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In This Issue:

Doctor of Influence
Dr. Mary Krempasky Smith ......................................28
Contributing Writer: Holly Kean
Print Media Manager
Contributing Photographer: Anthony Björn Roslund

Practice Management
Invest in Your Practice in an Economic Downturn ..........4
Contributing Writer: Margaret Boyce-Cooley
Director, Practice Leadership, Burkhart Consulting
The Art of Effective Case Presentation .....................7
Contributing Writer: Katharyn Edwards, RDH
Consultant, Practice Leadership, Burkhart Consulting
Burkhart Selected Office Manager Superstar .............10

Office Design
Great Planning: Big Payoff ......................................11
Contributing Writer: Andy Hutson, Branch Manager, Burkhart Eugene
Contributing Photographer: Artistic Portraits & Mountain Brook Studios
Treatment Room Design ......................................... 18
Contributing Writer: Lee Palmer, CBET, BS, Facility Designer and Equipment Specialist, Burkhart San Diego

Assistant Success
Burkhart Selected Assistant Superstar .......................21
Win, Win, Win .............................................................22
Contributing Writer: George Reed, Oklahoma Regional Manager

Clinical
Real Life Aesthetics: Turning a Failed Case into a Success ..........25
Contributing Writer: Rhys Spoor, DDS, FAGD
Images Courtesy of Rhys Spoor, DDS, FAGD

Technology
Bringing the Benefits of Digital Imaging into Focus ..........33
Provided by Gendex
Good Sense for Sensor Care ......................................36
Provided by Gendex
Mobile Computing in the Dental Office ....................39
Contributing Writer: Dawn Christodoulou
President, PEB/XLDent®
ImagesCourtesy of PEB/XLDent®

Business of Dentistry
Numbers Don’t Lie ....................................................40
Contributing Writer: Bob Creamer, CPA

Wealth Management
Wealth Management: Real Life Returns .....................44
Contributing Writer: Sam Martin, CPA, CFP®

Hygiene Success
Burkhart Selected Hygiene Superstar .......................49
Advances in Remineralization Therapy ....................50
Provided by Dentsply
GUM® Soft Picks® - What a Treat! ............................54
Contributing Writer: Sheri B. Doniger, DDS

Index of Advertisers:
3M ESPE: Lava™ C.O.S. .................................................8
A-dec®: A-dec 300™ & A-dec 500™ .......................9
A-dec® W&H: Syene TA-97LED ........................................53
Air Techniques: ScanX Inside Front Cover
Brewer: Ergonomic Seating ........................................42
Burkhart: Your Team of Experts ................................36
Cadent: iTero .................................................................3
Clement & Associates .................................................41
DentalEZ: Simplicity ..................................................34
DentalGroup LLC: .........................................................46
Denticator®: Prophy Pals™ ...........................................48
Dentsply: Cavitron .........................................................48
Dentsply NUPRO® NUSolutions™ ................................51
DigiDoc®: ICON ..........................................................24
Forest: Designer Friendly ............................................52
Galaxy: Ergonomic Stools .............................................27
Gendex®: CB-500® ......................................................35
Gendex®: Visualix® e-HD Inside Back Cover
GUM®: Soft Picks® .......................................................55
Instrumentarium: OP200 VT Back Cover
J. Morita USA: Veraveiwepocs 3De ................................56
Pact_One: Dental Technology Experts ............................37
Pelton & Crane: HELIOS 3000™ ....................................32
Planmeca: Think Planmeca .............................................38
Practice Leadership: Zip Code Analysis .....................6
Royal: Biotec .................................................................20
SciCan: STATMATIC ....................................................23
Sirona: Imaging ...........................................................17
Summit Dental Study Group: 2009-2010 Speakers ..........43

Cover Photo: Dr. Mary Krempasky Smith at her practice in Spokane, Washington. Photo by Anthony Björn Roslund.
Several times each year, I have the pleasure of helping to kick off the Business of Dentistry class attended by a group of our associates and led by our consulting division, Practice Leadership. The class is always inspiring because it gives the participants a chance to learn how they can make a positive impact on the lives and practices of our clients.

Recently, I started a session by asking the attendees why they were excited to be there. I was amazed by the answers I received! “If I can help my doctors succeed, it fulfills what we talk about as our statement of purpose,” said one student. Another observed that “If I provide maximum value to my clients, it makes them want to talk about me with their friends. It helps them and it helps me.” Finally, one commented, “I got into this business to help and serve. What better way is there to do this than to help a dentist have a more successful business?”

For three days, this group of associates is focused on learning the intricate details of what makes a practice healthy. They learn about the key benchmarks and ratios in a practice, how doctors can lead and influence their teams most effectively and how to realize when they can lend a hand. They also learn about scheduling, case presentation, and overall staff proficiency. I told them that they need to be completely excited—pumped up—about how they would be able to help our clients. As well, I explained that for many of them, their clients are staring at a 40-foot putt, and they can definitely benefit from a good caddy to help them read the green. They can be that caddy and when the putt is sunk, I want them to give the Tiger fist pump along with you.

The last thing I shared with them is that it is their responsibility to share with their clients what they learned and how they can really make a difference. They have the knowledge—as well as the support of a great team at Practice Leadership—to help any practice grow and thrive. Knowledge for the sake of knowledge is nice but when applied to foster another person’s success, it is magical.

Almost all of Burkhart’s Account Managers, Equipment Specialists, and Branch Managers have attended the Business of Dentistry training. With that in mind, I encourage all of our current and prospective clients to tap into this resource to help you with your practice. Allow them to be a Catalyst in your success.

Greg Biersack, Vice President of Corporate Operations

At Burkhart we realize that our clients are both dental professionals and business owners. It is our goal to help them be successful at both aspects of their careers. Catalyst is fully dedicated to that success. The articles in this publication vary from product use and selection to business management topics and provide information and guidance that can lead to a more successful practice. Throughout the publication are stories of Burkhart clients who have succeeded in the areas that are highlighted. We hope that you enjoy.

If you have a request for a topic that you would like us to cover in Catalyst, please contact Greg Biersack at: gbiersack@burkhartdental.com

Greg Biersack, Vice President of Corporate Operations
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How can you insulate your practice from the economy?

Once upon a time, during the “golden age” of dentistry, the economy was booming. A practice could get by pretty well, and a dentist could make a comfortable living while having a decent practice. Over the past few months, we learned that the good economy had masked poor systems and sometimes poor leadership in many practices. Now that the fairy tale is over, it’s time to take a “mirror, mirror on the wall” approach to your practice. Doctors who have sound business systems and positive leadership and who are providing exceptional experiences for their patients are the heroes and heroines in this tale.

We at Practice Leadership have the distinct pleasure of working closely with many practices that have begun working proactively with PLBC to enhance their systems, patient experience, and leadership. Many people might question why these doctors have chosen to make a substantial investment in their practice given the current economic situation. While the doctors come from different backgrounds and practice situations, they share a desire to improve and grow despite the events on Wall Street. The facts support their decisions to invest in their practices, and many of the practices we serve have enjoyed their best months yet!

Dr. Ben Bushnell moved recently from associate to owner of his practice located in Kalispell, Montana. “Dental school did not teach me how to manage a practice or run a business—that’s a role PLBC has filled. They have been an invaluable asset and reference for me. I wish I could’ve started working with PLBC before I bought the practice and had additional guidance through that process as well. I love what I do. I love the relationships I’ve developed. The actual dentistry is the least of my concerns. It took me 3 – 4 years to feel comfortable clinically. I’m not a natural “leader” but have been growing into this role with PLBC’s support. They have been guiding me in this process, not dictating how things will be done. I appreciate this approach.”

Dr. Lyle Beck and Dr. Steven Haws, partners in practice in Silverdale, Washington, recently made significant investments in a new building, additional technology, and practice management services. Along with keeping an upbeat feel in the practice, their initiative has proven invaluable.

“Our team has made growing the practice a priority. We make it a point to ask for referrals and stay in contact with our patients through personal cards and phone calls when appropriate. We’re fortunate to be in an industry that provides needed services regardless of the status of other sectors of the economy. We’re committed to providing our patients a lifetime of exceptional dental care in a friendly, modern, comfortable environment. The short-term ups and downs of the economy shouldn’t significantly affect our practice plans for the next 20-plus years.”

By Margaret Boyce-Cooley, Director, Practice Leadership, Burkhart Consulting

Invest in Your Practice in an Economic Downturn
Interviews with Drs. Ben Bushnell, Lyle Beck, Steven Haws and T. J. Baumgardner

“Dental school did not teach me how to manage a practice or run a business—that’s a role PLBC has filled. They have been an invaluable asset and reference for me. I wish I could’ve started working with PLBC before I bought the practice and had additional guidance through that process as well. I love what I do. I love the relationships I’ve developed. The actual dentistry is the least of my concerns. It took me 3 – 4 years to feel comfortable clinically. I’m not a natural “leader” but have been growing into this role with PLBC’s support. They have been guiding me in this process, not dictating how things will be done. I appreciate this approach.”

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years. The economic environment was very different when we started the initial planning of this project. I’m glad in many ways we didn’t know some of the challenges that we would encounter, because it may have dissuaded us from beginning. While it has been somewhat sobering taking on such a large investment, I feel very certain that building Clear Creek Dentistry was the best decision for us. We have a great team that is excited to come to work each day, and it’s wonderful to be a part of this practice.”

Dr. Steven Haws went on to add the rationale for hiring a practice management firm despite so much going on in the practice already.

“Early in the process of planning our new practice, Dr. Beck and I recognized the need to look for an outside source to help correctly set the foundation for Clear Creek Dentistry, right from the beginning. Rather than wait until we had developed poor practice habits and systems, we decided to invest in the future of our practice by finding the “right coach” to teach us how to create an enjoyable and successful place to treat our patients.

I have spoken with colleagues who feel dentists should be smart enough to figure out how to run a dental practice. I have thought a lot about this view and though I do believe that we have the capacity to learn and are smart enough to run a successful practice, I don’t want to make all of the mistakes I would if I did this on my own. The most successful and talented athletes have coaches who observe and meticulously critique their performance. The coach has a different vantage point and perspective that is impossible for the athlete to have. As players, we can’t see what we look like while we are in the middle of the game or see what all the other players are doing because we are too close to the action. This is why I wanted to search for the best coach to help our practice grow faster and more effectively while concurrently helping our patients.

The timing of Clear Creek Dentistry’s grand opening was remarkable. It was on the eve of a financial crisis that we saw our first patient in the new building. This did not dissuade us from our search to find a program to help us in our practice. If anything, the crisis reinforced our resolve to seek for the best training to help us smoothly move through the next couple of years without fear of financial trouble. After significant research and hands-on trial, we discovered Practice Leadership. We have found that our business is growing and not just weathering the economic downturn. There is great peace of mind and confidence in knowing that we are doing our best. We have received effective, applicable, and appropriate coaching. Everything, from consulting with our patients to managing the accounts receivable more efficiently, has played a part in our early success. Dr. Beck and I have never regretted the investment we have made in working with Practice Leadership. They have helped us as the doctors to develop confidence in ourselves. This is felt by our team, and in turn, this confidence is transferred to our patients, counteracting the prevalent lack of confidence related to the current financial crisis. Dr. Beck and I feel this is one of the intangible benefits that we have received from Practice Leadership.”

Dr T. J. Baumgardner, who practices in Colorado Springs, also saw investing in his practice as a high rate of return investment.

“As the time came nearer for me to purchase my practice, I realized a few things. First of all, as an associate, I still had never received what I believed to be adequate “training” to run a practice successfully. My practice had the basic systems in place, but I felt that it could use refinement of those systems to take it to the next level. My decision was to look to a consultant who I felt had the experience to provide flexible guidance that could give my practice that refinement. I felt that the old adage of “you have to spend money to make money” was necessary in these economic times. I did not want to sit back and let my practice and its processes dictate how I would survive this period. I wanted to be proactive. That is the main reason I turned to the guidance of a consultant, specifically Practice Leadership. Secondly, I am a firm believer that technology is as important to a practice as any effective system. In fact, technology can only enhance those systems, making them more efficient, educative, and convenient. That is why I have also invested in my practice’s future by purchasing what I believe to be essential technology, intraoral cameras. I believe that the combination of these two things will not only allow my practice to survive this economic turmoil, but also grow within it.”

So what is the moral of the story? Investing in your practice can be a sure thing in these economic times. Maximizing your team, improving systems, and enhancing technology will help you create an exceptional and efficient patient experience, and it will get you and your practice one step closer to “happily ever after.”

Practice Leadership, Burkhart Consulting, is a full-service consulting firm specializing in developing leaders and teams in dentistry. For more than a decade, Practice Leadership has helped hundreds of practices achieve new levels of success. Contact your Burkhart Account Manager or Practice Leadership directly at 800.665.5323 for more information.
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Eighty percent of all restorative treatment originates in the hygiene chair. Yet most dentists are only afforded 5 – 7 minutes in the schedule for a routine hygiene exam. For a practice to reach its true potential, it becomes imperative that the hygienist master a consistent, methodical approach to discover patient desires and communicate those effectively to the Dentist to maximize his or her time. Even in the current economic climate we find it is possible to move from a “needs-based” to a “desire-based” practice by refining the patient progression through the routine hygiene appointment. Fortunately, an easy to implement, four-step scientific case presentation process can be used in the hygiene department that will not only increase communication effectiveness, case acceptance levels, and clinician confidence, but will also provide a greater level of professionalism to your patients. It will focus on creating long-term patients—not one-shot presentations. Remember, happy patients refer their friends!

This innovative four-step case presentation process is based on sound and ethical principles. Implementing this process effectively should provide each clinician with a sense of integrity rather than inner conflict that they are engaging in a form of sales tactics. The motivation behind the process is to create value for your patients by discovering their unique desires and sincerely presenting options that are based on the philosophy of your practice. The four steps for case presentation are:

1. **Relationship**: Every successful patient experience begins with gaining their trust. Sharing common interests and getting to know what is important to your patient will help build trust and credibility in your professional relationship. As you become more in tune with patients on a personal level, they will feel increasingly confident that you will continue to look out for their best interests. After all, good presentation skills are based on filling needs, satisfying wants, or solving problems. But here’s the tricky part, once these relationships have become well established over time, it is crucial to confine the time spent to 3 – 5 minutes of the allotted hygiene appointment time. It is only possible to discover their unique needs and wants if enough time is devoted to the remaining three steps. In addition, patients must feel confident that the hygienist is operating on a consistently professional level and is devoted to their oral health care during their time in the hygiene chair.

2. **Interview**: A successful interview engages the patient in the process, effectively co-discovering possibilities that will be valuable to the patient. Keep in mind that the patient will only invest in treatment that benefits them. The clinician’s challenge is to help patients verbalize and clarify those values. This can be achieved by asking open-ended and elaborative questions. Encourage your patients to do 80% of the talking while you listen attentively, paraphrase their dialogue, and take notes. This allows patients to recognize your attention to detail, thus instilling in them a sense of assurance that you are indeed concerned for their best interests. Remember as well that patients certainly do not buy braces; instead, they buy the stunning smile. Clinicians who remain focused on the benefit the patient will receive are more successful than those that focus on the steps required to achieve the end result. Ask yourself how you can help your patients look better, enjoy improved self-esteem, or benefit from the tranquility that accompanies stable oral health. Patients rely on you to present options for their consideration. Again, it’s not a function of selling but one of providing solutions intended to fill needs, satisfy wants, or solve problems.

3. **Substantiate**: The substantiation phase should begin only after co-discovering the patient’s needs or desires. Paraphrasing the patient’s desires is one of the simplest ways to start the substantiation process. For example, let’s assume your patient has expressed an interest in whitening her teeth. Restating those desires in your own words will help both of you clarify the objective, which will also allow your patient an opportunity to elaborate further if needed. For example, “Mary, it is my understanding that you would like to have a brighter smile and are interested...”

4. **Commitment**: The commitment phase is all about delivery of the treatment plan that aligns with the patient’s desires. Effective communication skills are essential in this phase to ensure patients are fully committed to their treatment plan. This involves discussing the treatment options, explaining the benefits, and addressing any concerns or questions the patient may have. Remember, the goal is to ensure patients are confident in their decision and feel comfortable with the treatment plan.

By following these four steps, practices can create a more effective and profitable environment for patients and clinicians alike.
in whitening your teeth.” Part of the substantiation process now involves clarifying the outcome that your patient anticipates. In our whitening example, take out the shade guide and ask your patient to identify the shade she would like to reach in order to meet her expectations. This will help the doctor customize the patient’s treatment. In doing so, it may become immediately apparent that whitening alone will not satisfy the patient’s expectations and that veneers are a more appropriate option. In this process, all of the information you gather enhances the doctor’s ability to design a suitable treatment plan. Remember, the doctor only has 5 – 7 minutes with the patient, which makes it difficult for him or her to uncover the patient’s desires to the extent necessary to ensure the patient is delighted with her results. Throughout this phase, focus on the benefit or end result the patient wishes to achieve rather than the steps necessary to get there. Keep the benefit in mind when using tools, such as an intraoral camera, brochures, before and after albums, or models.

It is also important to uncover any objections the patient may have prior to proceeding. As she transitions from the clinical area to the administrative area to schedule treatment, she should be prepared to select a time for treatment and work out financial arrangements. A good indicator that objections weren’t fully discovered in the clinic will become evident if the patient continues to ask questions beyond the administrative scope of expertise.

**Commitment:** Asking patients for a commitment to proceed with treatment is often difficult for clinicians. Nevertheless, this should be the easiest step! In our earlier example with Mary, this can be stated simply as “How does this plan sound to you?” The question assures you that you are on the right track while at the same time, it provides Mary with an even stronger confidence that you desire to meet her needs or wants.

As with most people, we need to believe the benefit will outweigh the cost. Imagine a balance scale with the benefit (a beautiful smile) on one side opposed on the other side by the possible negatives of cost, time, and discomfort. This is the appropriate time to address those patient concerns while you concentrate on keeping the scale carefully in balance. Once treatment has been accepted, it is up to the doctor to offer a reasonable timeframe to allow the patient to plan. This can be anywhere from “within the next couple of weeks” to “I wouldn’t recommend that you wait more than a month.” Avoid phrases like “as soon as possible” since they are too vague.

As you practice this four-step consultative case presentation approach, be sure to incorporate your unique style. It can be daunting to make changes in your routine, so try it out on new patients and patients with whom you have a good rapport. A nice lead-in for established patients is “Brian, I know I haven’t asked you this in a while, but how do you feel about your smile?” Alternatively, you can practice on those grumpy patients; after all, what is there to lose?

**Practice Management**

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Hobbies: I love working with our three horses and my two daughters who compete in Hunter/Jumper shows.

What I like about my job: The people I work with... from the great doctors to the fun hardworking, creative staff and the truly special patients we care for.

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Diane Aulabaugh

Huffman Family Dentistry, LLC - Anchorage, Alaska
Great Planning: Big Payoff
By Andy Hutson, Branch Manager, Burkhart Eugene

The practice you see on these pages is the culmination of a calculated and thoughtful process that may be accomplished by anyone with grit and fortitude. Are there distinct pros and cons to such BIG thinking? Absolutely. Nevertheless, such well-planned forward thinking has typically had a substantial payoff, and this case is no exception. But first, a little background on the people who made this happen.

Dr. Nathan Doyel attended BYU for undergrad studies and then OHSU for dental school. His wife, Polly, was the catalyst for him becoming a dentist. As a dental assistant, she worked for a group of doctors that was very energized about dentistry, which infected Dr. Doyel with the mixture of creativity, artistry, science, and business that dentistry has to offer. After he completed dental school in 1997, he became an associate for the group practice at which Polly worked during his four years of dental school. In 1999, after 2 years of working together, Polly and Dr. Doyel started Pacific Family Dental in Sherwood, Oregon. Today, they have five children and are extremely active. “We love exercising, including running, biking, hiking, and weight training. For the past 6 years, our office has participated in the Hood to Coast Relay Marathon, where a group of 12 team members run a total of about 200 miles from Mount Hood to the Pacific Ocean. We have two office teams: ‘The Molars in Motion’ and ‘The Blazing Bicuspids.’ These are made up of staff and patients, and the event is a ton of fun.” He is also the sprint coach for the Sherwood Track Club and three of his kids run with the team. He and his wife sing in the Sherwood Chorus and love to dance.

Dr. Benjamin Aaderud, also a BYU and OHSU graduate, spent a year completing an AEGD program with the U.S. Army at Ft. Lewis, Washington. He is active with his church, has served on the Sherwood, Oregon Chamber of Commerce board for five years, and will be serving as President of the Chamber beginning July 1, 2009. Also with 5 kids ranging in age from 2 to 12 years, he and his wife, Kimberly, make family time their main focus outside of dentistry.

Dr. Wendell King was raised in Beaverton, Oregon, and graduated from Sunset High School. A BYU and OHSU graduate, his practice focuses on general and cosmetic dentistry. He and Michelle, his wife of 9 years, have 3 children. Dr. King enjoys yard work, family day trips, spending time with extended family, and playing the piano.

Early Start
Before Doctors Aaderud and King joined the practice, Dr. Doyel and Polly wisely spent a significant amount of time developing a practice philosophy, mission, and vision. “Our vision included growing into a group practice and expanding it into a facility that was capable of comfortably housing the larger practice we envisioned as well as several supporting specialties that would create synergy.”
Top Left: The reception desk features beautiful wood work contributing to the Northwest feel the doctors wanted for the facility. Top Right: Waiting area is spacious and accommodating. Bottom: Two private consult rooms situated very close to the front desk for patient and staff convenience. Photos by Artistic Portraits.
After 3 months in their 1,400 square foot storefront facility, they hired their first part-time associate. Two years later, in 2001, Dr. Doyel purchased the land where they would build their future office and brought on a full-time associate, Dr. Ben Aanderud. The same year, they also expanded into the adjacent orthodontic office by renting their chairs on the days they were at their satellite office. In 2005, Doctors Aanderud and Doyel became partners.

Now that the land had been secured, their project took on a new sense of planning and urgency. In 2006, they brought in two part-time associates, a pediatric dentist, Dr. Bittner, and another general dentist, Dr. King. During the growth years of the practice, Drs. Doyel and Aanderud designed and redesigned the future building as well as all of the associated real estate development. “I knew something soon had to give,” Dr. Aanderud explained. “For several years, our staff endured an extremely insufficient facility. We were literally crawling over each other. Patients had to walk through our sterilization room and our staff lounge to get to an additional hygiene operatory we were utilizing in an unused space adjacent to our office. I hated turning away patients, not because I wasn’t available, but because the rooms were all full.”

Planning and Perseverance
A major component contributing to the success of Pacific Family Dental’s transition was a full commitment to a hands-on planning regimen. Through equal effort and possessing a single goal, Dr. Doyel and Dr. Aanderud split the duties of running a successful practice while planning and building a new, much bigger one. The two spent endless hours at city hall looking over projections and growth boundary areas to choose a site that would be central to future growth. Once narrowed down, the land was purchased years in advance based on the location and the anticipated urban growth. Dr. Doyel also did all the internal space planning. Attendance at numerous dental facility planning courses and four years of architecture classes at BYU proved to be time well spent. When the space planning seemed appropriate for future needs, it was presented to the architects who made recommendations and finalized the drawings.

Years were spent designing the facility based on future needs, ever-changing city standards, and the shifting lot size. When the local department of transportation condemned a quarter of the land, the facility layout had to change. This resizing forced them to coordinate a street vacation that took two years to finalize, tripled development fees, and
again required a layout change. (A street vacation is a process where an individual who owns property adjacent to the right-of-way can petition to acquire public right-of-way for private use.) During the process, the city adopted a trip cap that affected building size according to usage, resulting in a significant reduction in allowable square footage for the building. That required several more redesigns. Then, they learned that a traffic study was required, which altered the allotted trip count for the specific dental use—and yet another redesign was needed. “The building layout was like an accordion being played; as the song went on—whatever current obstacle we were facing—the building size expanded and collapsed over and over.”

With so many hurdles in the way, they were often asked if the project just “wasn’t meant to be,” but the response was always the same. “We never lost sight of our goal, no matter what the obstacles. Challenging, yes, but that just means the victory will be that much sweeter and in the end it will all be worth it.”

The Move
The challenge lay not only in design, permits, and construction, but also in mental preparation for the staff. In May of 2008, they held a staff retreat which focused on change. The book “Who Moved My Cheese” was the centerpiece of the retreat and helped stimulate conversation about the move that would occur in August. Dr. Aanderud goes on to say, “This kind of team outing was just what we needed. The book helped us talk about the limitations of always going back to the same constricting environment for the same reward and never looking around for something better. It helped to solidify our resolve and prepare for the immense change about to take place by knowing it would pay off.”

Finally, as scheduled, they moved into their new facilities in August 2008. The entire building is over 14,000 square feet. The main group practice, with three full-time general dentists and a part-time oral surgeon, is on the main floor. The move meant a change from 1,400 square feet and 5 cramped operatories to 7,000 square feet with 15 operatories, one of which is a surgical suite. Two specialists are situated upstairs, an orthodontist and a pedodontist. Everyone shares a common lobby, fully equipped with three bathrooms, one upstairs and two downstairs. On the second floor, there is an outdoor terrace for the staff. “We wanted the design of the building—inside and out—to have a definite Northwest, homey feel. We get great feedback from patients on many aspects of our new facility, especially the reception area: a large, warm living room with soft leather couches, coffee tables, and a refreshment bar. This initial impression of our new space helps patients feel relaxed and content before their appointment ever begins.”

Big Change Yields Big Rewards
The new facility has allowed creativity to flourish. They began a “Free Whitening for Life” program for all of their patients, a service they wanted to perform before but could not due to the limited space. “We are able to accommodate patients with more flexibility, and the assistants are able to perform expanded functions, freeing the doctors’ time for additional fee-generating activities or consultations. We have added more hygiene days, a part-time oral surgeon, and transitioned a part-time associate to full time.”

Referrals have increased dramatically. Since they leased space to a pedodontist on the second floor, they are seeing more adults and fewer children—an anticipated development which fits in with their mission to concentrate on adult care. “Patients have been so excited. Nathan, Wendell and I feared the patients might get the perception that the new facilities would require them to pay more or have added expenses in order for us to ‘pay for the new facilities.’ This has not been the case. We also made a conscious effort not to have our fees change within 6 months of entering the new facilities.”

Of course, the expenses went up, but many of the increased costs have been offset by some interesting savings. Previously, they were forced to expand hours of operation to compensate for the lack of space, including adding Fridays, which increased staffing expenses. This has since been eliminated. In addition to reducing overtime for hygiene, the administration staff hours also decreased. “We could now accomplish our production and new patient exam benchmarks working normal hours Monday through Thursday, hygiene and doctors hours went up creating more production potential, and the admin staff hours actually went down.” This, coupled with a modest 15% increase in production, resulted in a reduction in total staffing expense from 38% of collections to 28%.

And the Staff’s Reaction?
“They LOVE it,” Dr. King eagerly states. “They are proud of where they work. The new facilities have allowed us to think differently. Not only are they proud to be associated with such a beautiful facility, but if a provider is running behind, the next patient is able to get their appointment started by simply using another room, a luxury we were not afforded before.” No longer is a patient being escorted through the break room during the end of lunch to get to an operatory for a cleaning or treatment. Also, the addition of a nicely appointed staff lounge with lockers was a
welcome change; the previous office had none. The staff is much more content and comfortable, and productivity has increased.

**Equipment and Layout**

“The addition of more rooms has allowed our dental assistants to use more of their expanded function skills.” Dr. Doyel goes on to explain, “My time with a patient for a crown preparation has been cut in half. Once the impression is in place, I am able to move on to our next patient while my assistant does the temporary crown and selects a shade. The number of patients we now see in a day is way up.”

There is also a separate X-ray room for overflow, which is usually used by hygiene assistants before the hygiene appointment. They have also added electric handpieces to all doctor delivery units, and the results have been dramatic. “They are full of amazing torque and have changed the way we do crown preparations, yet they are sensitive enough to do rotary endo, including auto reverse torque control. The time savings per patient has been surprising.”

Previously, there had been only one small consult room. Now, there are two full-sized consultation rooms that have greatly facilitated patient education regarding dental needs and proposed treatment plans. Dr. King adds, “…it provides a private, comfortable setting for our treatment coordinators to discuss scheduling and financial considerations. I cannot stress enough how important it is to offer a quiet, confidential setting away from the front office area to discuss sensitive treatment and financial matters with patients. It benefits both the doctor/patient rapport and case acceptance, and with three full-time general practitioners, it was a must.”

**Picking the Right Team**

Burkhart Equipment specialist David Webb worked tirelessly through the whole project. His attention to detail was thorough, and he performed myriad tasks, such as getting to the building site early on—before the foundation was poured—and making sure the low voltage conduits were correctly located.

“We were very pleased with the professional way the Burkhart staff stepped in and supported us. Even though we had switched companies during this lengthy project, they did not speak unkindly of the competition, but helped us move on.”

As the need to build out all of the operatories became apparent, one big concern was the ability to finance all of the equipment. “Again, Jeff Reece stepped up to the plate and helped us so we could afford to pay the remaining 20% owed to Burkhart. Burkhart Dental
Office Design

has always taken the high road and helped guide us on the right path about our dental equipment purchases.

Customer service has been outstanding. Andy Hutson started this eight years ago. He was attentive, professional, friendly, and in our minds, irreplaceable. Still, Noey Siler has filled his shoes well and gives us the same level of customer service. Burkhart did a great job in helping us feel grounded during the majority of the project. I think Dave ‘Big Dave’ Cronan, a fantastic Service Technician, almost lived at our facility for a few weeks. Dave and Jeff have been there to help us feel good about our purchases and our choice to use Burkhart Dental.”

Do Unto Others…

There are several clinical philosophies to which the staff at Pacific Family Dental adheres, and these can be condensed into a simple rhetorical question: “What treatment would I recommend for this patient if she were my mother, sister, or child? What would I want done if I were in the chair?” These questions have led to the standard of care for which Pacific Family Dental is known, which is also the reason they are so often referred to by their patients.

“We always take the high road, because that’s who we are. Customer service is first. Take care of the patients and make them into raving fans. Patients care about the relationships we create with them. Treat them like family and provide quality care.”

Advice to Others?

The word of the day for completing large projects like this is sacrifice. “My words of advice for others considering a project on this scale are to live below your means personally in order to make the necessary business investments,” Dr. Doyel reflects. “My wife and I made many sacrifices to make this dream happen. We have lived in a 1,400 square foot farmhouse for the past eight years with our five kids. We kept our personal expenses low in order to invest in the building and in our practice.”

Also, don’t be afraid to get professionals involved. They can be expensive, but may save you more money in the long run. Stay closely involved without getting in the way. Keep a watchful eye on avoidable cost overruns. Dr. Aanderud goes on to explain, “Sometimes the architects went in directions that we did not approve of and we had to rein them in. For example, they were working with the city to determine an acceptable front door orientation. After several redesigns and several thousand dollars later, I stepped in and worked directly with the city to create a solution. Had the architects continued, the additional bill would have been much higher.”

Unquestionably, all three doctors would agree that the right people can make things happen. It is impossible to be everywhere and watch everything all the time. Pick the team, and the trust you give them will be rewarded.
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In dental office design, the first question we ask our clients is whether they want traditional closed rooms or modular cabinetry. Most of the time clients have initial opinions of what they want, but they also want to know the advantages and disadvantages to using the other design methods. In Part I, we will explore why some practitioners choose completely closed and walled in environments and others have open environments while yet others select some hybrid in between. There is not a right or wrong approach, just one that feels right and makes the most sense for you.

Design choices are common to particular specialists:

Oral Surgeons have totally closed treatment rooms with doors and smaller exam rooms usually with doors. This is for both asepsis and sound control.

Periodontists usually have one or two closed surgery rooms with doors and then a traditional walled or modular group of rooms without doors for exam and hygiene. The growing trend is towards modular design.

Orthodontists usually have one or two exam/consult rooms with doors and then a totally open bay with no walls. Recently, however, many doctors have requested partial walls between chairs in the bay area to separate chairs and improve operator to patient and parent communications.

Pediatric Dentists have two or more “quiet rooms” which are not only closed with doors but usually have extra soundproofing applied. I guess the name “quiet room” is the optimistic expectation! They will then have a totally open bay for exam/hygiene; however, lately the trend is to go more modular design with some division between the chairs.

Endodontists will vary from all closed rooms to totally modular treatment rooms. Many times the walls are more for mounting microscopes, x-rays and lights than for sound control.

Prosthodontists will also vary widely from closed rooms to modular treatment rooms. The difference seems more in the personality of the doctor than in actual needs one way or the other.

General Dentists are the most varied group just like the types of practices they have, choosing from closed rooms with doors to almost totally open environments. The most common trend lately is a modified modular approach that utilizes modular for its strengths and walls for theirs.

A closed room is defined as one with four walls and at least one entrance. The closed room may or may not have doors on it; however, it is getting exceedingly difficult to put doors on a treatment room and meet the restrictions of the Americans with Disabilities Act. At least one door has to be ADA compliant, which means it has to have an unrestricted opening of at least 36”. That’s not too hard to achieve, but, in addition, you have to have 18” clear away from the door jamb so a person inside the room in a wheelchair can get his or her feet out of the way to open the door unassisted. Additionally that 18” from the jamb has to remain clear out into the room for 60”.

(Fig 1) That means you can almost never open a swinging door inward.
Office Design

A modified closed room is one where there is no 12 o’clock wall and you utilize a freestanding modular unit to form the wall between the treatment room and the hallway. (Fig 4)

The totally modular concept uses divider walls to separate the treatment rooms as well as the 12 o’clock wall, and these not only form a barrier but act as the support for the x-ray and lights, and the unit provides the hand washing station and drawer support to the treatment rooms on both sides of it. (Fig 5)

A newer modification breaks down the modular concept into “pods” of two treatment rooms separated by a modular wall, but then they have traditional walls on both ends of the “pod”. This uses all the advantages of the modular concept and most of the advantages of the traditional walled treatment room. Note that the newer modular divider walls are now 7’4” to 7’6” high and have a flat top. This means they do not have much opening to communicate sound over the top and a background music speaker placed directly over them pretty much shuts off effective transfer of sound. You can also fill the area between the top of these modular walls and the ceiling with either a manufacturer provided extension or glass mounted in a track system on the top of the wall and the ceiling. (Fig 6)

Whatever plan you choose to design your treatment rooms, you will want to consider the size of the rooms. A closed room is generally 10’W x 11’D. The room can be wider than 10’, but extra width puts you too far from the side cabinetry and lessens your efficiency. If you have a 10’ room and you have an 18” deep cabinet on each side wall, then you have 84” between the two cabinets, and when you subtract the average chair width of 26”, you are left with 58” or approximately 29” on each side of the chair. This is generally adequate unless you have an over-the-patient delivery system with a cuspidor; then you should add at least 6” to the overall width. A-dec makes a trimmer line of cabinets that are only 16 7/8” deep which provide a little more room as an 18” cabinet is generally 19” deep at the countertop. (Fig 7)

Most practitioners ask for ambidextrous treatment rooms to enhance the resale value of the practice or to accommodate an opposite-handed partner or associate. This also helps accommodate hygienists or expanded function assistants who may be opposite-handed from the primary practitioner.
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Introducing a new, attractive style from the leader in custom cabinets

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The new finished back offers a smooth and attractive appearance and is available as an optional upgrade on all freestanding cabinets.

The new style is available as an optional upgrade on all Biotec operatory cabinets.
Hobbies: I love to snowboard in the winter, camp in the summer and coach my son’s soccer team.

What I like about my job: When I can make a patient who is clearly uncomfortable to be in a dental office happy and at ease.

Success at our office means: That we have gone beyond our patients’ expectations.

What Burkhart means to me: Can I say everything? Rick Deming at Burkhart makes our jobs easy. The personal touch that Rick gives us and knowing that we don’t have to worry about ordering or repairs is so important to us. Rick is an essential part of our team and we are lucky to have found him.

Danielle Rosenthal, RDA
Peninsula Periodontal Associates - San Natio, California
Dr. Mark Willis began practicing dentistry in 1985 with a partnership in Fort Smith, Arkansas. He and his partner outgrew the building and he decided to open his own practice in 1992. Jack Powers, the Burkhart Equipment Specialist, helped to equip his new office. “He was instrumental in helping me plan and set up the practice, including a plan for the future. We were able to avoid a lot of expense for remodeling that comes with growth.” Recently, I had the opportunity to ask Dr. Willis a few questions about his business relationship with Burkhart and about the Supply Savings Guarantee Program.

Dr. Willis: Burkhart offered us a program that would guarantee our supply cost percentage. The percentage is not as important as the fact that we monitor the cost quarterly and can see any trend change in supplies. We started the Supply Savings Program on April 11, 2000.

What was the appeal of the program that won your confidence?

Dr. Willis: Our Burkhart Account Manager, Dennis Pogue, implemented the program by taking inventory of all of our supplies. He pointed out areas where we were overstocked, identified the supplies that were not cost effective, and organized the supply room so he could easily scan the supplies that were low or needed restocking. Since Dennis’ retirement two years ago, Gary Harris has come in and continued the program without missing a beat.

What part of the Supply Savings Program do you find most valuable to you and your practice?

Dr. Willis: I think it is having someone like Gary looking out for my best interest, watching the inventory, and asking questions about items that may be obsolete. Did I mention that the guarantee is helpful? The quarterly printout enables us to see how the supply costs are running.

What thoughts could you share with other dentists who might be considering the SSG program?

Dr. Willis: The SSG program simplifies ordering and supply inventory... we do not stock unneeded supplies.

Our logo tagline states “Integrity, Knowledge, Client Success.” How does the SSG program fit with that statement?

Dr. Willis: The SSG program is a win-win-win: good for patients, doctor and staff, and Burkhart.

When you define success, does your relationship with Burkhart help you reach your goals as a dentist and business owner?”

Dr. Willis: Success is a culmination of all the small, daily details that make life easier, and this program is an important part of that.

Over the past three years, Burkhart has saved Dr. Willis $54,377 a year on average. His current supply percentage is almost half of what it was prior to working with Burkhart.
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Real Life Aesthetics: Turning a Failed Case Into a Success

By Rhys Spoor, DDS, FAGD

This is a review of a failed full mouth reconstruction case in which a patient had sought to improve the appearance and function of her teeth. Approximately 16 months before, she had 28 ceramic restorations placed. Afterward, she was disappointed in the shape, shade, and opacity, and she had developed multiple TMD symptoms. Attempts were made over the last year to correct the occlusally generated TMD symptoms but met with limited success (Figures 1 and 2).

“Aesthetic dentistry is a substantive part of dentistry, and its practice comes with high demands.”

Objectively analyzing the patient’s complaints relative to the physical presentation, the following was observed:

• The occlusion was significantly unbalanced and not in harmony with the muscles of mastication
• The maxillary anterior teeth were relatively narrow although the relative position of the incisal edges to the whole face was good
• The teeth in general were fairly light and slightly opaque
• Several posterior teeth were either chipped or had fractures
• The gingival margins of the maxillary anterior teeth were such that the lateral incisors were higher than the centrals
• The posterior teeth had been adjusted extensively

After defining and agreeing to the changes to be made and the result desired, we used TENS (Transcutaneous Electro Neural Stimulation) in conjunction with specific occlusal adjusting to almost completely eliminate the TMD symptoms (Figure 3). Note the amount of change in shape that was required, specifically on numbers 23 – 26 and 28. This process was completed over three appointments.

Some residual pain issues persisted, the resolution of which required the extraction of number 30 and the placement of an implant, and endodontic therapy on numbers 18 – 19. Once we had controlled the pain, we were free to focus on solving the patient’s aesthetic dissatisfaction. This is critical in any case in which a prior attempt has been unsuccessful, especially when pain has either been created or increased.

Figure 1 Unacceptable result for this patient, previous full mouth reconstruction. Figure 2 Previous occlusal position that had created general TMD symptoms. Figure 3 Post-occlusal adjustment with TENS. Figure 4 1987 photograph from the patients records. Figure 5 1980’s model before any reconstruction was done. Figure 6 Minimal diagnostic wax-up incorporated the stabilized bite and the shape of the original dentition. Photos courtesy Rhys Spoor, DDS.
The patient commented that the whole picture just did not look like she used to look. With this in mind, a very good way to determine the efficacy of such an observation is to have the patient bring in a photograph of a time when they approved of their appearance. Typically, such pictures will be from events, such as a graduation or wedding—notably, photos from driver’s licenses or passports usually do not work. We also had the advantage of dental models from about 1987 (Figures 04 and 05). A diagnostic wax-up (Figure 06) was then created using the adjusted and comfortable bite. This makes the occlusion much easier to deal with because it is now a centric occlusion case. Here, the key is to not lose the bite position in the transition from the existing to the final position.

The maxillary arch was prepared first and a tripod of contact was left to maintain the stabilized bite (Figure 07). A solid anterior and two posterior stops were left and the original full arch bite registration was relined. The vertical height (vertical index) was also recorded and tracked through the final delivery (Figure 08). Recording this measurement in the anterior and two posterior regions was used to confirm redundantly a constant position.

A stick bite impression was made and sent with the case to the laboratory to establish the relative horizontal line of the incisal edges. This information, along with its accompanying photograph (Figure 09) greatly enhances the ability to create an aesthetically pleasing smile line.

During the provisional stage, everything needed to be acceptable, including shape, color, texture, phonetics, and function. It was prudent to deal with any negative issues during this stage because these were still relatively easy to modify and correct. The continued lack of pain was critical before moving into the delivery of the final maxillary restorations. It was important to communicate with the patient and discuss clearly any changes with the ceramist. Once the final maxillary restorations were placed, all adjustments were refined to the mandibular arch. A lag of several weeks was deemed necessary to be certain that no pain returned and if it did, to correct the cause before finishing the mandibular arch. At this point, the patient was very pleased with the aesthetic changes and her continued comfort. The psychological security of knowing that there was light at the end of the tunnel now made completing the case successfully much easier.

The mandibular arch was then prepared, impressed, and temporized just as we had done with the maxillary arch. Three weeks in, the provisionals gave positive assurance to seat the final mandibular restorations (Figure 10). A post treatment maxillary Talon Nightguard was constructed, fit, and adjusted.

Approximately four weeks after placement, the final results were excellent, and the patient was extremely satisfied (Figures 11, 12, and 13). The occlusion required several more very minor adjustments to get it just right. The aesthetics were not only very attractive and age appropriate, but the patient was satisfied that she looked like she did before.

The key points in this case are:

- Gingival form with the central incisors dominating is an integral part of the overall appearance and is often overlooked
- Anytime a case is started for...
Aesthetics and pain is introduced, the equation becomes much more complex; the patient must feel good before she or he can look good.

- Listen to what your patients say; they are always right.
- Provisionals are critical to final acceptance.
- Communicate with the patient and the laboratory.
- Success is only achieved when the patient is happy.

Aesthetic dentistry is a substantive part of dentistry, and its practice comes with high demands. These include physical, technical, and emotional challenges, and they all are equal. Real-life aesthetics is a balancing act of art, science, and compassion, which keeps our professional lives interesting.

Acknowledgements
The exquisite ceramic art was created by Daniel Sorenson, CDT, Experience Dental Studio, Provo, Utah. Thank you to Dr. Daniel Friedman, Burien, Washington, for his precise care in placing the implant and gingival grafting, and to Dr. Mark Freeman from Seattle for his compassionate endodontics.

Dr. Spoor maintains a private practice in aesthetic and restorative dentistry in Seattle, WA and can be contacted at www.RhysSpoor.com.

Figure 13 The face of a happy and comfortable patient. Photo courtesy of Rhys Spoor, DDS.
Doctor of Influence: Dr. Mary Krempasky Smith

By Holly Kean, Print Media Manager

What does it take to have influence? For Dr. Mary Krempasky Smith it’s all about direction, leadership and impact. She has tirelessly developed a career of influence; on her patients, on her staff, on her community and on her profession.

Developing Her Own Direction
This Spokane, Washington dentist admits she didn’t start out thinking about influence and leadership from the beginning but had a strong sense of herself - a confidence - with what she wanted to do with her life. “I never planned to be a leader, I just wanted to be the best dentist I could be.”

You see, her start in dentistry wasn’t an easy start to her career. Upon graduating from the University of Minnesota in 1982, Dr. Smith returned to her hometown of Spokane, Washington intent on buying an established practice to get her start. In those years, female dentists were few and far between. Dr. Smith learned along the way that despite her own confidence in herself, others were less enthusiastic about her career as a dentist. Without a reason, the first practice deal fell through. And then, so did the second. Without being given any legitimate reason, Dr. Smith’s suspicions drew her to conclude that it had more to do with the fact that she was female rather than any other reason.

On the third purchase agreement, she “got smart” (by her own terms) and built a clause into the agreement requiring just cause for cancellation of the agreement. Needless to say, she purchased that third office.

Dr. Smith’s financing search followed much of the same path, the first bank wanting to charge 19% interest. The second discounted her instantly by her youthful looks saying, “Honey, first you go to college, then to dental school.”

Those experiences must have helped Dr. Smith develop a thick skin. As the adverse reactions to her becoming a practicing dentist continued to come at her, she flatly and plainly refused to work with anyone who didn’t believe in her. “I remember my own attorney saying, ‘Honey, do you really think you can handle this?’ I found a new attorney the next day. I needed someone to believe in me.” And out of spite or not, Dr. Smith paid the loan off six months early and continued to grow her practice.

The third bank turned out to be a stark contrast to the previous two. “The loan officer was not condescending and was eager to work with me.” So much so that he wrote a letter of thanks which garnered a call from the bank’s Vice President thanking Dr. Smith for the business. As it turned out, the loan officer was having a difficult time getting new business because of his link to an individual with a negative personal reputation in the community. Just as she needed someone to believe in her, he needed someone to give him an opportunity to succeed.

“My first couple of weeks were tough. My first patient wouldn’t have a female dentist working in his mouth.” Making somewhat of a scene in front of other patients in the waiting area, one kind man stood up as the other left the office. “I’d be honored to be your patient,” he told Dr. Smith. “He took my hand to lead me back to the operatory and took a seat in the chair. Then he turned to me and said, ‘But I’ll need to fill out the new patient paper work – I was just here with my wife who had the appointment.’”

Things in Dr. Smith’s office eventually found a rhythm but it was still a challenge. “When I started, I was the youngest in the office so it was a hard start. Everyone had more experience than me.” She points to her being a woman as an interesting facet to the office dynamics. “Women often find compromise by nature I needed experience with management before I understood how to handle staff issues in a more mature way.” Since then, Dr. Smith has developed an interesting approach to deciding policy and guidelines for her office. Her team annually reviews the staff manual and makes suggestions on changes. Not all things are up for discussion, but Dr. Smith sees

“It became evident to me that women in leadership was possible, even important.”

- Dr. Mary Krempasky Smith
Dr. Smith in her Spokane, Washington office where her start as a dentist began. Photo by Anthony Björn Roslund.
this as a way for her staff to make decisions together.

**Leadership**

Early on in the start of her practice, Dr. Smith got a call from a fellow female dentist to attend the Spokane District Dental Society meeting. “We’re dentists. We need to do this,” was her friend’s compelling invitation. At first, her involvement was just in attending the regular monthly meetings but soon Dr. Smith’s interest and relationships developed. In 1987, she was invited to join the society’s Executive Council. The start of her professional leadership was challenged in a new way as the group struggled to boost attendance. One doctor suggested hosting an open bar at their meetings and Dr. Smith was quick to counter. “I don’t want to be a part of an organization that has to lure people to attend.” Over time, her leadership and dedication in creating a more dynamic local chapter made an impact. She welcomed the camaraderie, networking and learning from other more seasoned dentists. She believes now more than ever that the role of local dental societies and study clubs is critical to a dentist today. “We live in our own little silo. It’s nice to get out and get support from others.”

Being a young dentist, wife and mother, Dr. Smith faced different challenges than her male counterparts, balancing both personal and clinical responsibilities along with her involvement with the community. “I knew I had made it (with my dental colleagues) when we were talking and I was referred to as ‘one of the guys’ even with a baby in tow!”

Dr. Smith has been a lecturer and guest speaker on topics like mouth guards and sports injuries, Peer Review and Ethics for the ADA, HIPAA, WISHA, Insurance and Third Party Issues, and the ADA Success Program. She jokes, “I talk about all the stuff no one else wants to talk about.”

Her commitment to the advancement of dentistry brought her through the ranks at the Spokane District Dental Society and eventually led her to Washington State Dental Association (WSDA). Active within the organization, Dr. Smith served on several committees including the Washington State Legislative Testifying Panel, Washington State Joint Select Committee on Access to Oral Health (1996-1998), WSDA Executive Council and on the Legislative Committee where she’s led as the Assistant Legislative Director (2003) and Legislative Director (2004-2006), working to improve the quality and access to dental healthcare. From 1999 to 2000, Dr. Smith served as President of the organization. To date, Dr. Smith is still the youngest dentist and the first female dentist to be elected to this position at the WSDA. “It became evident to me that having women in leadership roles was possible, even important.” Since 1993, Dr Smith has been active with the ADA working on several projects, committees and councils. Today, Dr. Smith serves as the ADA Trustee of the Eleventh District which includes Alaska, Washington, Idaho, Oregon and
Montana. She travels to the ADA in Chicago and throughout her territory states often, taking her out of her practice about 120 days each year. She works on developing national program guidelines, building relationships with dentists in the states she represents and advocating political and technical advancements in the profession.

“I got involved because I thought I could make a difference and help shape the future of dentistry.”

As a Trustee of the ADA, it’s clear that Dr. Smith truly believes in the strength and longevity of the organization. “I like the interaction with people and the diversity of ideas. There are so many different ways to do the same thing and opportunities to ‘bounce ideas off’ of a peer group.” She credits the national organization’s membership; “70% professional membership makes it the strongest professional non-profit in the country.”

Dr. Smith believes in a few keys to her success in practice. 1. Develop listening skills for patients and for your staff. 2. Never be afraid of a quiet office. “I don’t have music playing in my office on purpose. It helps me stay focused.” 3. Don’t always be in a hurry. Success will come in time. “If you’re always in a hurry, you might miss the ‘good stuff.’” 4. The first impression and last impression your clients have in your office matter the most.

Dr. Smith’s ultimate measure of success with her patients? “When they trust you enough to bring their child to you – that’s the ultimate trust!”

Impact
When she bought the practice in Spokane, Dr. Smith became the team dentist for the Spokane Chiefs, a major junior ice hockey team. Not a distant departure from her past, Dr. Smith had made mouth guards for the school’s hockey team at the University of Minnesota. Over the years she’s treated several players but one injury sticks out in her mind. “A young man had taken a puck in the face during a game. After the game the team physician asked me to take a look at a player saying that he believed “a tooth was out of alignment” One look and I knew the jaw was broken. The next day, the player came into the office for x-rays of the injury. When I reviewed the x-ray with the player and pointed to the two fracture lines, the player commented, ‘Thank God nothing’s broken!’.” Today that player is a dentist. “I’ve seen a lot of the players I’ve worked with go into the medical or dental professions over the years.”

Dr. Smith’s dedication to the future of dentistry is clear. “Things change. (Public opinion, science, the law, etc). We [dentists] have to be adaptable to change. We have the ability to shape the profession for the future, otherwise [change] will happen to us.” Dr. Smith is equally committed to leading that future. “It’s not about who knows the most, it’s about how we maneuver and adjust to the changing health care environment.”

She is equally dedicated to professional growth for the industry as a whole. “I’m excited for people to better themselves, looking for ways to better serve our patients. Anyone who works for me and who strives to know more and grow gives me the ultimate compliment.”

What does Dr. Smith think it takes to excel as a dentist? “Curiosity. Be willing to take a chance and expand yourself. You can move forward. You learn through adversity. When things go wrong, I always ask myself, ‘Now what was I supposed to learn here?’ “

With over 25 years in practice and almost the same in leadership, Dr. Smith has treated hundreds of patients, met thousands of dentists, spent countless hours educating, advocating, lecturing and serving all in the name of building relationships and working to improve the profession as a whole. If influence is the capacity to be produce effects on the opinions of others, then Dr. Mary Krempasky Smith definitely has it.
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Bringing the Benefits of Digital Imaging into Focus

Provided by Gendex

For those who have entered the digital age, radiography will never feel the same again. Fortunately, it will never smell the same or take the same amount of time, either. Randi Lavery, a dental assistant for 35 years, recalls the days when “We used to hand dip X-rays and hang them up to dry. Sometimes the doctor couldn’t even review them until the next day.” Life got easier when automatic processors became available, but she still stumbled around in the darkroom that reeked of toxic chemicals. After all, the processor needed to be cleaned on a weekly basis. “That was the dreaded job in the office,” she says. Presently, Randi works with Dr. Frankie Sulaiman at Pacific Prosthodontics in Seattle, a digital X-ray owner and Burkhart customer. When the practice moved into a new office space, their digital pan—a Gendex 8500—moved in with them, bringing with it the many benefits of digital technology.

Digital radiography improves the communication between doctor and patient. Before accepting treatment, patients should understand their condition, and digital imaging in its many forms facilitates the necessary patient-doctor discussion. Intraoral digital cameras help patients see their mouths as the doctor sees them.

Lorin Berland puts it this way: “It has often been said that a picture is worth 1,000 words; that’s because it’s true. If you are practicing cosmetic or general dentistry, camera images displayed on large computer monitors offer the opportunity to connect with your patients on many levels.” Additionally, cameras including the AcuCams and GXC-300™, offer options in price and connectivity that keep them affordable, portable, and networkable.

For Craig Harder, DDS, general dentist and Burkhart customer, his digital intraoral sensors, Gendex eHD, improved patient communication by giving him the opportunity to explain their conditions more succinctly. “Just being able to enhance and enlarge images—to lighten, darken, and contrast—helps me point out areas of concern so much better,” he says. “The ability to speak with patients directly with the image displayed on the screen in front of them is spectacular. It really helps with our diagnosis and treatment acceptance,” he adds.

Patients consistently reinforce his decision to invest in digital imaging. He says, “Even after having digital for eight years in one form or another, I am still amazed at how many patients tell me that they have never experienced this before and how nice it is to finally see what we’re seeing.” Improved patient education also tends to speed up the process. “We schedule patients for their exams and their imaging in the same appointment,” says Lavery. “The doctor discusses his diagnosis with them and in a few minutes, they understand the treatment plan.”

Digital imaging also accommodates patients’ different abilities. Lavery notes that the system in her office works with the patient in the standing position. “When we work with elderly patients, taking a pan X-ray is so quick and easy,” she says, adding that the machine also adjusts in height to accommodate patients in wheelchairs. “It takes about 10 seconds to revolve around the patient’s head and then you can see the image instantly,” she says, estimating that digital X-rays shorten the imaging part of the appointment by as much as half an hour.

Digital radiography is so efficient and quick that during a military dental event that offered dental exams and care to reservists, “we were able to see up to 500 reservists in one weekend,” Lavery notes. In a busy dental office, any time not spent with patients is...
wasted time. Instead of waiting in the darkroom for traditional X-rays to develop, assistants’ time is best spent chairside. “It is so much better,” describes Dr. Harder. “The speed is fantastic. It just makes everything more efficient.”

Digital intraoral sensors are indeed patient pleasers. Designed to maximize patient comfort with their smooth edges and round corners, they are a great change from traditional film X-ray with cardboard corners that can cut into delicate tissue. The sensor’s ergonomic shape permits quicker and more accurate positioning, which is also a time saver.

Digital radiography is often a new concept to patients, which creates a “buzz” in a technology-savvy practice. Besides word-of-mouth referrals that attract new patients, referring dentists appreciate the improved communication digital technology provides. “We e-mail the images to the referring dentists, or we can print them out and mail them,” says Lavery.

While improving patient care, digital imaging technology saves money and the environment. The storage and disposal of chemicals that were once emptied into the drain is now regulated in certain states. With film X-rays, money that could represent profit is used to purchase supplies and cleaners for the processor, not to mention labor involved with cleaning the equipment and documenting chemical storage. In addition, a professional hauler is often needed for removal and disposal.

Given the many forms of digital imaging available, dentists have the opportunity to add this technology to their toolbox at their own pace and within their own budgets, thus bringing into focus all of the necessary details for a successful practice.

Digital imaging with the Orthoralix® 8500 DDE makes imaging simpler, more clear and more precise. Photo courtesy of Gendex.
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the eyes as “the mirror of
the soul.” Comparatively,
the sensor serves as the eyes
for digital radiography systems,
allowing dental professionals to
delve, maybe not as far as the soul,
but certainly into the recesses of
the dentition. Because imaging is a
significant part of diagnosis, proper
care and handling of the digital
sensor can prolong the life and use
of this small but hearty piece of
equipment.

Caring for a quality sensor takes
very little effort. General dentist
and Burkhart customer Dr. Craig
Harder of Moses Lake, Washington
invested in 2 Visualix® eHD sensors
for his 5 operatories approximately
2 years ago. He assigned one
sensor to hygiene duties and the
other to the treatment area for
endodontics and emergencies. He
expects to implement a third sensor
soon for his newly completed sixth
treatment room, dedicated to new
patients.

For the past two years, Dr Harder's
eHD sensors have operated
consistently without service issues.

He advises, “The most important
precaution that we take is hanging
the sensor on the wall mount
accessory provided by the company
to keep the cords off the floor,” he
says. If the wire gets tangled in the
chair wheels, “the sensor can get
pulled off the counter and banged
on the floor.” Still, his sensors have
withstood some mishaps. “We
have really been impressed with
their sturdiness,” he says. “We
have dropped ours a few times, but
we haven’t seen any deterioration
of images or any problems.” He
continues that after two years, “We
haven’t had a single problem with
a sensor.”

While sensors are built for durability,
taking simple precautions can
protect from unnecessary damage.

• Do not sterilize the sensor using
  an autoclave or a UV oven

• Do not decontaminate the sensor
  using inappropriate cleaners or
  methods

• Safeguard sensors by storing
  them in an area where they will
  not be damaged

• When in use, ensure the workflow
  procedure keeps the sensor
  cables out of the operator's
  walking path

• Do not coil the cable tightly so
  as to prevent the wires from
  breaking

The positioning devices supplied
with most systems are autoclavable
by the standard method or by using
cold chemical disinfectants as per
the operating manual.

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members probably have some
great ideas of their own to protect
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care for sensors will keep them
traveling between operatories
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Mobile Computing in the Dental Office

By Dawn Christodoulou, President, PEB/XLDent

Considering that the very first dental practice management programs ran on mainframe computers housed in large “computer rooms,” it’s hard to believe that mobile computing devices like the Tablet PC are now becoming a mainstream care delivery tool in the health industry.

Following the mainframe, the evolution of computers continued with mini-mainframes and finally personal computers. IBM introduced the PC in 1981 and in 1983, Professional Economics Bureau launched its first PC-based Dental Practice Management system after migrating its original mainframe-based dental service bureau concept to the new platform. The IBM PC had an 8088 processor, 16 KB of memory, and utilized MS-DOS as the operating platform. It did not have a hard drive, so data storage was something of a problem. Does anyone remember 256K floppy disks? I do, and although switching floppies in and out to run programs and store documents was a confusing chore, the very idea that I could write and rewrite a term paper without a bottle of whiteout was simply amazing! The level of technology that exists today is sometimes mind boggling, but the fact is that traditional personal computers have evolved into personal mobile assistants, and these devices just keep getting cooler by the day. Now, like most everyone, I can’t think of working or playing without some type of mobile technology within reach. Again like everyone else, I want my IT devices to be small, powerful, energy wise, and fast.

One of those devices is the Tablet PC. Since 2004, Intel has explored ways new mobile technologies could improve the delivery of health care, and they’ve committed to working with hardware and software vendors to refine products and applications based on the Mobile Clinical Assistant (MCA) design. Since Motion Computing’s launch of the M-1200 Tablet in 2002, we’ve seen this hardware manufacturer improve upon its design with the 2007 introduction of the C5, which centers on the clinical environment and more recently, this year’s unveiling of the company’s J-3400. Astoundingly, these units just keep getting lighter, slimmer, and more powerful. They include better power management and have hot swappable batteries. In addition, wireless technologies continue to become faster and more stable. The new J-3400 model supports the wireless draft-n (up to 300 MBps) standard, and the associated routers coming to market offer expanded range and tremendous stability for the wireless signal.

Of course, it’s only a matter of time before wireless mobile devices become the new standard for computing platforms across all industries and software developers write applications to optimize functionality for the mobile environment. As far as the dental industry is concerned, there is already one software company that focuses on taking advantage of these mobile technologies. The XLDent Dental Practice Management system is a complete suite of dental software products designed for the Tablet PC. The product is comprehensive and is far ahead of competing products in this arena. The XLCheckIn™ module, for example, allows patients to complete forms in the waiting room on a Tablet PC as if they were completing them on a clipboard. With a Tablet PC and XLChart™, doctors can move freely from room to room with technology in hand. This mobile element not only offers the clinician greater freedom and flexibility, it also enhances doctor/patient communications and helps to improve case acceptance.

While slow adapters and developers of dental software applications that are not engineered to capitalize on this technology may downplay MCAs, the fact is that Tablet PCs and mobile computing are here to stay. The technology is making its mark in the health care arena and since XLDent™ is the first and only suite of dental products developed for this technology, it represents the perfect match for the doctor who wants the best the future has to offer for his or her practice.
There is an old adage which holds that “numbers don’t lie” and often, they tell important truths. As a CPA, I work with numbers every day. I often rely upon numbers to provide a window into the well-being of a business.

Each year, our firm performs surveys based on the dental clients we work with. In this process, we measure their income, their expenses, and their resulting net profit. Our 2009 surveys provided positive substantiation of the early verbal feedback we received from our clients regarding how they were doing in this difficult and challenging economy. On the bottom line, our dentists are doing well.

In the fall of 2008 and through the winter of 2009, we met with the majority of the dentists we work with and asked how their dental practices were performing in light of our fallen economy. While most were guarded in projecting future growth in profitability, their current numbers showed positive trends.

We were anxious to complete our survey using our dentists’ numbers to verify what we were being told. The data for the survey is taken from the tax returns we prepare for our clients. Since the tax returns are signed under the penalty of perjury, we feel there is little concern that collections will be understated. Moreover, we feel very comfortable that all expenses are being reported.

Our survey results were very positive when reflecting upon the general economy. Over the years, our surveys have shown a continued trend of both higher collections and higher net profit. For 2009, the surveys showed that this trend continues, even though the overall economy has suffered greatly.

The results of one of our 2009 surveys is comprised of individual general dentists we represent in Alaska, Oregon, and Washington. These are solo practitioners who have been in practice for at least 12 months and work at least 3 days per week. We noted several interesting comparisons when reviewing the 2009 survey against our 2008 results.

Collections were up $46,251, from $843,924 to $890,175, representing a 5.5% increase over the 2008 survey. Net operating income before depreciation increased $30,040, from $283,321 to $313,361. This represents a net increase of 11% over the 2008 figures and left practices with a net profit of 35.2% of collections.

Net operating income after depreciation (for tax purposes) saw a growth of $37,487—nearly a 17% increase—to $258,485. These numbers ought to boost dentists’ morale regarding the impact of the recession on the dental industry as well as the financial health of their profession.

I discussed our survey results with other members of the Academy of Dental CPAs across the country. Generally, their surveys also showed a trend of continued profitability growth in the dental industry.

While many businesses have suffered greatly in this economy and some entire industries seem to have vanished, the dental industry has continued to hold its own. The

“While many businesses have suffered greatly in this economy and some entire industries seem to have vanished, the dental industry has continued to hold its own.”

A few dentists were experiencing substantial drops in both production and collections. However, the majority we talked with not only finished 2008 well, their early months of 2009 were strong.

question of “why” and “how” thus begs an answer. I certainly do not claim to have the complete response but I do have some general thoughts and strong feelings regarding the “why” and “how.”
“How” is it that our surveys showed that our clients were able to experience increased profitability even when costs were rising and some practices were experiencing less treatment case acceptance? Indeed, expenses were up $16,211 over the previous year according to our survey, but this actually represented a decrease of 1.6% as a percentage of collections. Again, “how” and “why” did this happen? I believe it occurred because we advocate strongly the need to adjust, rebalance, and increase the practice fees annually. This can be difficult but with proper assistance from someone who knows the market, fees can be increased to correspond with the current trends in your geographical area.

Things do cost more and just like any other business, those costs must be passed on to the consumer. Intelligent adjustments and increases in patient fees can offset the rise in overhead expenses. As discussed, this allowed our dentists to experience both a growth in overall collections and profitability.

But “why” the continued demand for dentistry? I believe the dental industry, and specifically each individual dentist, are great educators for their families of patients regarding the direct correlation between good dental health and an individual’s overall health. Patient education is not limited to the actual office visit but is instead continued through the practice’s Web page, frequent newsletters, and even e-mails to keep patients aware of the necessity and value of good dental care. As patients learn, they have a growing concern for their own well-being and that of their entire family. This concern translates into a desire to seek quality care and maintain their oral health.

I also believe baby boomers—I am one—are enjoying more active and wonderful lives than those of any previous generation. Clearly, these longer lives demand an extended need for dentistry. As we get older, we are not only concerned about good health but we also want to maintain the best smile possible. For most, the fate of having dentures at 50 or 60 is no longer inevitable as was the case for our parents and grandparents. Dentistry has improved our lives, such that most of us can count on taking our own teeth with us when we pass on. Until then, many have money and will spend it on items of personal importance. For most, this definitely includes quality dental care.

“How” has the dental industry accomplished this? As a CPA who has worked with dentists for the past 33 years, I continue to be awed by the advances in clinical treatment and the improved supplies, technology, and equipment used to support clinical treatment. For me, the “how” is answered quickly when I review the numbers posted by my dentists in the “best practice” category. I see their continued investment in technology and equipment, and
it is no coincidence that our most profitable practices are up-to-date in both technology and equipment. They are able to provide top quality care efficiently and effectively in an atmosphere that is enjoyable for both their teams and their patients.

I also see that these “best practices” are involved actively in continuing education, not only for the dentist but for the whole dental team. Advancements in equipment and technology drive the need to remain current with the latest techniques and systems. These advancements ultimately improve efficiency but more importantly, they have improved the quality of care the patient receives. If a dentist can improve care and do so efficiently in an atmosphere where everyone seems happier about the experience, then we have a real win-win situation, which promotes growth and increased profitability.

An individual dentist might feel completely lacking in the ability to improve the faltering economy or even his or her own 401(k) retirement plan. However, that same dentist realizes the unrestricted ability to be in charge of his or her own dental office. Thus, there is no better time to invest in your practice.

In some of previous articles that have appeared in Catalyst, we have elaborated on areas of the practice where concentrated efforts have generated great rewards. The positive and profitable results of a dental practice are a direct reflection of the investment of time and money into the practice; you know it and your patients know it. After all, it’s just good business!

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Bob Creamer is a CPA and President of Creamer & Associates, P.C., an accounting firm. For the past 30 years, his firm has emphasized financial and retirement planning, dental transitions, practice enhancement, wealth creation, tax savings and related accounting and consulting services for maintaining an efficient and profitable dental practice. He is also a member in the financial advising and investment company of Salem Asset Management, LLC. He is a founding member of the Academy of Dental CPA’s (www.adcpa.org).

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Wealth Management: Real Life Returns

By Sam Martin, MBA, CFP®, CPA

Unfortunately, “Wealth Management” is a phrase that is tremendously and often inappropriately used. According to a study by the financial research firm CEG International, some 80% of all investment oriented professionals identify themselves as “wealth managers.” Yet when defined as a comprehensive approach to financial planning and management (including investing), only about 7.5% of this group actually fit the description accurately. On further inquiry, CEG determined that only about half of this smaller group was truly following through with a comprehensive approach.

The point of the foregoing is that while there are many folks who would be pleased to invest your money for you, only a small fraction of them take a comprehensive approach. The majority are people we refer to as “investment-centric.” Certainly, the management of your long-term investments is important, but is investing for investing’s sake or investing in a vacuum really in your best interest?

Real Life Returns

Ultimately, what really matters is achieving your goals. For many, that may mean replicating your lifestyle in retirement or as retirement unfolds. For most, it means having the wherewithal to maintain independence and dignity. Achieving this has much more to do with planning and investor behavior than it does achieving phenomenal investment returns.

Chasing Returns is Harmful to Your Financial Health

Wall Street and the financial press (paid by Wall Street) have a vested interest in making you believe that not only can you achieve above average returns but that you would be ignorant not to try. The problem is that the preponderance of peer-reviewed academic research shows that a strong majority (70% +/-) of professional money managers fail to “beat their benchmarks.” Further, the managers who do exceed their benchmarks over a given period tend not to repeat this performance. In other words, there is no “persistence” in their performance. In fact, studies have shown that the upper 25% of money managers in any given year are more likely to end up among the bottom 25% the following year rather than somewhere in the middle (where we might expect them to land).

Often, the managers who outperform over time will be shown either to have done so randomly—if enough of them throw darts at a list of stocks and/or asset class allocations then some will indeed appear to be investment geniuses—or to have taken significantly more risk than perhaps can be understood; for example, many hedge funds fall into this category. Regarding the latter type of manager, his or her performance should be measured on a risk adjusted basis since when this is done, we will find in most cases that no outperformance actually took place. Worse, investors rarely understand the level of risk they are incurring until it is too late—and 2008 is a good example.

As individual investors, we are even worse. We tend to trail our own investments by 5 – 10% by basing our actions on the “noise of the markets” and/or on our normal human emotions: greed getting in and fear getting out. A Morningstar study evaluated 199 mutual funds for which they had performance data for the period 1989 – 1994. The average total return for the 199 funds over this 6-year period was 12.01%. The return to individual investors in those same funds over that same period was just 2%.

Either market timing or chasing the hot manager turned their potential 12% returns into 2%. Another way to state this is that an investor who put his or her money in these funds in 1989, and then let it ride, would have received a 12.01% return. In contrast, the collective investor, who got in and out (typically at the worst time), frittered away 84% of her or his returns by buying high and selling low.

The point of this and many similar peer-reviewed studies is that it is not the manager of the money who makes the real difference, it is investor behavior.

Please Behave

The following is based on my real-world observations and on the knowledge and experience of other true wealth managers. Consequently, I cannot provide you with scientific proof or cite peer-reviewed studies. Nonetheless, I believe the following to be the rough formula for successful investing:

Formulas for Financial Success

- Investor Behavior 80%
- Investment Management 20%

At first glance, you might find it odd that someone who earns his living in large part from managing the investments of successful dentists and specialists would suggest that the investment management part of the process only accounts for 20% of the outcome. However, if you understand that the comprehensive approach taken to...
Wealth management integrates all facets of financial life (including the dental practice for those dentists and specialists not yet retired), then you might not be surprised to learn that managing client assets is the simplest part of a true wealth manager’s job. In fact, the difficult part of the job is helping clients plan and then managing their emotions, expectations and motivating them to take the various steps required to achieve their long-term goals in order to protect who and what is most important to them.

**Investor Behavior – 80%**
- Planning/Savings – 50%
- Patience – 15%
- Discipline – 15%

“Among successful dentists and specialists, the single largest cost associated with investing is taxes.”

**Planning/Savings:** Although Planning and Savings may sound like two different things, planning is often the key to motivating an individual or couple to take the lifestyle steps necessary to save at a rate that offers a realistic chance of achieving long-range goals. Without significant savings, of course, there is no investment and consequently, no ability to fund those long-term goals. So savings or its inverse, establishing a lifestyle that allows for significant savings, is at least 50% of the formula. Planning helps to quantify savings and serves to motivate individuals to save and/or reorganize their lifestyle to allow for appropriate savings.

**Patience:** Patience is indeed a virtue, and one need look no further than 2008-2009 to find a classic example. How difficult is it for us, despite our frail human emotions, to “hold still” and “stay the course” in light of the incessant drumbeat of the financial and mainstream press, such as around-the-clock cable and Internet news, etc. Yet having the patience to stay the course on a well considered plan is precisely what is needed to achieve successful, real-life returns.

**Discipline:** “If patience is tolerance and restraint in the face of provocation—the decision not to do something wrong—discipline is more properly the decision to keep doing the right things. Persisting in one’s accumulation program is one common and all too rare, manifestation of discipline” (Nick Murray, “Behavioral Investment Counseling,” 2008—from which also comes the term “Real Life Returns”).

But this time things are different! That is what we always hear, in up and down markets alike. But in reality, no, they’re not. Clearly, 2008 was a doozy, and the economy still has a long way to go to catch its breath. Nonetheless, (for instance) the S&P 500 went from 676.53 on March 9 of this year and closed yesterday (June 2) at 944.74, an increase just shy of 40% in less than 3 months. I pity those who capitulated somewhere in late 2008 or early 2009 when they could no longer stand the pain. They got out low and are today thinking about getting back in—some 40% later. I also pity those who reduced or terminated their accumulation plans and likely missed out on some of the best bargains on equities (stocks) that we may ever see. On the other hand, I admire and appreciate the 97% of my clients who were no doubt unhappy and perhaps upset to see large declines in their portfolios, but who stayed the course in any event and have benefited significantly from the turnaround we’ve seen to date. There are no guaranties in investing, yet there is also no reason to be anything other than optimistic about the economic future, particularly when you think about the technological advances to come—and they are numerous and mind-blowing.

**Asset Allocation – 10% (assumes allocation to high quality, low cost assets)**
- Diversification – 5%
- Cost & Tax Management – 5%

**Asset Allocation:** By far, asset allocation has the biggest influence on your portfolio returns, assuming that investor behavior is not an issue. Various peer-reviewed studies, most famously the “Brinson Study,” have found that asset allocation alone accounts for about 94% of the influence (good or bad) on an investment portfolio. Consequently, we had better pay close attention to how we allocate assets within a portfolio and perhaps more importantly, that allocation should represent the implementation of your written investment plan or policy.

The single biggest decision in asset allocation is that related to the mixture of equities (stocks or stock mutual funds) and fixed income (bonds, bond funds, or other fixed income instruments). Focusing too
much on equities and not enough in high quality fixed income sets an investor up to fail when times get tough—as noted above, this is a long-term investment killer. If you allocate to little to equities and too much to fixed income, then combined with the long-term impact of inflation, you’ll run out of money before you run out of time. Stated another way, you will eventually lose your independence and dignity in retirement. Obviously, a great deal of discussion and thought should go into this basic question of asset allocation.

**Diversification:** Each of us likely understands the important concept of not placing too many eggs in one basket. However, beyond diversification for diversification’s sake, you can achieve strategic or smart diversification. Overall, this is simply the process of tilting the equity allocations among asset classes to either increase expected returns relative to expected volatility (risk) or maintain the expected return while decreasing volatility (risk). Although this approach is built on some pretty intense academic research—the foundational pieces of which are Nobel Prize winning achievements—the good news is that it is relatively simply to deploy. As planners, we can compute the rate of return required by the client to achieve his or her goals once we have made assumptions about timing, savings, spending, etc. That way, we can make relatively accurate assumptions about expected returns, volatility, and inflation. In most cases, we are attempting to allocate assets and diversify in order to minimize volatility at a given expected rate of return.

**Cost and Tax Management:** Once you wrap your brain around what is important (and what is not) in investing for real-world returns, you understand that any cost that is either unnecessary or can be reduced should be. Among successful dentists and specialists, the single largest cost associated with investing is taxes. Poorly managed, taxes will cost you more than the underlying costs of your investments combined with any fee or commission you might pay to an investment advisor or broker. Managed properly, however, tax costs can be kept to a dull roar by using techniques that are unique in the investment world at large but are everyday stuff to the true wealth manager. These include utilizing passively managed asset class funds (which are also low cost in general), including tax managed versions of these same funds; strategic asset location, whereby a portfolio consisting of taxable and tax deferred (or tax free) accounts places the tax inefficient asset classes in the tax deferred or tax free accounts while the tax...
efficient asset classes are placed in a taxable account; as well as other techniques that include tax loss harvesting.

So now that you know the broad strokes of this formula for financial success, I am going to suggest that the items that comprise 100% of the formula above really represent much less than 100%. If you noticed, this article centered primarily on what makes long-term investing successful. Of course, there are many other aspects of comprehensive wealth management. Beginning with planning, the purpose of which is to optimize the probability that you will achieve all of your long-term goals and protect who and what is most important to you, there will be a number of other areas to address. Briefly, these include wealth enhancement (assertive tax planning); wealth protection (mitigating and/or transferring risk through the use of various legal entities and insurance policies (such as life, disability, malpractice, long-term care, property/casualty, etc.)); wealth transfer (estate planning and related); and for some, charitable goals. In addition to the foregoing, for those dentists and specialists who are not yet retired, there need remains to optimize the income and quality of life as these relate to your practice. All of the above would be addressed in a comprehensive financial plan (wealth management plan) that integrates the financial aspects of your practice and personal finances.

**Conclusion**

Some individuals—and these are true rarities—are capable of managing their behavior when it comes to planning and investing. I would suggest that if you attempt this on your own, you should still hire an expert team to assist with implementing the overall financial plan. At a minimum, that team should consist of a dental CPA, an estate attorney who works with professional practices, and a high quality life insurance agent. For investing, I recommend that you read the following two books: “Wise Investing Made Simple,” by Larry Swedroe and “The Smartest Investment Book You'll Ever Read,” by Daniel R. Solin.

For those who see the value in hiring a true wealth manager, I suggest that you refer to the following criteria or include some of the questions that follow as part of your interview:

- Entirely (or mostly) fee based with detailed disclosure of any financial products that are commission based
- Takes an academic approach to investing
- Utilizes low cost, passively managed funds
- Will put a financial plan in writing, which also provides details about your asset allocation
- Utilizes tax management strategies to minimize tax costs
- Legally has a fiduciary duty to his or her clients and puts this in writing. Note: Not all financial advisors are required to provide a fiduciary duty, and this is not well disclosed to the public. Such a fiduciary requirement means that the advisor is held to a standard of “in your best interest.” Alternatively, brokers are only held to a “suitability” standard regarding the investments they recommend. Often, this means they will concentrate on the investments that are in their best interest—or certainly could be. Can you imagine investing your life savings with someone who is not required to have your best interest in mind at all times? At best, I would consider this foolish. As they say, “A fool and his money are soon parted.”
- Finally, a wealth manager uses a comprehensive approach and is genuinely interested in you, your family, your goals, and what and who are most important in your life. If there is a rush to invest your money, there may be a lack of genuine caring.

One final note on the comprehensive approach. No single wealth manager can be a master of all the complex aspects of financial life. Ask the wealth manager about his or her “expert team.” If that team is entirely “in house,” I would be skeptical of its capabilities. It is unlikely that any single firm will have on staff the best and brightest in all of the areas mentioned above as well as in a number of other areas that play equally important roles. In my opinion, while the consummate wealth manager has some outstanding core competencies “in house,” he or she still scours the local and national landscape to create a team or Rolodex reference of the various experts his or her clients may need, always, sometimes, or even occasionally.

Sam Martin is Director of Wealth Management Services and Advanced Tax Planning for the Dental Group, LLC / Martin Boyle PLLC / Dental Group, LLC, a CPA, practice advisory, financial planning and Wealth Management services group exclusively serving dentists and their practices. Sam is a Certified Public Accountant (CPA), a Certified Financial Planner (CFP®), and holds a Masters Degree in Federal Income Taxation. Located in Kirkland, WA – Sam can be reached at 425.216.1612 or Sam@cpa4dds.com.
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Hobbies: I spend endless hours out on my patio attending to my flower beds and potted plants. I also devote a few hours every month to a ladies' investment club.

What I like about my job: I love working with people. I enjoy being a part of the patient’s health process; it is always rewarding seeing the patient’s health improve knowing you are an instrumental part of the process.

My Greatest challenge is: My greatest challenge and frustration is trying to help an individual who has dental needs but is controlled by his/her insurance plan.

Success at our office means: We know we are successful when we are improving the quality of life for our patient via delivery of services or consultation.

What Burkhart means to me: Burkhart is the key that makes the engine run. Without products we obviously cannot function as a practice, but the key element is our representative Mike Zimmermann. Mike’s willingness of service is outstanding.

Ramona Z. Solis, R.D.H.

Hygienist, Doug McMaster, DDS - Tuscon, Arizona
During the past few decades, a more comprehensive understanding of the process of demineralization coupled with scientific developments in diagnostic systems and dental materials have facilitated change in dentistry’s approach to the management of demineralized lesions. The “minimally invasive” approach to treating demineralized lesions incorporates detecting, diagnosing, and treating these areas earlier, and employing a medical model, emphasizing prevention, rather than the traditional surgical model. Each member of the dental team should understand this approach in order to take a more active role in caries prevention and treatment.

Though we are familiar with the preventive properties of fluoride, both from community water supplies and topical applications, and have made fluoride a part of our preventive strategy, caries continues to be a major problem in both children and adults. Dental caries is now the most common chronic disease in children. There are five times more children in the United States with untreated dental disease than with childhood asthma. We have focused our efforts on treating the symptoms of the disease, rather than to treat the disease itself. We must continue exploring additional measures for reducing dental caries. This includes addressing the bacteria and breaking the chain of infection, as well as enhancing remineralization and repair of early lesions.

Enamel, cementum and dentin are composed of millions of tiny crystals of carbonated hydroxyapatite. During the demineralization process, acids may readily diffuse into the tooth and dissolve the vulnerable mineral, producing calcium and phosphate into the aqueous solution between the crystals. These calcium and phosphate ions diffuse out of the tooth leading to the formation of an initial carious lesion, which eventually may develop into a cavitated lesion if the process continues without reversal.

Remineralization occurs when the acid in the plaque is buffered by saliva allowing calcium and phosphate to flow back into the tooth and form new mineral on the partially dissolved subsurface crystal remnants. The key is to reduce mineral transfer out of the tooth during acid attacks, and to promote transfer into the tooth following acid attacks. This can be achieved by ensuring the availability of fluoride, calcium and phosphate adjacent to the tooth during and after an acid attack.

Our understanding of the demineralization/remineralization process presents the opportunity to pre-empt cavitation of demineralized lesions and intervene at a much earlier stage, offering a different type of treatment. This is a paradigm shift from the traditional way of treating the disease. Because of this opportunity, we are obligated to understand what products are currently available to assist the clinician in sound recommendations for patient interventions. Several technologies are now available to slow the progression of caries and remineralize enamel subsurface lesions.

Bioactive glass materials have been used in medicine and dentistry for years. This unique material (NovaMin®) has numerous novel features, including the ability to act as a biomimetic mineralizer, matching the body's own mineralizing traits, while also affecting cell signals in a way that benefits the restoration of tissue structure and function. Bioactive glass is considered a break-through advance in remineralization technology. This is because the current standard treatment for tooth remineralization and prevention of decay is slow acting and is dependent on adequate saliva as a source of calcium and phosphorus.

NovaMin, when in contact with saliva or water, first releases sodium ions. This elevates the pH into the range essential for hydroxyapatite formation (7.5 – 8.5). The calcium and phosphate are released to supplement the normal levels found in saliva. This increase in ionic concentration, combined with an increase in pH, causes the ions to precipitate onto the tooth surface and form calcium hydroxy carbonate apatite (HCA) to remineralize the defect and to occlude open tubules. Studies have shown that this new mineral is a form of crystalline hydroxyapatite which is just like natural tooth mineral.

“We owe it to our patients and to ourselves to continue to evolve in an effort to provide the very best care.”
NUPRO® NUSolutions™ products combine the preventive benefits of fluoride with the calcium phosphate technology of NovaMin®. NUPRO NUSolutions in-office Prophy Paste, and the new 5,000 ppm Take-Home Remin Toothpaste offer comprehensive protection that extends beyond the appointment. For in-office prophy plus at-home treatment, give your patients the protection of NUPRO NUSolutions.

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- Remineralizes teeth, relieves sensitivity and prevents caries
- Higher remineralization of white spots & root lesions compared to leading brands
- Can be used in place of regular toothpaste – refreshing mint flavor

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1 In-Vitro Testing of Prophy Pastes - Feb. 2009
2 In-Vitro Testing versus topical remin creme & 5000 ppm (1.1% NaF) prescription toothpaste
An in vitro study demonstrated that treatment with a NovaMin-containing prescription fluoride dentifrice improved hardening of white-spot lesions compared to fluoride-only dentifrice. From that study, preliminary data also indicated that NovaMin®-containing fluoride dentifrices have greater potential to remineralize and repair white spot lesions than fluoride-only dentifrices. An additional in vitro study indicated that incorporation of NovaMin into fluoride dentifrices could arrest the tooth decay process earlier than currently available fluoride dentifrices.

An in vitro study demonstrated that treatment with a NovaMin-containing prophy paste immediately occluded the tubules by the formation of a protective layer of HCA (hydroxyapatite) and apatite. Samples were polished for 10 seconds and rinsed (after waiting one minute). Occlusion of the tubules is evident in the treated sample compared to the control sample (Figure 1).

NovaMin is found in two new NUPRO® NUSolutions™ products. NUPRO NUSolutions Prophy Paste (DENTSPLY Professional York, PA) delivers the benefits of tooth desensitization, tubule occlusion and stain removal; it integrates a desensitization treatment into standard prophy treatment. NUPRO NUSolutions Remineralizing and Desensitizing Take-home Paste contains 5% NovaMin and 5000 ppm sodium fluoride for the prevention of caries and the relief of tooth sensitivity.

Conclusion
As our profession and professional knowledge continues to evolve, our diagnostic procedures, techniques and therapeutic options will follow. We owe it to our patients and to ourselves to continue to evolve in an effort to provide the very best care.

Dental health care providers now have the ability to address the infectious agents causing caries; we can now eliminate or reduce their effect rather than surgically removing the damage created. The goal is to implement the technologies and products for prevention, early detection and intervention such as fluoride varnish, dental sealants, caries detection devices, and remineralization treatment which will ultimately result in conservative, long-lasting dentistry.

References:


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Aside from the gift of clean teeth after their preventive visit, we give our patients a “goodie bag”, filled with oral care products. Yes, we have the typical dental propaganda with our names emblazoned on the toothbrushes along with the obligatory floss, but we also have accessory oral care aids for the reluctant flosser. It does not matter how many times we discuss the need to floss with our patients, they promise they will but the evidence that they are not following our instructions is overwhelming. We try all sorts of ideas to make flossing easier but, the results are always the same.

One of the accessories we have in our post care bag is the Soft-Picks. I cannot tell you how many patients get excited when they see these. Just yesterday, a female patient said it is her favorite part of the “goodie bag”. When I asked her why, she said, “They are simple”. A new mother of twins, she has so little time for personal care, let alone flossing. She knows the importance of great oral hygiene, but finding the time doesn’t always happen. With the Soft-Picks, she is able to floss on the go.

I find that demonstrating oral care with Soft-Picks is a great way to ease the reluctant flosser into experiencing the benefits of interproximal care. If you start slowly, with the Soft-Picks, and the patient sees a decrease in bleeding, they may be more motivated to actually start flossing. Regardless, the mere act of getting something between the teeth to disturb the plaque and biofilm is a step in the right direction. Due to the tapered construction of the Soft-Picks it is very easy to get into tighter spaces, hence cleaning and stimulating the tissue at the same time. Another great benefit of Soft-Picks, as my patient mentioned, is the portability. One would be more apt to pull out a Soft-Pick to remove an errant piece of steak than drag out the roll of dental floss. A few years ago, during Chicago’s Taste of Chicago, a huge food extravaganza on our lakefront, Soft-Picks were passed out to the fest attendees. I thought what a fabulous idea!

It was a portable way to dislodge unwanted food while exposing folks to interproximal care. I hope Sunstar will continue the tradition this year!

Finally, Soft-Picks are highly universal. Not only are they great for the reluctant (and the tried and true) flosser, but they are easy to use for those patients with orthodontics and implants. Young teens with orthodontics are one of our most difficult age groups to motivate regarding interproximal care. With the Soft-Picks, plaque removal is easier without the messy string. For patients with implants, the soft rubber bristles are perfect to clean around the abutment. Finally, they are great under fixed prosthesis.

Yes, we would all love it if our patients followed the flossing mantra, but with Soft-Picks, we will know they are attacking the interproximal plaque and reducing the biofilm more than if they did nothing at all. Our office is a huge fan of this product and so are our excited patients. ©sbd 2009
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The reconstructed image is produced from a set of projection images taken from a region of interest. The region of interest can then be evaluated using measurement tools as well as implant samples to ensure an effective treatment plan is established.

3. How does VT work?
A 60mm cube shows the region of interest for proper and effective treatment planning. The resulting 3D model is reconstructed from a set of projection images targeted only on the region of interest. The wide volumetric view offers 256 slices, with a minimum slice thickness of 0.23mm, from which the optimal slice or any number of slices can be viewed.

Interested in clinical cases?
See how VT works at www.vt-cube.com

Contact your Burkhart Account Manager for more information.

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