are highly prone to an imbalance between the upper trapezius and middle/lower trapezius muscles, often resulting in painful trapezius myalgia.

Many of the Crossfit exercises are unsafe. However, the overhead deadlift (Fig. 4) is undoubtedly the most unsafe exercise for dentists, as it is a ballistic movement with little stabilization that places a heavy load on the upper trapezius and shoulder joint. Both areas are prone to injury in dental professionals.

Many of the original Pilates exercises lacked a stability component, causing them to be unsafe. Based on today’s scientific evidence, the APPI (Australian Physiotherapy & Pilates Institute) has modified and/or eliminated many of the original Pilates exercises to make them safe. There are eight of the original Joseph Pilates exercises that should be eliminated altogether, and several more that should be modified. One example of a Pilates exercise to eliminate is the Roll Over exercise (Fig. 5), which places a high compressive force on the cervico-thoracic junction and should be avoided.

I love yoga for dental professionals, however many of the poses should be modified, especially for female dental professionals. Since women tend to be more flexible than men, they are vulnerable to over-extension injuries and hand/wrist injuries. Weight bearing through an extended wrist dramatically increases pressure in the carpal tunnel and should be avoided.

Developing an effective exercise regimen

This is just a partial list of numerous exercises, gym machines, Pilates, P90X and Crossfit exercises that are problematic for dental professionals. An effective exercise regimen for dental professionals will correct their imbalances by targeting key shoulder girdle, rotator cuff, trunk and back stabilizing muscles, without engaging the muscles that are prone to tightness and ischemia. This requires expert knowledge of biomechanics, kinesiology, anatomy and dental ergonomics. In addition, specific muscles that are prone to tightness and ischemia must be targeted with stretching exercise and avoid over-strengthening. These concepts are the cornerstone of my “Home Exercise Program for Dental Professionals.” The DVD fuses the latest research on preventive exercises for neck and back pain with Pilates, yoga and dental ergonomics. Each exercise targets a specific movement, position or pain syndrome common in the dental operatory.

As long as you are delivering dental care chairside, you should be regularly correcting your muscle imbalances with proper exercise, since dentistry is an exacerbating activity. Resolve to make 2017 a year to balance your musculoskeletal health!

Dr. Bethany Valachi, PT, DPT, MS, CEAS is author of the book, “Practice Dentistry Pain-Free” and clinical instructor of ergonomics at OHSU School of Dentistry in Portland, OR. A doctor of physical therapy who has helped thousands of dental professionals prevent pain and extend their careers, she is recognized internationally as an expert in dental ergonomics, and has provided more than 700 lectures worldwide. She offers additional dental ergonomic resources on her website at www.posturedontics.com.
Dental professionals should avoid over-strengthening the muscles in red, that tend to become overworked, tight and ischemic. Rather, they should focus on muscular endurance training, targeting the muscles in blue. (Figs. 1A and 1B). One example of a gym machine that can worsen the rotator cuff imbalance and lead to impingement is the shoulder abduction machine. (Fig. 2). One example of several P90X exercises that should be eliminated from dentist’s workout. (Fig. 3). The overhead deadlift is unsafe for most people, but especially so for dentists! (Fig. 4). An example of a Pilates exercise that dentists should eliminate from their routine. (Fig. 5).
USE DIGITAL IMPRESSIONS FOR BETTER IMPLANTS

How using digital implant impressions streamlines the restorative workflow.

[ By Paresh B. Patel, DDS ]

Information provided by Glidewell Laboratories.

A FEMALE PATIENT in her early 20s presented for initial consultation with a congenitally missing maxillary lateral incisor. She had been wearing a flipper appliance for much of her life and desired an implant restoration for her missing tooth now that her dental development was complete.

The patient had been saving money for treatment but was told by another doctor that, as a result of bone loss that had occurred over the years, her ridge was too thin to receive an implant without extensive grafting.

The initial patient examination, including measurements of bone volume with ridge calipers, determined that, although the ridge was thin, there was sufficient facial-palatal bone volume and mesial-distal space to accommodate a 3.0 mm Hahn™ Tapered Implant, which excels at fitting within tight anatomical spaces. This implant would also prove advantageous because it could be restored using a custom zirconia hybrid abutment, which was important because of the restoration’s location in the esthetic zone.

The patient agreed to the treatment plan and returned for the implant placement appointment. After anesthetizing the area of treatment, an envelope flap was reflected just palatal to the crestal ridge so the bone volume and osteotomy trajectory could be visualized. The osteotomy was created following a simplified drilling protocol, with periodic X-rays taken to verify proper positioning and alignment with the long axis of the adjacent roots. After placing the Hahn Tapered Implant to depth, a cover screw was inserted and the implant site sutured.

After healing for 17 weeks, the patient returned for final impressions. An intraoral scanner was used in order to provide the patient with a highly accurate implant crown in as little time as possible. The final digital impression was taken with the iTero® intraoral scanner (Align Technology, Inc., San Jose, California) and submitted to the lab along with the parameters for the restoration, without the need for physical paperwork or shipping.

Using the virtual model generated by the digital impression, an Inclusive® Custom Abutment was designed with CAD software to optimize the emergence profile and esthetics of the BruxZir® Anterior restoration. At the final restoration appointment, the custom abutment and implant crown were seated and established the desired form, function and esthetics without the need for any chairside adjustments.

“Using the virtual model generated by the digital impression, an Inclusive® Custom Abutment was designed with CAD software to optimize the emergence profile and esthetics of the BruxZir® Anterior restoration.”

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1. The patient presented for treatment with a flipper appliance in the area of her maxillary right lateral incisor.

2. Initial condition of edentulous space.

3. Occlusal view of edentulous area shows facial-palatal resorption of the ridge.

4. Caliper measurements indicated ridge width of approximately 5.5 mm, which was sufficient for the placement of a 3.0-mm-diameter Hahn™ Tapered Implant.

5. A surgical flap was reflected to visualize the bone crest.

6. Proper positioning of the initial osteotomy was confirmed radiographically with a parallel pin in place.

7. The 3.0 mm x 16 mm Hahn Tapered Implant was initially inserted with a handpiece and threaded into final position with a torque wrench.

8. Treatment area after full seating of the implant.

9. Post-operative radiograph verified that the implant was fully seated and didn’t impinge upon the periodontal ligament spaces of the adjacent teeth.

10. Condition of patient after 17 weeks of healing.

11. A tissue punch was used to expose the implant.

12. A scanning abutment was attached so a digital impression could be taken.

13. Radiography verified complete seating of the scanning abutment.

14. The iTero intraoral scanner was used to create the final digital impression and submit the case to the lab for restoration.

15. The lab digitally designed the Inclusive Custom Abutment without having to wait for a physical impression or pour a stone model.

16. The final crown was designed in concert with the custom abutment to optimize the gingival margins and emergence profile.

17. To maximize esthetics in the smile zone, the final restoration consisted of a BruxZir® Anterior crown over an Inclusive Custom Zirconia Abutment with titanium base.

18. Complete seating of the custom abutment was confirmed with a periapical X-ray.

19. The custom abutment fit perfectly, establishing margins just below the soft tissue. Teflon tape was placed over the fixation screw.

20. The final crown was cemented over the custom abutment.

21. The patient was very happy with the final restoration, which exhibited a lifelike appearance among the patient’s natural teeth.

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**AT A GLANCE**

- The patient presented for treatment with a flipper appliance in the area of her maxillary right lateral incisor.
- Initial condition of edentulous space.
- Occlusal view of edentulous area shows facial-palatal resorption of the ridge.
- Caliper measurements indicated ridge width of approximately 5.5 mm, which was sufficient for the placement of a 3.0-mm-diameter Hahn™ Tapered Implant.
- A surgical flap was reflected to visualize the bone crest.
- Proper positioning of the initial osteotomy was confirmed radiographically with a parallel pin in place.
- The 3.0 mm x 16 mm Hahn Tapered Implant was initially inserted with a handpiece and threaded into final position with a torque wrench.
- Treatment area after full seating of the implant.
- Post-operative radiograph verified that the implant was fully seated and didn’t impinge upon the periodontal ligament spaces of the adjacent teeth.
- Condition of patient after 17 weeks of healing.
- A tissue punch was used to expose the implant.
- A scanning abutment was attached so a digital impression could be taken.
- Radiography verified complete seating of the scanning abutment.
- The iTero intraoral scanner was used to create the final digital impression and submit the case to the lab for restoration.
- The lab digitally designed the Inclusive Custom Abutment without having to wait for a physical impression or pour a stone model.
- The final crown was designed in concert with the custom abutment to optimize the gingival margins and emergence profile.
- To maximize esthetics in the smile zone, the final restoration consisted of a BruxZir® Anterior crown over an Inclusive Custom Zirconia Abutment with titanium base.
- Complete seating of the custom abutment was confirmed with a periapical X-ray.
- The custom abutment fit perfectly, establishing margins just below the soft tissue. Teflon tape was placed over the fixation screw.
- The final crown was cemented over the custom abutment.
- The patient was very happy with the final restoration, which exhibited a lifelike appearance among the patient’s natural teeth.

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HOW TO

EFFICIENTLY PLACE A CEMENTED IMPLANT CROWN

Exploring a better way to work on an implant-based restorative option.

FOR PLACING CEMENTED implant crowns in the past, I would place a cotton pellet over the implant screw, add temporary cement over the cotton pellet and cement the implant crown with either temporary cement or a final cement. Recently, I have discovered a more efficient technique. By using chlorhexidine gel (Go-Chx-Gel), Liquid Magic Resin Barrier and Zero G Bio implant cement by TAUB Products, I can achieve a clean and well-sealed cemented implant crown.

Case study

STEP 01 The patient in Figure 1 was ready for implant crown placement at tooth #14. In Figure 2, you can see the zirconia oxide implant abutment, the retaining screw and the IPS e.max crown ready for placement.

STEP 02 After the healing abutment was removed, Go-Chx-Gel was used to clean and disinfect the implant site. The gel was delivered using the applicator supplied (Fig. 3). After the leaving the gel in place for 30 seconds (Fig. 4), it was thoroughly rinsed and dried (Fig. 5).

STEP 03 The zirconia oxide abutment was placed and torqued (Fig. 6) and Liquid Magic Resin Barrier was applied (Fig. 7) and light cured for 20 seconds with an LED curing light (Fig. 8). Liquid Magic sets in a “rubbery” state. No cotton pellet is needed over the screw head and the resin barrier can be easily removed when needed. It can be seen in Figure 9 after light curing.

STEP 04 Zero-G Bio Implant Cement was placed into the IPS e.max crown (Fig. 10) and placed on the abutment (Fig. 11). Zero-G has a one-minute and 45-second working time with a full set at two minutes and 30 seconds. An LED curing light can be used to accelerate the set. Excess cement can be visualized around the crown and tissue (Fig. 11). It is also radiopaque so it can be seen on a radiograph. Excess cured Zero-G was easily removed with a scaler (Fig. 12). Floss was worked into the interproximal areas to remove cured cement there (Fig. 13).

STEP 05 The final restoration can be seen from the occlusal view (Fig. 14) and the facial view (Fig. 15).

Conclusion

By using TAUB Products’ new implant cementation system, I was able to place an implant abutment and crown efficiently and quickly.

ABOUT THIS COLUMN

Every month in DPR, Dr. Ross Nash’s how-to column showcases a variety of products he uses to provide great care for his patients. Each month focuses on a particular procedure or material that Dr. Nash has used in his practice, with the goal of providing practical information for every dentist.

“Recently, I have discovered a more efficient technique [for placing cemented implant crowns]. By using chlorhexidine gel (Go-Chx-Gel), Liquid Magic Resin Barrier and Zero G Bio implant cement by TAUB Products I can achieve a clean and well-sealed cemented implant crown.”
AT A GLANCE

1. Integrated implant with healing cap at tooth #14
2. Implant abutment, retaining screw and crown ready to place
3. Applying Go-Chx-Gel in implant site
4. Go-Chx-Gel in place
5. Implant site cleaned
6. Zirconia oxide abutment in place
7. Liquid Magic Resin Barrier applied
8. Liquid Magic light cured
9. Liquid Magic in place
10. Zero G Bio Implant Cement applied to internal surface of crown
11. IPS e.max crown placed on implant abutment
12. Excess Zero G removed with scaler
13. Floss removes excess interproximal cement
14. Final result, occlusal view
15. Final result, facial view

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SOLVE A CLINICAL CHALLENGE

The Canary System detects caries around the margins of amalgam restorations.

[by Dr. Stephen Abrams]

Information provided by Quantum Dental Technologies.

DETECTING CARIES AROUND amalgam restorations is a major clinical challenge. Typically, older amalgam restorations may cause some marginal staining, but visually the margins may appear intact and sound. The detection of secondary caries in its early stages is not easy. Using detection methods such as radiography, explorer, fluorescence caries detection aids and visual examination may not provide any relevant information. Discoloration next to the restoration or ditched amalgam margins is not necessarily predictive of secondary caries.2

STEP 01 In this clinical situation, the patient had been complaining of pain on the maxillary left side. Visually, the restorations appeared worn but the margins were intact (Fig. 1). A bitewing radiography did not reveal any radiolucency around the restorations on the teeth (Fig. 2). Bitewing radiographs may not be the ideal for detecting enamel secondary caries.3, 4, 5 particularly if they are located on the occlusal or smooth surfaces. The restoration also masks the ability of radiographs to detect caries along the preparation walls. All of these factors create difficulties in determining the source of pain.

We were faced with a challenge. Do we watch and wait for further symptoms to develop? Do we remove the restoration to see if we can detect caries? Are there other caries-detection devices that can detect caries around the amalgam margins?

There are a number of caries detection devices on the market today, but they have limitations. The fluorescence-based devices such as SPECTRA, DIAGNODent and SOPRO are not detecting caries, but other components that glow or fluoresce at a particular wavelength. The literature indicates that:

- bacterial porphyrins (bacterial breakdown products)
- stain
- tartar
- food debris

all fluoresce under the wavelengths used in these devices, whether or not caries is present.7 8 9 A number of studies have concluded that measuring fluorescence is not suitable for detecting caries around restoration margins or beneath dental sealants due to false positive readings.10, 11, 12, 13 The CR Clinicians’ Report (March 2012) found that existing restorations interfered with readings.14 Fluorescence does not give any information about lesion size or depth, and does not penetrate beneath the tooth surface due to the scattering of light from stain, plaque, organic deposits and surface features such as pits and fissures.15 16

STEP 02 The Canary System (Fig. 3) uses energy conversion technology (PTR-LUM) to image and examine the tooth. Pulses of laser light are aimed at the tooth, and the light is then converted to heat (Photothermal Radiometry or PTR) and light (luminescence or LUM), which are emitted from the tooth surface between pulses. These harmless pulses of laser light enable the clinician to examine sub-surface caries up to 5 mm below the surface.17 18 Caries modify the thermal properties (PTR) and glow (LUM) of healthy teeth. As a lesion grows, there is a corresponding change in the signal. In effect, the heat confined to the region with crystalline disintegration (dental caries) increases the PTR and decreases the LUM. As remineralization progresses and enamel prisms start to reform their structure, the thermal and luminescence properties begin to revert towards those of healthy tooth structure.19, 20, 21

The Canary System creates a Canary Number (ranging from zero to 100) from an algorithm combining the PTR and LUM readings, which are directly linked to the status of the enamel, dentin or cementum crystal structure22 (Fig 4). A Canary Number of less than 20 indicates healthy crystal structure. A Canary Number greater than 70 indicates a large lesion that may justify restoration. Canary Numbers falling between 20 and 70 indicate the presence of early carious lesions or cracks that may require restoration, particularly at restoration margins.21 If the caries is located beneath a healthy layer of enamel, The Canary measures...
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both healthy tissue and caries. The healthy crystal structure overlying the caries dampens the signal, decreasing The Canary Number.

STEP 03 We scanned the margins of the maxillary first molar with The Canary System and found Canary Numbers ranging from 47 to 76 around the margins of the amalgam (Fig. 5). Removal of the amalgam restoration confirmed the presence of caries in both areas (Fig. 6).

A study presented in July 2016 at the European Organization for Caries Research on detection of caries beneath intact amalgam margins found that Spectra data and images were inconclusive due to signal interference from the amalgam. Visual examination, as expected could not detect caries beneath an intact amalgam margin. DIAGNODent could not accurately detect caries around amalgam margins because of the signal or glow coming from the amalgam, microbial debris and stain. The Canary System had very high sensitivity (95 to 100 percent) and specificity (100 percent) in examining and detecting caries at various distance from margins of an amalgam. The study concluded that Canary System could detect secondary caries around amalgam restorations more accurately than visual exam, SPECTRA and DIAGNODent.24 Research has shown that the Canary System can detect caries around the margins of restorations,15, 24, 27 including intact ceramic crown margins.

In January 2017, the American Dental Association will be adding a new code (D0600) for caries detection. Examination with The Canary System involving quantifying, monitoring and recording changes in the structure of enamel, dentin and cementum, and so it is a device that can be appropriate to use for this procedure code. Detection methods using visual examination, explorers and other tactile probes, fluorescence or transillumination may not fall under the code’s definition. This is because of their inability to detect changes in all the tissues or to record and quantify changes in these tissues as shown in this clinical case and reported in the literature.

STEP 04 Using The Canary System we were able to diagnose the source of the pain—secondary caries around the margin of an amalgam restoration. Accurate detection allowed us to correctly identify the pain source, treat the caries and preserve tooth structure. Caries detection is more than simply shining laser light on teeth and looking at the glow. It involves understanding how energy interacts with tooth structure and restorative materials. Using the PTR-LUM technology in The Canary System, one can accurately examine the margins of restoration to detect caries and cracks.

Full references available at DentalProductsReport.com

ABOUT THE AUTHOR

Stephen Abrams is a general dental practitioner with more than 36 years of clinical experience. Upon graduation from the University of Toronto, Faculty of Dentistry in 1980, Dr. Abrams established a group practice in Toronto, Canada which has grown to involve both general dentists and dental specialists.

“Accurate detection allowed us to correctly identify the pain source, treat the caries and preserve tooth structure. Caries detection is more than simply shining laser light on teeth and looking at the glow.”

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Citanest® Dental (procaine and epinephrine injection, USP) 4% injection with epinephrine 1:200,000

4% Citanest Plain Dental (procaine hydrochloride injection, USP)

BRIEF SUMMARY

[See Package Insert for Full Prescribing Information]

Use

Citanest® Dental and 4% Citanest Plain Dental are indicated for the production of local anesthesia in dentistry by nerve block or infiltration techniques.

CONTRAINDICATIONS

Prilocaine is contraindicated in patients with known history of hypersensitivity to any amide-type local anesthetics and in patients with congenital or idiopathic methemoglobinemia.

WARNINGS

PRACTITIONERS WHO USE LOCAL ANESTHETICS SHOULD BE WELL VERSED IN DIAGNOSIS AND MANAGEMENT OF EMERGENCIES THAT MAY ARISE FROM THEIR USE. RESUSCITATIVE EQUIPMENT, OXYGEN AND OTHER RESUSCITATIVE DRUGS SHOULD BE AVAILABLE FOR IMMEDIATE USE. To minimize the likelihood of intravascular injection, aspiration should be performed before the local anesthetic is injected. If blood is aspirated, the needle must be repositioned until no blood can be elicited by aspiration. The absence of blood in the syringe does not assure that intravascular injection will be avoided.

Citanest Dental Forte Injection contains sodium metabisulfite, a sulfite that may cause allergic-type reactions (including anaphylactic shock) in susceptible individuals. The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic and nonasthmatic people with a history of bronchial hyperreactivity but may also occur in nonasthmatic people.

Methemoglobinemia: Prilocaine has been associated with methemoglobinemia. Very young patients, patients with congenital or idiopathic methemoglobinemia, or patients with glucose-6-phosphate dehydrogenase deficiencies are more susceptible. Patients taking drugs associated with methemoglobinemia (e.g., sulfonamides, acetaminophen, acetazolamide, anileridine, dapsone, benzocaine, chloroquine, diphenylhydantoin, naproxen, nitrofurantoin, nitroglycerin, nitroprusside, pamaquine, para-aminosalicylic acid, phenacetin, phenobarbital, phenylbutazon, phynolmin, and quinine) are at greater risk.

PRECAUTIONS

General: Prilocaine’s safety and effectiveness depend on proper dosage, correct technique, adequate precautions, and readiness for emergencies. Resuscitative equipment, oxygen, and other resuscitative drugs should be available for immediate use (see WARNINGS). The lowest dosage that results in effective anesthesia should be used to avoid high plasma levels and serious adverse effects. Repeated doses of prilocaine may cause significant increases in blood levels with each repeated dose because of slow accumulation of the drug or its metabolites. Toleration to the local anesthetic varies with the patient. Patients that are debilitated, elderly, acutely ill, and children should be given reduced doses commensurate with age and physical status. Prilocaine should be used with caution in those with severe cardiovascular, hepatic, or renal disease

Local anesthetic injections containing a vasoconstrictor (Citanest® Dental) should be used with caution during or after administration of potent general anesthetics, since cardiac arrhythmias may occur. Cardiovascular and respiratory (adequacy of ventilation) vital signs and the patient’s state of consciousness should be monitored after each local anesthetic injection. Restlessness, anxiety, tinnitus, dizziness, blurred vision, tremors, depression or drowsiness should alert the practitioner to the possibility of central nervous system toxicity. Signs and symptoms of depressed cardiovascular function may result from a vasovagal reaction; particularly if the patient is in the recumbent position (see ADVERSE REACTIONS, Cardiovascular System).

Since amide-type local anesthetics are metabolized by the liver, prilocaine should be used with caution in patients with hepatic disease. Patients with severe hepatic disease, because of their inability to metabolize local anesthetics normally, are at greater risk of developing toxic plasma concentrations. Prilocaine should be used with caution in patients with impaired cardiovascular function since they may be unable to compensate for functional changes associated with the prolongation of A-V conduction produced by these drugs.

Many drugs used during the conduct of anesthesia are potential triggering agents of familial malignant hyperthermia. Since it is not known whether amide-type local anesthetics may trigger this reaction and since the need for supplemental anesthesia cannot be predicted in advance, it is suggested that a standard protocol for the management of malignant hyperthermia should be available. Early unexplained signs of tachycardia, tachypnea, labile blood pressure and metabolic acidosis may precede temperature elevation. Outcome of rapid absorption or unintentional intravascular injection, or may be the result patient hypersensitivity, idiosyncrasy or diminished tolerance. Serious adverse reactions are generally systemic in nature and include cardiovascular, neurologic and central nervous system toxicity. Identification of such reactions is facilitated by reporting. Central Nervous System: CNS manifestations are ataxic and/or depressant and may be characterized by lightheadedness, dizziness, confusion, drowsiness, hallucinations, after local analgesic injection, or may be the result patient hypersensitivity, idiosyncrasy or diminished tolerance. Serious adverse reactions are generally systemic in nature and include cardiovascular, neurologic and central nervous system toxicity. The overall presence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic and nonasthmatic people with a history of bronchial hyperreactivity but may also occur in nonasthmatic people.

DOSAGE AND ADMINISTRATION

[Seeackage Insert for Full Prescribing Information]

Use in the Head and Neck Area: Small doses of local anesthetics injected into the head and neck area, including retrobulbar, dental and stellate ganglion blocks should correspond to approximately 50 times the maximum amount of drug that would be injected intramuscularly to produce anesthesia equivalent to that produced after dental nerve block injections (see WARNINGS). Information for Patients: The patient should be informed of the possibility of temporary loss of sensation and muscle function after infiltration or nerve block injections. The patient should be advised that this can result in inability to extend the lips, to talk, or to breathe. Prilocaine should be used with caution in patients with known history of hypersensitivity to any amide-type local anesthetics.

Clinically Significant Drug Interactions: The administration of local anesthetic injections containing epinephrine or norepinephrine in patients receiving monoamine oxidase inhibitors, tricyclic antidepressants or phenothiazines may produce severe, prolonged hypotension or hypertension. Concurrent use of these drugs should be avoided if possible. In situations when concurrent therapy is necessary, careful patient monitoring is essential. Concurrent administration of vasopressor and ergot-type oxytocic drugs may cause severe, persistent hypertension or cardiovascular accidents. Prilocaine may be metabolized in patients treated with other known to cause this condition (see WARNINGS).

Drug/Laboratory Test Interactions: Intramuscular injection of prilocaine may result in increased creatine phosphokinase levels. Thus, the use of this enzyme determination, without isoenzyme separation, as a diagnostic test for the presence of acute myocardial infarction may be compromised by the intramuscular injection of prilocaine.

Central Nervous System

Neurologic: Adverse reactions as a result of sensitivity to prilocaine are extremely rare and, if they occur, should be managed by conventional means.

Allergic: Allergic reactions are characterized by cutaneous lesions, urticaria, edema or angioedema-like reactions. Allergic reactions as a result of sensitivity to prilocaine are extremely rare and, if they occur, should be managed by conventional means. Management of anaphylactic reactions should include, at a minimum, the institution of these ventilatory measures, the adequacy of the patient’s airway and assisted or controlled ventilation. Appropriate measures should be taken to ensure the patient’s oxygenation and ventilation. If possible, the cause of the reaction and since the need for supplemental anesthesia cannot be predicted in advance, it is suggested that a standard protocol for the identification of such reactions is facilitated by reporting. Central Nervous System: CNS manifestations are ataxic and/or depressant and may be characterized by lightheadedness, dizziness, confusion, drowsiness, hallucinations, after local analgesic injection, or may be the result patient hypersensitivity, idiosyncrasy or diminished tolerance. Serious adverse reactions are generally systemic in nature and include cardiovascular, neurologic and central nervous system toxicity. The overall presence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic and nonasthmatic people with a history of bronchial hyperreactivity but may also occur in nonasthmatic people.

DOSAGE AND ADMINISTRATION

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WARNINGS

The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic and nonasthmatic people with a history of bronchial hyperreactivity but may also occur in nonasthmatic people.

Clinically Significant Drug Interactions: The administration of local anesthetic injections containing epinephrine or norepinephrine in patients receiving monoamine oxidase inhibitors, tricyclic antidepressants or phenothiazines may produce severe, prolonged hypotension or hypertension. Concurrent use of these drugs should be avoided if possible. In situations when concurrent therapy is necessary, careful patient monitoring is essential. Concurrent administration of vasopressor and ergot-type oxytocic drugs may cause severe, persistent hypertension or cardiovascular accidents. Prilocaine may be metabolized in patients treated with other known to cause this condition (see WARNINGS).

Drug/Laboratory Test Interactions: Intramuscular injection of prilocaine may result in increased creatine phosphokinase levels. Thus, the use of this enzyme determination, without isoenzyme separation, as a diagnostic test for the presence of acute myocardial infarction may be compromised by the intramuscular injection of prilocaine.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Studies of prilocaine in animals to evaluate the carcinogenic and mutagenic potential or the effect on fertility have not been performed. Chronic oral toxicity studies of ortho-toluidine, a prilocaine metabolite, in mice (150-4800 mg/kg) and rats (150-800 mg/kg) have shown that ortho-toluidine causes toxicity at high doses. The lowest dose corresponds to approximately 50 times the maximum amount of ortho-toluidine to which a 50 kg subject would be expected to be exposed following a single injection (3 mg/kg) of prilocaine. Ortho-toluidine (0.5 mg/ml) showed positive results in Escherichia coli DNA repair and phage-induction assays. Urine concentrations from rats treated with ortho-toluidine (300 mg/kg, orally) were mutagenic for Salmonella typhimurium with metabolite activation. Several other tests, including reverse mutations in five different Salmonella typhimurium strains with or without metabolic activation and single strand breaks in DNA or V79 Chinese hamster cells, were negative.

Use in Pregnancy: Teratogenic Effects — Pregnancy Category B.Reproduction studies have been performed in rats at doses up to 30 times the human dose and revealed no evidence of impairment of fertility or adverse effect on the fetus due to prilocaine. There are, however, no adequate and well-controlled studies in pregnant women. Animal reproduction studies are not always predictive of human response. General: Consideration should be given to this fact when administering prilocaine to women of childbearing potential, especially during early pregnancy when maximum organogenesis takes place.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when prilocaine is administered to a nursing woman.

Pediatric Use: Dosages in children should be reduced, commensurate with age, body weight, and physical condition (see DOSAGE AND ADMINISTRATION in package insert).

ADVERSE REACTIONS

Swelling and persistent plethora of lips and oral tissues may occur. There have been reports of persistent plethora lasting weeks to months, and in rare instances paresthesia lasting greater than one week. Adverse reactions should be reported to those observed with other amide-type local anesthetics. These adverse reactions are generally dose-related and may result from high plasma levels caused by excessive dosage, rapid absorption or unintentional intravascular injection, or may be the result patient hypersensitivity, idiosyncrasy or diminished tolerance. Serious adverse reactions are generally systemic in nature and include cardiovascular, neurologic and central nervous system toxicity. The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic and nonasthmatic people with a history of bronchial hyperreactivity but may also occur in nonasthmatic people.

REFERENCES

[See package Insert for Full Prescribing Information]

Manuscript references not listed above will be found in the references section of the appropriate package insert.
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We can make your Dental Chairs look brand new!
Considerations when selecting a new practice management software

Are you asking the right questions when weighing your practice management software options?

by Patterson Dental

Whether you are a new office searching for your first practice management software or an existing office considering a change, finding the right solution is important. This is a decision you will have to live with for a long time and it emanates into nearly every aspect of the dental office, from the front desk to the operatory.

So, how do you ensure that you make the right choice?

There are fundamental considerations to keep in mind when selecting the appropriate software to gear your office towards maximum success. The below considerations can help you guide you towards the best choice for your office.

Functionality to meet current and future state

Software should meet both an office’s current needs and future goals. It’s important that dental offices not choose a solution with limited possibilities. Once implemented, switching software can be difficult and costly.

When it comes to functionality, does this practice management solution allow for the most efficient ways to provide your patients with the care they need for years to come?

Consider:
• Are you planning on going completely paperless, including electronic charts?
• Will your images be electronic?
• What products does your software need to integrate today? What about in the future?
• How will you bill medical insurance companies? Do you plan to automate this process? Will all billing be electronically processed?

• Do you need to save existing paper files in your new electronic files?
• Do you need to store daily, weekly and monthly reports in the system?

Determine your needs and requirements in advance, and compare your preferences to the solutions offered by a new system. Assign values of importance to each preferred feature requirement on your list to make the most objective decision. Keep in mind that your practice needs will be constantly evolving, and you will want a system capable of growing with them.

Support, training and learning tools

Place the most advanced software in the hands of an inexperienced staff member and you will have problems. For this reason, it’s important that you are able to provide your team with the training tools needed to bring them up to speed.

You should also make sure that the resources your staff needs is available as long as you are using the software—not just when you initially onboard. Think about ongoing needs for continued education to improve software usage or what would happen when staff turnover occurs.

Consider:
• Does your solution provider assist you every step of the way?
• Is there a variety of different training methods available? Reliable resources should there to help you any time you need them, through various channels—online resources, real-time chat, on the phone and in person.
• If the product’s customer support team is unable to answer any of your preliminary questions, even the most seemingly perfect solution could be a bad investment. Confirm that the product comes from a company with an outstanding reputation in customer service and support.

Deciding which software program your office should adopt is not a decision to be made lightly. Be confident that your software provider will be the long-term partner that your practice needs for success. Determine the solution that you would be happiest to use for years to come and confirm the company you are purchasing it from will be there to help you make the most out of your commitment and investment.
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**Dark Side Belief #2:** Marketing and Selling is Unprofessional or Bad!

...and MORE!
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- **Why some dentists have to turn away new patients because their practices are so successful while others are struggling to make payroll and keep their doors open** (even though their skills and practices are comparable).

- **The vital truth about why you MUST ignore the self-appointed money police** and why following their advice may lead you closing your practice doors for good.

- **Learn one simple shift in your practice that can open the new patient flood gates** and put at least an extra $250,000 in the next 12 months in YOUR bank account!

- **If you want to learn the quickest, easiest, and most powerful ways to get a steady stream of patients who are going to pay, stay, and refer—then you would be foolish not to get this while you can.** Get your FREE copy of this controversial report while supplies last (we’re running out fast)!

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