Aesthetic Dentistry

TECHNOLOGY AND [illegible]THETICS • VOLUME 17 ISSUE 3 • FALL 2018

Threading the Needle

The Pinhole® Surgical Technique in action.

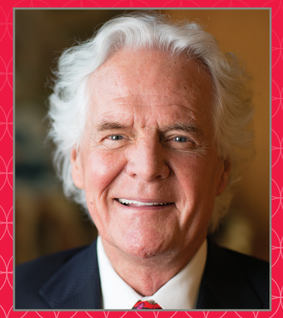
Show Them the Money

Helping patients pay for the dentistry they need.

Get Ready!

Preparing for life's unexpected events.

Hope Gordon, Elite Full Arch Reconstruction by Dr. Jim Downs, 2013.



Pay It Forward

Mentor: a wise, trusted, experienced advisor; a consultant; one who advises or trains someone else (especially a younger colleague).

In 1969, Assistant Dean Dr. Harvey Coleman asked me to teach at the University of Southern California School of Dentistry in Los Angeles, CA. Every Wednesday I drove an hour to the dental school and shared my expertise as a successful general dentist with the dental students. From that experience, I first became a mentor and teacher.

A dentistry mentor is someone with expertise who teaches and gives help and advice to less-experienced and often younger dentists. That mentor has more experience and can impart valuable experience and knowledge to help guide the less-experienced or less-knowledgeable dentist. I have been a mentor for about 50 years.

I started Arrowhead Dental Laboratory about 40 years ago both to provide a high-quality product and to facilitate a way to mentor other dentists. The Dr. Dick Barnes Group (DDBG) was established as a way for me to share my experiences with dentists throughout the world and teach dentists techniques and strategies to become better and more productive.

I can tell you with all humility that doing seminars is not profitable financially, but as a mentor, sharing my knowledge of finance and dentistry has given me some of the most rewarding experiences of my life. Mentoring dentists and watching them become better technically and financially brought me a great deal of satisfaction.

I remember a young dentist from many years ago who wanted to be involved in teaching with our group. He taught a few classes with the Dr. Dick Barnes Group. He thought that because dentists called him after the seminar and took up his time with questions about their practices he should be remunerated for that time. When I explained to him that the time he spent on the phone with those dentists was called mentoring—sharing your expertise at your own expense—he decided not to remain a part of the DDBG.

OPPORTUNITIES ARE EVERYWHERE

As dentists, we sometimes have opportunities to help other people—whether colleagues or patients—with something that is beyond their means. In return, we are blessed with the knowledge that we have made a difference.

By advocating that we help others, I don't mean to encourage free dentistry, but I do feel that dentists have a special responsibility to help those in pain. Forty years ago, an elderly woman needed my help with a dental case. After her examination and diagnosis, she realized that she was unable to pay the fee for the work.

She made a beautiful quilt for me in exchange for the $12,000 of dental care. I knew that a proud woman like her would not want to receive pure charity. I knew she would want to contribute toward the fee in some way. It was a rewarding exchange for us both.

Instead of "showing her the door," I asked her what she liked to do in her retired years. She replied that she liked to quilt. I told her that if she would make a quilt for me, I would restore her teeth. She willingly agreed to the arrangement. She made a beautiful quilt for me in exchange for the $12,000 of dental care. I knew that a proud woman like her would not want to receive pure charity. I knew she would want to contribute toward the fee in some way. It was a rewarding exchange for us both.

There are many opportunities in our careers as dentists to mentor and share our skills with others. The blessings of life come from giving of your expertise to your colleagues. And making a difference in the lives of others is a huge reward. I will never forget Dr. Omer Reed, who inspired me to become the best and most productive dentist that I could become. I am grateful for what I learned from him and the opportunities I've had to pay it forward. I hope you will too. ■

Aesthetic Dentistry
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A Reason to Smile

A Musician Sings a New Tune After a Full Arch Reconstruction.

For most of my life, I've had problems with my teeth. Growing up, I had crooked teeth that were prominent in front (one was longer than the other), and one of my incisors was set back from my other teeth with a noticeable canine.

To make matters worse, when I was nine years old I hit my face on the bottom of a swimming pool and broke my front tooth in half. My dentist, who was also a family friend, tried to help by fixing the tooth with a bonding agent, but the material often failed and would fall out.

My dentist who was also a family friend, tried to help by fixing the tooth with a bonding agent, but the material often failed and would fall out.

Once, while in junior high, the composite fell off. I went to class anyway, thinking my classmates somehow wouldn't notice. Of course, everyone noticed! I was teased so much in the first few minutes of class that I called my mom to take me home.

A TIGHT BUDGET

As the youngest of ten children, the family dental budget was often stretched thin. When I needed to have cavities filled, the dentist used silver-colored amalgam fillings as an economic and durable solution, but they made my already-troubled smile look even worse. I had a "metal mouth" from so many silver fillings.

(Above) Christina at 12 years old. She started having dental problems at a young age.

When I asked the dentist to use white fillings, he told me that the silver amalgam fillings were an overall better option for my mouth because of our family budget. Therefore, he used the silver fillings all the way to my canines, and they were very obvious when I smiled.

At age 16, a different dentist approached my parents about my smile. He was not an orthodontist, but he had started doing braces and asked my parents if I would like to be his patient.

I was so excited for this opportunity! I never thought that I would be able to get braces and I was thrilled. I thought that at least if my teeth were straighter, the dark fillings wouldn't be as noticeable.

Many of my friends had already had braces, and I remember everyone complaining about them. But I never complained. I was thrilled to have them because the braces and elastics covered my dark fillings. I wore them for about a year and a half, and when they came off, my teeth were much better than before. I was much more confident with my smile.

I never complained about my braces. I was thrilled to have them because the braces and elastics covered my dark fillings.

Unfortunately, not long after getting my braces off, I lost my retainer and couldn't afford to get another one. By the time I found it, my teeth had moved so much that the retainer no longer fit. My teeth were not as crooked as they had been originally, but they were not straight. The dentist told me that my only option was to put braces on again. I mowed lawns, cleaned houses, and babysat to save up money to pay for braces a second time.

TRY, TRY AGAIN

The outcome after the second round of braces was less than I had hoped for. The dentist suggested "shaving" down my front six teeth to adjust my bite. I trusted him, having no real idea of how that procedure would affect my bite and the problems it would cause.

A friend who was working for an orthodontist suggested that I have her doctor examine my bite. This doctor told me that my teeth were now too small for my bite, and that I needed to have braces a third time to space out my teeth. I would also need veneers.

At the time, I could not afford veneers, so I went with a temporary solution, which was to ›

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put composite on my teeth. I researched dentists to find someone to do the composite work after the second attempt at orthodontia was complete. I was told that the bondings would become discolored over time and would only last six to eight years at the most—and probably less because of my broken front tooth.

> The dentist told me that my only option was to put braces on again. I mowed lawns, cleaned houses, and babysat to save up money to pay for braces a second time.

Initially, everything looked great. But within six months, my teeth started chipping. Bits of composite would pop off when I flossed, and when I bit into certain foods. I was constantly going back to the dentist to have him refill the chips. It ultimately became a very expensive fix because I was constantly paying to get the composites filled.

The next six years were especially difficult because I had a restricted diet for fear that something would stain or chip my teeth. I couldn't drink grape juice or eat any foods with certain colors.

PAIN AND SUFFERING

My problems weren't just cosmetic. During an 18-month volunteer church mission in South Florida, I started having a lot of pain in my lower jaw. My left cheek swelled to the size of a softball due to an abscess. It was so painful that I couldn't eat or see very well. At the time, I lived near a dental school in Fort Lauderdale, so I went to the clinic and they got me in the same day.

(At Left) Before image, closeup.

(Below) Closeup image after the full arch reconstruction.

(Above) The Keller Family Band in 2007. Christina plays the mandolin and sings vocals with her parents and nine siblings. Each year, members of the group tour Europe, playing at festivals.

> The next six years were especially difficult because I followed a restricted diet for fear that something would stain or chip my teeth. I couldn't drink grape juice or any foods with certain colors.

The student doctor who I saw was specializing in endodontics. He cleaned out the infection in my mouth, gave me some antibiotics and pain medications, and asked me to come back in a week.

During that week, the pain and swelling continued. When I returned to the clinic, the infection remained. The dentist started digging into my mouth. After about 30 minutes or so, he pulled out a strip of metal. It was part of a file that had been used to prepare my tooth for a root canal, almost a decade earlier, when I was 14 years old. It had broken off in my mouth and had been there ever since.

It took nearly two months for the infection to completely subside. During that time, the doctor found two more pieces of file in my mouth. Finally, after the third piece was removed, the infection went away. During those difficult months, the doctor also switched out several of my dark fillings for white ones, and I was very grateful.

THE LAST STRAW

In early 2017, I was chewing on a sunflower seed, and my two front teeth chipped—both the tooth that was already broken and a huge piece of the tooth next to it. I finally decided it was time to invest the money to get veneers!

After doing research online, I narrowed down my options to several dentists, all of whom I met with and interviewed in person. I even drove to California for a consultation.

I brought a list of questions, told each one about my experiences, and explained why I was so terrified to have this dental work done.

As I was moving forward with my research, a friend told me about someone she knew who had veneers, and she showed me pictures of her gorgeous smile. She gave me the number for Arrowhead Dental Laboratory and suggested I give them a call.

In May 2017, I met with Dr. Jim Downs of LêDowns Dentistry while he was visiting Utah. After seeing my teeth and hearing my story, Dr. Downs told me I would be a good candidate for the full arch reconstruction course.

He said most of his patients who needed full arch veneers were twice my age, and the fact that I had so many problems with my mouth would be a good learning experience for the dentists who came to the course.

> I brought in a list of questions, told each one about my different experiences, and explained why I was so terrified to have this dental work done.

He explained that as part of the course, he would be teaching other dentists and explaining everything he was doing as he worked. That was extremely appealing to me because I knew he would be doing things right. Being a part of a course sounded amazing!

A NEW SMILE

When it finally came time for me to have the procedure, I appreciated that Dr. Downs took the time and effort to explain the process to me. Because he did that, I had confidence in his dental work.

The temporaries were the greatest advancement in my oral health up until that point. Each stage *(continued on page 43)*

Course Correction

What I Learned After a Brain Tumor Diagnosis.

I was recently at a continuing education dental seminar with the Dr. Dick Barnes Group when the conversation shifted to course corrections—the events that have the power to change the direction of your entire life. 'Yes, I know what that means,' I thought. In my life, I've had a course correction. So I decided to share my story.

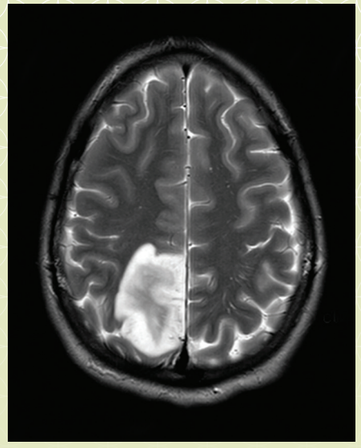
One afternoon in January 2017, two hours before I was supposed to finish my work day, I was suddenly overcome by horrible vertigo. I decided to sit down, so I walked slowly to my office. I missed the door handle when I tried to open the door, and then I nearly missed the chair. I'd been fighting a cold, so I thought it was likely due to an inner ear problem, and in 15 minutes the dizziness went completely away. Later that evening, I barely mentioned it to my wife.

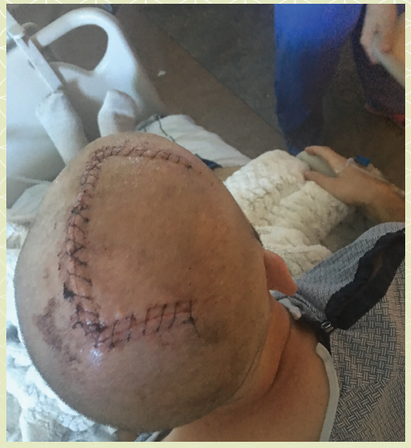
I reasoned that the appointment was more for my peace of mind, to confirm that I didn't have a big problem.

It happened again in April 2017, but this time it was much more serious: my left leg and arm got really clumsy, and the episode lasted 12 hours—long enough that I started worrying about a stroke. Strangely, the next day I felt completely normal. Fortunately my friend, a neurologist, told me I needed to see a doctor.

It took two and a half months to get into a neurologist, but I wasn't in a hurry, even though my friend kept pressuring me. I hadn't experienced any further symptoms, so what could be wrong? I reasoned that the appointment was more for my peace of mind, to confirm that I didn't have a big problem.

(Above) Dr. Brett Richins on his mountain bike in Utah.





(Far Left) An MRI showing Dr. Richins' tumor.

(Near Left) Dr. Richins' scalp after surgery.

At the appointment, I specifically asked the doctor if he thought it might be a brain tumor, and he said no, because symptoms almost never go away. Nonetheless, we decided to do an MRI. My medical insurance had to pre-approve the procedure, and it seemed like wasted effort to push for it, but for some reason we persisted. A month later, I had the MRI.

I asked for a copy of the images. As soon as I looked at them, it was obvious that there was a big difference between the left and right sides of my brain. I don't know much about the inner workings of the brain, but I knew they should be symmetrical.

The doctor called the next day to confirm that something was growing. He specifically said he didn't think it was malignant—the borders of the tumor and its rate of growth weren't consistent with that—but he said that I needed to have surgery to remove it right away.

Later, I met with a surgical oncologist, who presented a grim diagnosis. Judging from the scans, she said it was likely a grade-three glioma, a cancer which is always fatal; average life expectancy from diagnosis is three years. I was 34 years old at the time.

BRAIN SURGERY

The surgery lasted nine hours, and I was awake during most of it so the doctors could test the effects and determine how far to go. But that was the easy part. Next I had to deal with the immediate aftermath. The hospital staff had me standing up and trying to walk the very next day. It was excruciating.

The entire left side of my body was affected. I still had motor control, but the neural feedback and sensory perception were harmed, so I had no spatial recognition; I couldn't tell where my left foot and arm were, and I couldn't judge how much weight I was putting on my leg. It was more difficult than you could possibly imagine.

I was an in-patient for ten days, doing intense physical therapy for seven of those days. For the next few months, I kept doing physical therapy—four times a week, then three, then twice a week. (I still do physical therapy once a week.) I took walks with my wife, and I felt lucky to take 150 steps.

My first day home from the hospital, I fell six times. During physical therapy, I spent five to seven hours a day practicing basic tasks, things that used to be effortless: buttoning a shirt, tying a shoe. It was the most difficult period of my life, physically and emotionally.

She reaffirmed the value of something that I've always tried to do in my own practice: under-promise and over-deliver.

Before surgery, the surgeon and I had talked about the best approach, and I told her not to be conservative, but to get everything she could. Fortunately, she was able to remove the entire tumor.

Later, we discovered that the tumor had a mutation that makes it slow-growing and less aggressive than originally anticipated. She reaffirmed the value of something that I've always tried to do in my own dental practice: under-promise and over-deliver.

I went into the surgery thinking that I might have two years to live—never seeing my children grow up, never having the long marriage I had envisioned, not having the experiences I'd always dreamed of—and suddenly I was looking at 15 or 20 years, based on current science. It was great to have a measure of hope.

EFFECTS ON DENTISTRY

I experienced this difficult trial as a husband, father, and individual—and also as a dentist. There was so much to grapple ›

(Above) Dr. Richins spent months doing occupational therapy and physical therapy after brain surgery.

with. I've caught a few lucky breaks throughout this process, and now I'm determined to share some of those lessons.

Looking back, I would have done a few things differently had I known that I would face mortality head-on when I was 34 years old. I'm lucky that I already recognized how important my family was and already had a fairly good work-life balance, so I didn't have to do a lot of reprioritizing.

But I was young and healthy—a competitive mountain biker, a physically active person in the best shape of my life. And like most young and healthy people, I thought I had all the time in the world to prepare for "the worst," whatever that might be.

There are a few things that I now recommend all dentists take a look at, regardless of age or health, because I am living proof that it's never too soon to prepare for the unexpected. Here are five important ways to prepare:

1. Have as much insurance as you can afford (life, disability, practice overhead).
2. Have systems in place with your team.
3. Establish a network with local dentists.
4. Evaluate your priorities before you're forced to.
5. Have goals and a larger purpose outside of your professional aspirations.

DISABILITY INSURANCE

Having good insurance is the best, most practical advice I could ever give anybody. Most dentists think about disability and life insurance, but it's important to get disability insurance early. Most policies require a physical exam to ensure that you're in good health and don't pose an undue risk to the insurance company. Needless to say, the older you get, the more health problems tend to crop up, and the insurance companies may exclude coverage for specific issues.

For example, if you don't have problems when you are examined, but you injure your dominant hand, they will probably cover it. If, however, you have arthritis in that hand and then apply for insurance, the insurance companies may add a rider excluding coverage for problems with that hand.

Disability insurance is based on income, so when dentists start working and income is lower, they don't need as much coverage. I got a policy through the American Dental Association that allows an increase as my income goes up. There's a window of time every six months when I can review my policy and increase the amount. In the past, I missed a couple of opportunities to increase my benefits because at the time I didn't think it was critical.

I wasn't as oblivious as I might have been, however. Five years before the brain tumor, I had a wake-up call. One night I slipped in freezing rain and broke my left arm. While I was in the emergency room, I reevaluated a couple of things. I had been considering setting up a solo practice or joining with a partner, and that night I decided to make the partnership happen. Because of my broken arm, I realized it was a good idea to have backup plan, such as a dental partner. I also realized how much I needed a good disability policy. In hindsight, I'm really grateful that I broke my arm.

PRACTICE OVERHEAD INSURANCE

Another type of insurance to consider is business overhead insurance. At the time of my diagnosis my partner and I had recently started our practice, so when I was out of commission, he was able to take over my workload without missing a beat. However, in a sole practitioner's case, it wouldn't be so easy.

I wasn't able to practice dentistry for three months, and then I started with simple things, like doing a filling for a friend, and ramped up slowly. Six months after surgery, I finally had a regular patient schedule again.

5 WAYS TO PREPARE FOR THE UNEXPECTED

1. ***Have as much insurance as you can afford (life, disability, practice overhead).***
2. ***Have systems in place with your team.***
3. ***Establish a network with local dentists.***
4. ***Evaluate your priorities before you're forced to.***
5. ***Have goals or a larger purpose outside of your professional aspirations.***

(Above) Dr. Richins and his family in 2018.

Without a partner or insurance, I would have been forced to sell my practice. If only one dentist brings in revenue and he or she can't practice, the money stops coming in completely—but your bills don't.

Business overhead insurance can cover your lease, utilities, loan payments, taxes, and even your payroll, which is critical because your team members' bills don't stop either. And if they can't get paid, they're going to find other jobs.

HAVING SYSTEMS IN PLACE

The importance of having systems in place is easiest to explain if you think about it in terms of wanting to franchise your practice. To do so, you need employee handbooks with descriptions of each position and clarifications of office policies. For example, if a team member has a relative come in, what do you charge? With a handbook, you have a resource to refer back to, rather than trying to remember or decide in the moment.

I also recommend describing in detail the segregation of duties. The office manager is in charge of X, Y, and Z; the front office team member is in charge of A, B, and C. It's also important to have redundancy, so that if a team member gets hurt or has to take time off, his or her duties can be covered.

We have found it particularly helpful to have redundancy on the financial side of the practice. Business owners often worry about embezzlement, but more common than that is simple mistakes or clerical errors. Having more than one person reviewing the accounts cuts down on the risk of both mistakes and anything nefarious.

Again, prepare for the worst: if something happens to the financial coordinator, and no one else knows the ins and outs of that side of your business, you'll have more problems than you would if you had some redundancy in place.

ERGONOMICS

Another important system deals with the desired procedures for the clinical team. Before my tumor, I had certain preferences in terms of how the instruments were set up and handed to me, but it didn't do me any harm if I had to twist or bend to get something.

After my surgery, it was imperative that the ergonomics be correct. I went through a lot of physical therapy to strengthen my muscles and to ease neck and shoulder pain, so I couldn't afford to exacerbate the problems.

> If only one dentist is bringing in revenue and he or she can't practice, the money stops coming in completely——but your bills don't.

When I returned from surgery, I realized that I had poor chairside positioning, with my left leg out in no-man's land, for example. I had to position myself better, which required me to get comfortable asking for help and setting expectations. Now I proactively communicate how things should be laid out and handed to me, and if needed, I can offer a gentle correction to a team member. I had to adjust certain procedures so that we could continue to offer quality care to our patients without doing further damage to my body.

(continued on page 42)

A Team Effort

Noninvasive Soft Tissue Advancement in Conjunction with Aesthetic Dentistry.

Treating Gingival Recession

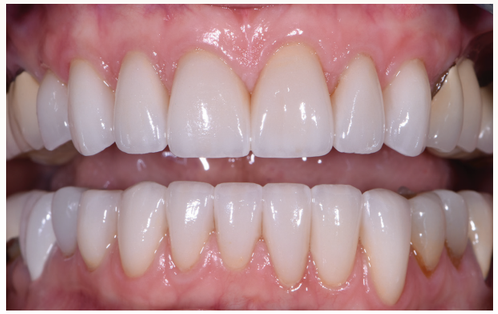
by John K. Zalesky, D.M.D., M.B.S.

Over the past couple years, several patients have asked me how they developed gingival recession and how it can be treated. Gingival recession can have a number of etiologies. It can be triggered by periodontal disease, which may stem from a patient's lack of home care.

Patients can also get gingival recession from overzealous brushing—applying too much pressure in an effort to get cleaner teeth, but aggravating the gingiva instead. In women, hormonal shifts can cause gingival recession at different times of life.

Over the past couple years, several patients have asked me how their gingival recession can be treated. Gingival recession can have a number of etiologies.

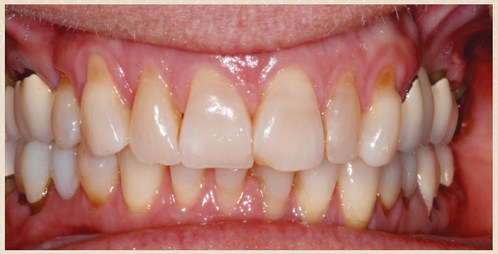
One of the most common causes of gingival recession is grinding and clenching, which many people do at night without being aware of it. Grinding places pressure on the teeth and can cause the gingiva to recede. Malaligned teeth can contribute to gingival recession as a result of bony architecture. Because the gingiva follows the bone, bone with irregularities will also result in irregular gingiva.



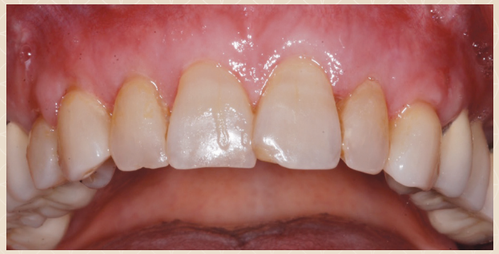
(Above) Retracted view after pinhole surgery and anterior restoration on uppers and lowers.

Traditionally, dentists treat gingival recession with a free gingival graft. The dentist makes an incision on the area of the mouth where the recession exists. A graft from the palate is then transferred to the recessed site, and the tissue is re-approximated back together with sutures. Because there are two surgical sites and sutures, it's a painful procedure for the patient. Everyone heals a little differently, but recovery normally takes anywhere from three to six months.

Also, because the graft tissue comes from a different site of the mouth, the color and texture of the tissue is often not aesthetically pleasing. Some patients get bumps and irregularities in the gingiva at the surgical site and aren't happy with the results.



(Above) Before pinhole surgery. Retracted view.



(Above) One week post-operative surgery. Retracted view.

Another treatment option is to fill recessed areas with composite to eliminate the yellow hue from the root where the gingiva has receded. While this option helps with aesthetics, it does not really address the underlying problem. The gingiva may continue to recede, and the use of composite may make the teeth appear longer.

A DIFFERENT METHOD

A periodontist colleague introduced me to the Chao Pinhole® Surgical Technique. It's a scalpel free, suture free, graft free, minimally invasive procedure that corrects gingival recession.

John Chao, D.D.S., M.A.G.D., from Alhambra, CA, invented and patented the instruments to use in the technique. He teaches a course to train and certify dentists on the procedure. I attended the course in August 2017. It was an intensive, two-day course packed full of instruction and hands-on training.

During those two days, dentists learned first from a lecture, followed by practicing the technique on typodonts and then pig jaws. Finally, we practiced on a cadaver. Dr. Chao gave each student a case and I completed a full upper and lower arch. On my own time, I returned to the classroom and put in extra time to practice another arch.

This session included five doctors, so we all benefitted from one-on-one time with Dr. Chao. I was thankful that he took extra time to sit chairside with me to go through a case.

The Pinhole® Surgical Technique is a highly technical procedure, but it requires less time to complete than traditional techniques.

While the Pinhole® Surgical Technique is a highly technical procedure, it requires less time to complete than traditional techniques and relatively minimal overhead. Upon completion of the course, I was able to implement the technique in our practice immediately.

PINHOLE® SURGICAL TECHNIQUE

To perform the procedure, a dentist uses a needle to make a small hole apical to the area that has the recession. All the work is then done through this pinhole. The dentist uses Dr. Chao's patented instruments to loosen the gingiva from the bone. Once the gingiva is loosened, the dentist gently glides it over the receded area. There is no cutting or stitching involved. Patients have very minimal post-operative pain, swelling, and bleeding.

Although the Pinhole® Surgical Technique is a minimally invasive process, post-op instructions are very rigorous. The patient must carefully follow instructions or risk reversing the procedure. Major restrictions include: the patient can't brush, floss, or even use a Waterpik® for six weeks. Patients must be as gentle as possible with the gingiva for it to heal properly.

During the initial post-op visits, I want to see as much plaque as there can be in this area, because then I know that the patient is following the post-op instructions.

In addition to hygiene instructions, the patient has to follow a soft diet protocol, since biting into certain foods could disturb the recovering tissue. Candy, gum, sticky, or crunchy foods are off-limits. Drinks should be lukewarm—the patient shouldn't drink anything hot, such as soup, coffee, or tea. During that time, patients should also abstain from drinking alcohol and smoking.

If patients have a history of clenching and grinding, it is important to either dial in their orthotic or fabricate one for them to use during the recovery period. Patients with sleep apnea can't use a CPAP device during recovery. The goal is for patients to leave the site alone to allow the tissue to integrate and heal.

Following the procedure, the patient has post-op appointments after one day, one week, one month, three months, and six months. During the initial post-op visits, I want to see as much plaque as possible in this area, because then I know that the patient is compliant with post-op instructions. I often use a plaque-disclosing tablet to show the patient that they are doing a good job. After the first six weeks, patients can brush with a soft toothbrush.

BENEFITS

The pinhole technique is beneficial because dentists can correct gingival recession in as little as one treatment session, ›

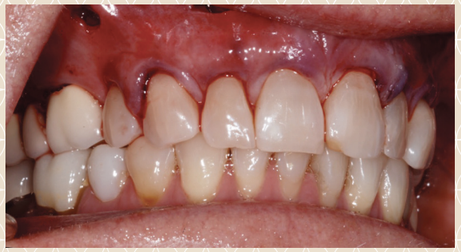
depending on the extent of recession. Patients experience minimal discomfort and swelling, because there is no cutting or suturing. Treatment sessions normally last between one and two hours, depending on how many teeth need to be done.

Dr. Chao conducted long-term studies demonstrating the procedure's effectiveness before introducing it to the public. The pinholes that are made during the procedure heal within about 24 hours. Most patients end up taking two Advil® and don't require any narcotic pain medication.

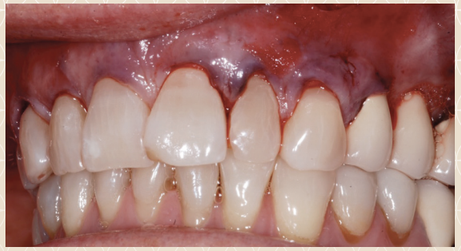
THE CASE

Since taking the course, I've completed four cases using the Pinhole® Surgical Technique. The first one was for Abby (not her real name), a long-time patient of our practice.

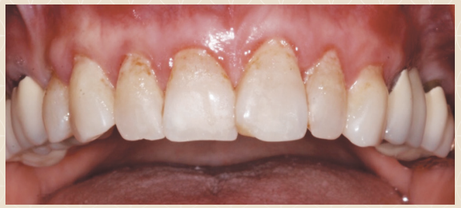
She had significant anterior recession on her upper arch and had been dealing with it for quite some time. She also had some bite issues (which Dr. Downs addresses later in this story). Abby finally decided to do something about both her receding gingiva and her bite issues.



(Above) Retracted right view, immediate post-surgery.



(Above) Retracted left view, immediate post-surgery.



(Above) Retracted view of uppers, one month post-surgery.

Dr. Downs had talked to her about veneers and correcting her bite, but indicated to her that she first needed to restore some gingival tissue so that her teeth did not look as long incisogingivally when she smiled. He suggested that she undergo the pinhole technique, so I had a consultation with her to discuss the process.

> She was skeptical at first, especially when I told her that she couldn't brush her teeth or floss for six weeks after treatment.

We discussed the pros and cons of traditional grafting as opposed to this procedure. She was skeptical at first, especially when I told her that she couldn't brush her teeth or floss for six weeks after treatment. I made it clear that we would have to wait six months after the pinhole treatment to proceed with restorative treatment. It was not a quick fix.

As dentists, we want the outcome to be aesthetically satisfactory. Patients are typically concerned with the intensity and duration of the post-op pain, whether there is bleeding, and whether they will be satisfied with the overall outcome.

I emphasized that this procedure has been deemed a predictable, effective, minimally invasive, time- and cost-effective alternative to a free connective tissue graft, in both the short and long term. Together, Abby and I decided to move forward.

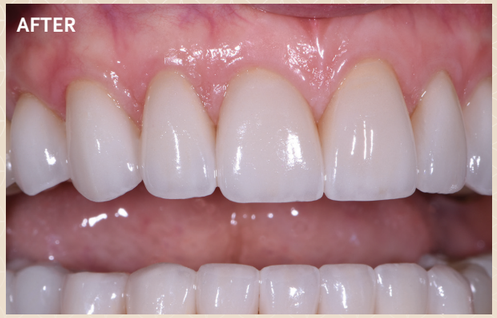
TREATMENT DAY

On the day of treatment, we proceeded carefully and systematically with the technique. Abby had recession that ranged from about two to four and a half millimeters across her maxillary anterior, from tooth numbers 5 through 12.

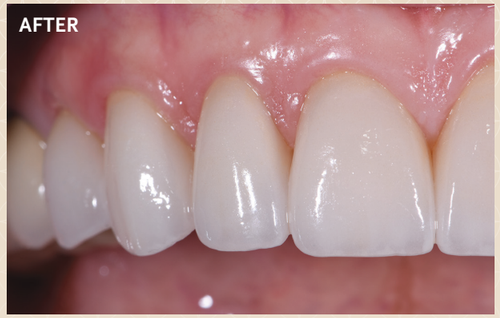
With the pinhole technique, to treat one tooth, you have to go two teeth and three papilla in each direction from the tooth you are working on in order to get a full release of the tissue for the desired coverage. Since we were treating tooth numbers 5 through 12, we ended up doing the entire maxillary arch to get full release of tissue.

The following are steps we took during the treatment:

1. On the day of the procedure, I anesthetized the areas we would be working on.
2. After she was numb, I made four pinholes on tooth number 4, tooth number 7, tooth number 10, and tooth number 13.
3. Using the instruments and the protocol, I achieved full release of the tissue across the entire maxillary arch on the buccal surface from an apical to a coronal direction.
4. I was then able to pull her gingiva about halfway down, covering half of her teeth. (You want as much coverage of the teeth as possible, so that when you're done, the patient looks like they have an extremely "gummy" smile.)
5. After this full release, I placed collagen in the pinhole in each of the papillas first, and then over the zenith of each tooth.
6. I packed the collagen in, so the gingiva looked very puffy and bulbous, and the patient had to sit with cotton rolls in for about 10 minutes to let everything settle.



(Above) Right retracted view.



(Above) Right retracted view, closeup.

And with that, Abby's procedure was completed. The entire process took 1 hour and 15 minutes. Immediately after we finished, Abby was surprised that she wasn't in much discomfort. When I made my post-op call that night, she said her gingiva felt mildly "agitated," but she didn't have any pain or discomfort.

> When Abby presented for her six-month appointment, Dr. Downs took over and started with the restorative work. He was pleased with how good everything looked.

When she came in the next day, everything looked like it was healing well. She mentioned that her gingiva felt a little tight, which was due to the packed collagen. She also said that it felt different when she smiled, which was because the musculature of her lips was affected when we released the tissue underneath. She ended up with great coverage on her gingiva. Her recovery went smoothly, and she followed the post-op procedures perfectly.

> On the day of treatment, we proceeded carefully and systematically with the technique.

When Abby presented for her six-month appointment, Dr. Downs took over and started with the restorative work. He was pleased with how good everything looked. Without this procedure, Abby would have had very long veneers, which would not have fit her facial profile, and which would neither have been symmetrical nor aesthetically pleasing.

This case is definitely not something I do every day, but the gratification I've gotten from training in the procedure and successfully performing it with Abby has been tremendous. Although skeptical at first, she too is very happy with the results.

The Pinhole® Surgical Technique can be a valuable extra tool in a dentist's back pocket that offers a patient concerned with gingival recession a nearly painless alternative to traditional gingival grafts.

Anterior Restoration

by Jim Downs, D.M.D.

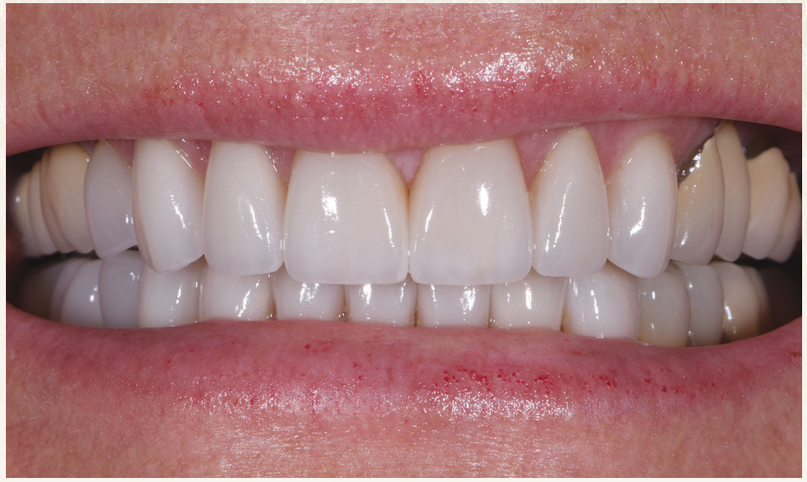
When Abby first presented at our office, the main goal was to treat the symptoms she was having. Her chief complaint was headaches and her bite not feeling "right." Patients often think they are suffering from temporomandibular joint dysfunction (TMJ), but most of the time their symptoms are caused by muscle issues that relate to how the teeth come together. Typically, the teeth aren't meeting in a way that supports the muscles.

> I used a diagnostic White Wax-Up to create a mockup of what the restoration would look like, and she was pleased with the direction of the treatment.

For such patients, it's important to eliminate the dysfunction and the pain as soon as possible. Because Abby's teeth had worn down, her muscles were foreshortened. This was the cause of her headaches and muscle dysfunction—her muscles would spasm. Additionally, her gingiva had receded quite aggressively.

Abby underwent splint therapy to re-establish the proper physiologic rest position for her muscles. Initially, we addressed the proper vertical dimension for her bite. Using that measurement, we created an orthotic that supported her muscles. This alleviated her pain, but she had to wear the orthotic continuously to be effective. ›

Our next step was to address the underlying issues so that her bite could be restored, giving her the dynamic necessary for her occlusion to support her musculature, preventing her headaches and also hopefully improving her sleep. After the restoration was complete, she would only need an orthotic at night to protect the restorations.



(Above) Full mouth closeup.

RESTORATION

It was important to address Abby's gingival recession first. Once the gingiva had healed sufficiently, we moved forward with completing Abby's anterior restoration on her uppers and lowers. I used a diagnostic White Wax-Up to create a mock-up of what the restoration would look like and she was pleased with the direction of the treatment.

On prep day, the patient arrived and we went through a series of steps to prep each tooth. We followed a protocol that I teach in the Full Arch Reconstruction course with the Dr. Dick Barnes Group. The protocol makes it possible for same-day large case treatment.

After the prep day, communication with the lab became critical. We communicated back and forth with the lab, making small alterations or corrections, then the lead technicians fabricated the final restorations.

For Abby, we prepped and temporized everything on the same day. She was in the temporaries for four weeks. At that time, we gave her a protective nocturnal orthotic, which she wears nightly to protect her teeth and gingiva.

After the prep day, communication with the lab became critical. The lab needed to know the desired color, shape, and size. We communicated back and forth with the lab, making small alterations or corrections, then the lead technicians fabricated the final restorations.

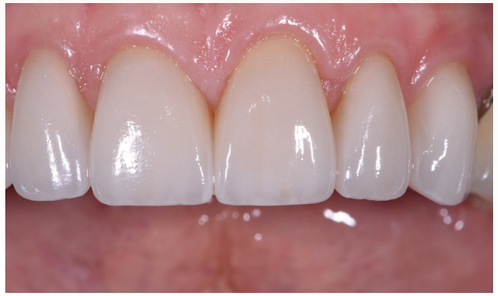
The next step was the insert appointment, which involved placing all the restorations, getting approval from the patient before cementation, and then following that checklist of how the restorations have to be placed.

SUCCESS

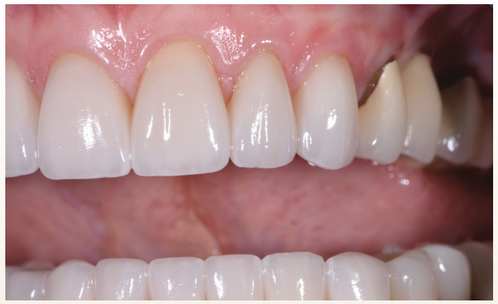
The after pictures show the outstanding results from the Pinhole® Surgical Technique and how the gingiva has matured.

The results were absolutely stellar. Grafted sites often have color differentiations, meaning the gingiva looks pink in some areas and has white patches in others. Abby's gingiva looks uniform and healthy.

The availability of the Pinhole® Surgical Technique has improved case acceptance for our patients who need gingival grafts. A lot of people understandably dread going through the pain and discomfort of a gingival graft. Decreasing the postoperative pain and the complications with traditional gingival grafting surgery has given us a new way to help improve our patients' overall dental health. It's more palatable, no pun intended. It's a really big improvement. Who wouldn't want a less painful procedure?



(Above) Retracted closeup.



(Above) Retracted left view.

Keep in mind, that even with the advanced technique, it's not an instant makeover. It takes time and patience from both the doctor and the patient to wait until you have confirmation that the gingiva has accepted that position and will stay in that position.

I'm really proud of Dr. Zalesky because he worked hard to learn the technique and our patients will benefit from his expertise.

If you asked Abby her favorite part of the whole procedure, she says not having headaches anymore and having a beautiful smile. The success of this procedure is unmatched from anything else we've seen in the area of gingival surgery. ■

After the prep day, communication with the lab became critical. We communicated back and forth with the lab, making small alterations or corrections, then the lead technicians fabricated the final restorations.

The after pictures show the outstanding results from the Pinhole® Surgical Technique and how the gingiva has matured.

Dr. Jim Downs received a D.M.D. degree at Tufts University School of Dental Medicine in Boston, MA. He is an expert in comprehensive restorative treatment and has completed numerous full mouth reconstruction cases. He maintains an aesthetic, family-oriented practice in Denver, CO. Dr. Downs is an instructor for several continuing education courses with the Dr. Dick Barnes Group seminars, including Implant EZ, Full Arch Reconstruction, and more.

Dr. John K. Zalesky received a Masters of Biomedical Science from the University of Medicine and Dentistry of New Jersey. He then received a D.M.D. degree from Nova Southeastern University College of Dental Medicine in Fort Lauderdale, FL. He completed a general practice residency at Denver Health Medical Center in Colorado, and he completed a second year as Chief Resident at University of Colorado School of Dental Medicine. He is a Clinical Assistant Professor in the Department of Surgical Dentistry at the Colorado University School of Dental Medicine. He is also the associate dentist at LêDowns Dentistry in Denver, CO.

Membership Has Benefits

Create and Grow a Successful In-House Membership Program.

Most dental practices would jump at the opportunity to reduce dependence on PPOs and build a loyal patient base. It can be done! The best way to do both is by utilizing an in-house dental membership program. It is a business model that can transform dental practices. An in-house membership plan also provides a recurring revenue cycle—which makes any business run more smoothly.

A dental membership program is an alternative to dental insurance that is managed by your practice.

For seven years I managed my father's dental laboratory. During that time, I saw a myriad of issues that many dental teams struggle with. I couldn't help but notice one universal issue: unpredictable cash flow cycles.

Some months, dental practices would collect more funds than ever before, but the following month would be a different story. Such unpredictability can cause stress, anxiety, and old-fashioned burnout for any business or practice owner.

What's more, I noticed that too often, practices were dealing with the "red tape" of dental insurance and fighting insurance companies for payment in order to help their patients.

Imagine what would happen if your practice could reduce or even eliminate worrying about rejected claims, insurance verifications and delays, and cashflow unpredictability. For most dental practices, the idea is at least worth investigating.

MEMBERSHIP PROGRAMS

The U.S. Surgeon General estimates that over 108 million Americans lack dental insurance, with other sources estimating that more than 60 percent of the population is uninsured. By implementing a membership plan, dental practices can offer a means for uninsured patients to get the dental care they need.

An in-house membership plan can provide practices with a predictable, recurring revenue cycle—which makes any business run more smoothly.

A dental membership program is an alternative to dental insurance that is managed by your practice. To join, patients pay a monthly or yearly fee that covers certain benefits and provides a cost savings at your practice.

Your membership program is just that—yours. Your practice decides if a patient can sign up, what the fee is on a monthly or yearly basis, which benefits are included, and how much patients can save off full-priced treatments.

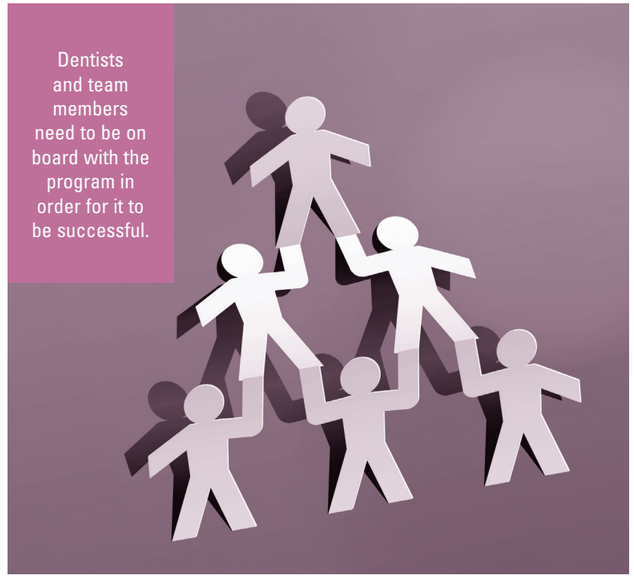
In a dental membership club, patients pay monthly or yearly fees to gain access to benefits at your practice. With no annual maximums, patients can get as much dentistry as they need—far different from an insurance company that stops paying out at $1,000 to $1,500 per year.

The practice wins because of recurring revenue, patient loyalty, and increased case acceptance. The patient wins by actually getting the needed treatment and saving money. It's a win-win strategy.

Main benefits of in-house dental membership programs include:

- **Reducing dependence on PPOs**
- **Creating patient loyalty**
- **Generating predictable recurring revenue (if it is not predictable and automatic, it is not a true membership program)**
- **Attracting more patients**
- **Encouraging wider case acceptance**

It's important to understand how to ensure a membership program's success. Here's what I recommend:



1. CREATE A SIMPLE PLAN

Some practices get so excited about a membership program that they create multiple plans with different benefits and price points. *Don't do this.* If you plan to enroll hundreds or even thousands of patients, make your plan super simple. A variety

The practice wins because of recurring revenue, patient loyalty, and increased case acceptance. The patient wins by actually getting the needed treatment and saving money. It's a win-win strategy.

of complicated plans will be challenging for your staff—both to understand and to educate your patients about. A complicated plan could result in fewer patients enrolling. I always recommend starting out with one or two simple plans that look like this:

Monthly: $30 per patient (additional family members can join for $25 month)

Yearly: $300 per patient (additional family members can join for $250 year)*

**price may vary based on your city/state*

You can give discounts for family memberships but I don't recommend excessive volume discounts.

The benefits included in the membership program can vary. Some examples include:

- **1 comprehensive exam**
- **1 Pano or FMX**
- **1 annual exam**
- **1 emergency exam**
- **2 cleanings** ›

- **2 oral cancer screenings**
- **2 fluoride treatments**
- **4 bitewing X-rays**
- **20 percent cost savings on oral surgery/extractions, fillings/core build-ups, scaling, and root planing**
- **15 percent cost savings on root canals, crowns, veneers, and implants**

I recommend the plan outlined above as a first-time in-house membership program. Remember, it is not considered a membership program if it does not offer predictability through automated membership payments.

Most practices think they have a membership program because a patient pays his yearly dues up front in cash, but that means there's no system in place for auto renewals and collection. Instead of an annual membership program, they've created a cash system, which does not offer the same benefits.

2. MAKE THE SYSTEM SCALABLE

Systems are essential for any business. Systems hold the team accountable for their responsibilities, offer predictability, help the business track its successes, and make it easier to train new team members.

"What you do in your model is not nearly as important as doing what you do the same way, each and every time."
— Michael Gerber, author of *The E-Myth Revisited: Why Most Small Businesses Don't Work and What to Do About It*

An organized system is a scalable one. I once worked with a practice enjoying a growing in-house membership program for which they used sticky notes to remind them when to run patient credit cards for payment. *(Note: saving payment information on a piece of paper is against Payment Card Industry compliance and can cost your practice tens of thousands of dollars in fees.)* The office manager lost one of the sticky notes and stopped billing the customer for the program, which is detrimental to the program and the practice.

The system should handle different size and service level changes almost instantly.

Michael Gerber, author of *The E-Myth Revisited: Why Most Small Businesses Don't Work and What to Do About It*, said, "What you do in your model is not nearly as important as doing what you do the same way, each and every time."

SCALABILITY

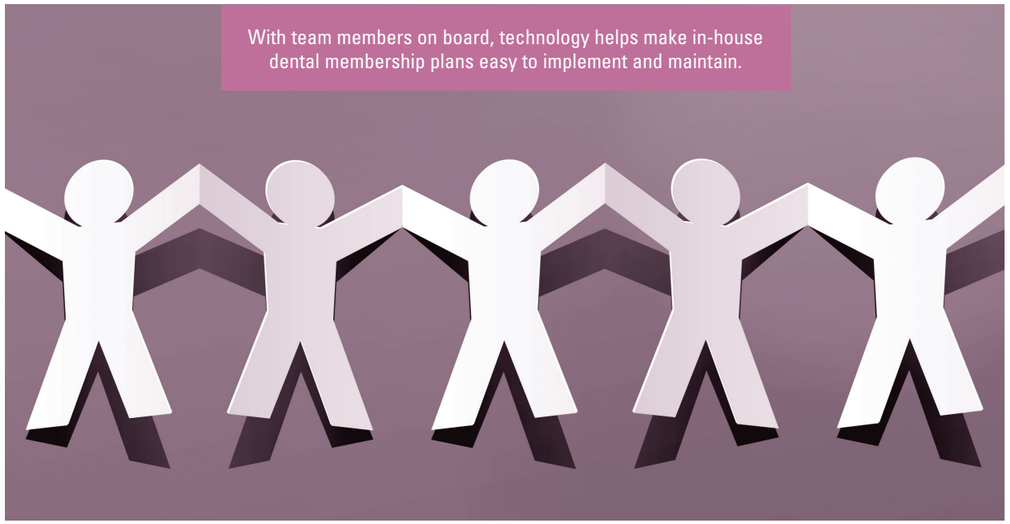
Businessdictionary.com describes a scalable system as one that is "designed to handle proportionally very small to very large usage and service levels almost instantly, and with no significant drop in cost effectiveness, functionality, performance, or reliability." Scalable systems almost always employ software technologies.

Do you think a sticky note system, Google docs system, or even a paper binder system is scalable? Dental membership software is available to help dentists and their teams manage such programs. The software handles recurring credit card data privately and securely and makes program metrics easily accessible for team members. By using software, in-house membership plans are much more scalable.

DENTAL MEMBERSHIP PROGRAM BENEFITS

- ***Reducing dependence on PPOs***
- ***Creating patient loyalty***
- ***Generating predictable recurring revenue (if it is not predictable and automatic, it is not a true membership program)***
- ***Attracting more patients***
- ***Encouraging wider case acceptance***

With team members on board, technology helps make in-house dental membership plans easy to implement and maintain.



3. KNOW YOUR METRICS

There's not enough time in the day for dental teams to manually manage the membership program sign-ups or the monthly/yearly recurring revenue the program is generating.

In general, if you can measure something, you can improve it. Metrics are critical for growth.

If you already have an existing program, make sure you can easily report your monthly-generated revenue. Ask yourself, "Can I easily access the number of active members that my practice has signed up?" In general, if you can measure something, you can improve it. Metrics are critical for growth.

Some important membership plan metrics include:

- **MRR (monthly-recurring revenue)**
- **ARR (annually-recurring revenue)**
- **Active patients**
- **Churn rate (cancellation rate)**
- **Total new patient enrollments (monthly)**
- **Online new patient enrollments (monthly)**
- **Lifetime value per member**
- **Refunds (monthly)**
- **Failed charges (monthly)**
- **Monthly enrollment goals**

4. GET YOUR ENTIRE TEAM ON BOARD

Dentists and team members need to be on board with the program in order for it to be successful. I have seen countless practices generate hundreds of thousands of dollars in predictable, recurring revenue because the team worked together to educate patients about the benefits of membership programs.

COMMITMENT STRATEGY

Every team needs a commitment strategy. Decide how much effort you are going to put into the program. Ask your team to set goals for how many patients you will speak to per day about the program. If you don't do both of these, you may fail before you begin.

ACCOUNTABILITY STRATEGY

As a practice owner, it is your responsibility to hold team members accountable for their responsibilities. If you decide that your team's goal is to sign up 30 patients per month, hold weekly or monthly meetings with whoever manages the program.

People tend to evaluate by comparison to accessible references rather than by using more correct, absolute values (as these aren't readily available for our brains to utilize), and this leads to biased judgments.

Ask specific questions such as: how many people did you talk to about our membership program? How many signed up this week or month? Dentists should create a predictable cadence for such meetings so that the team knows that you are conscious of the practice's goals and are eager to help fulfill them.

PRESENTATION STRATEGY

Presenting an in-house membership program to patients is an art, and it should be monitored. All dentists should read the book *Influence: The Psychology of Persuasion,* by Robert Cialdini, ›

which outlines the benefits of using the Contrast Principle. The book explores the way perceptions are formed with comparison techniques.

When people experience similar things in succession or simultaneously, they evaluate the lesser or greater value of the second through direct comparison with the first.

This contrast effect leads to an enhanced or diminished perception of the comparison. For example, when you first pick up a heavy box and then a second, lighter one, the second box will seem lighter than it really is.

The contrast is due to the fact that the brain evaluates things based on the mode of comparison that is most easily accessible at that given moment. In other words, people tend to evaluate by comparison to accessible references rather than by using more correct, absolute values (as these aren't readily available for the brain to utilize). Such comparisons can lead to biased judgments.

Knowing how to present an in-house membership program is essential to its growth.

In terms of dentistry, if an uninsured patient comes into your office needing a crown, after the exam, take them into a consultation room to discuss their financial options. Explain what the treatment fee would be if they were *not* part of the in-house membership program, and then explain what it would be if they joined the plan.

For example, if a crown costs $1,000 without any benefits, let the patient know that if he or she signs up for the in-house membership program, it will only cost them $800—plus they get all the additional benefits of the in-house membership program for a year.

Make sure the patient is told what the cost will be without membership in the plan *prior* to the discussion of the costs when using the plan's benefits. This is one of the best approaches when a patient needs a covered treatment. Knowing how to present an in-house membership program (and making sure team members know how to present it) is essential to its growth.

5. START WITH THE LOW-HANGING FRUIT

The easiest way to get traction on an in-house membership program is to start with your existing patient base. Most practice management software provides reports listing your patients who do not have dental insurance. That's a great place to start. Such patients may not be coming to your office on a regular basis and may assume they need benefits in order to receive dental care.

Reach out to those patients via text, email, or phone to gauge interest in your in-house membership program. This is the best way to generate early success.

6. THE VALUE OF EXTERNAL MARKETING

Once you get a solid list of existing patients signed up to your membership program, execute an external marketing strategy to keep the program from stagnating. There are so many marketing channels to choose from; pick one, and focus on making it successful.

You may want to consider getting help from a marketing agency if you do not have time to do the marketing yourself. Here are some channels that I recommend:

- **Facebook ads:** Target your local community and create ads that say something like: "Don't have dental insurance? No worries, we can help!"
- **Direct-mail marketing:** Target communities for adults ages 55 and older and send them a direct-mail message educating them on your membership program and how they can save by joining your program.
- **Ground marketing:** Appoint someone in your practice to go out and speak to small local businesses on the benefits of joining your program. Explain to them that it's just another benefit that their employees could receive for working at their company.

CONCLUSION

Dental membership programs can be a huge asset to your practice. Take advantage of the opportunity to give your patients more options than simply "insurance or no insurance." With the help of technology and by getting team members on board, in-house dental membership plans can be easy to implement and maintain. ■

Jordon Comstock is the founder and CEO of BoomCloud Apps, a software company that allows dental offices to easily create, organize, track, and automate an in-house membership program. To download a free e-book about membership programs, contact Jordon at jordon@boomcloud-apps.com.

Trading in for a New Model

Restoring the Smile of an Auto Shop Instructor.

Beau Nicoll, a mechanic and auto shop teacher, visited my dental practice in Logan, UT, after he married Jordan, one of my dental assistants. Jordan encouraged Beau to visit our office because Beau was self-conscious about his teeth and needed dental care. Jordan had encouraged Beau to take care of his dental issues, but she knew he didn't like dental work, so it took some persuading.

Because of his work, Beau had developed a bad habit of holding tools with his teeth while he was working on cars. Not surprisingly, the front teeth were a bit chipped.

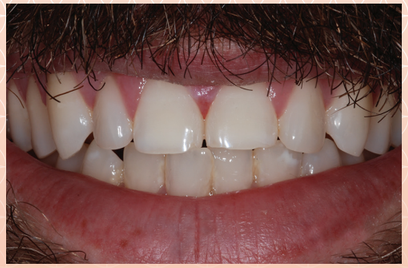
After performing a new patient examination, I noticed severe erosion on the lingual of all his upper teeth and also the occlusals of his molars. It looked like there was some reflux damage, and based on our conversation, it sounded like that might be a familial issue—with other family members suffering from the same affliction.

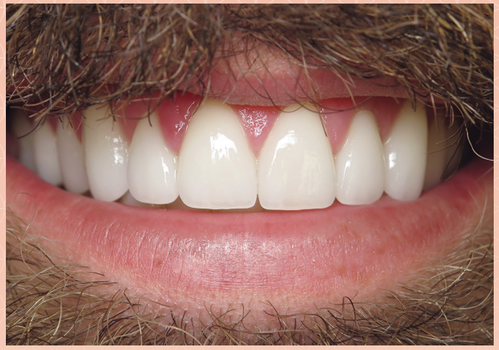
The erosion caused a lot of sensitivity from the dentin exposed on the posterior teeth. It also caused his anterior teeth to chip quite a bit. It wasn't noticeable to others, but all the incisors were very sharp. He had similar damage on some of the lower posteriors.

Beau also had issues with sleep apnea that he wasn't fully aware of. In addition, he had some slight crowding on the uppers, more jagged edges, some chips, and damage from the teeth being so thin.

Because of his work, Beau had developed a bad habit of holding some tools with his teeth while he was working on cars.

(At left) Before images—biting, and full face.





(At left) After images—biting, and full face.

Not surprisingly, the front teeth were a bit chipped. After the exam, Beau and I discussed the treatment options and talked about rebuilding his smile, starting with the upper arch and then, at some time in the future, restoring the lower arch.

Prior to our discussion, I had taken a series of courses from the Dr. Dick Barnes Group at Arrowhead Dental Laboratory in Sandy, UT, including the Full Arch Reconstruction course. I was interested in furthering my education by taking the Clinical Hands-On course from Dr. Jim Downs of LêDowns Dentistry, which was held at his dental practice in Colorado.

Dr. Downs reviewed the materials and agreed that Beau was an appropriate candidate, so we made plans to restore Beau's full upper arch.

I needed to bring a patient for the Hands-On course, so I asked Beau if he would be interested in being that patient. He agreed, and we took the necessary X-rays and impressions to confirm that Beau was a good candidate for the course. Dr. Downs reviewed the materials and agreed that Beau was an appropriate candidate, so we made plans to restore Beau's full upper arch.

In October 2017, Beau and I drove from Logan, UT to Denver, CO together to attend the course. Prior to treatment, Beau expressed some anxiety about the procedure, but we were able to talk him through it and make him as comfortable as possible.

Beau expressed his anxiety about receiving the dental treatment, but we were able to talk him through it and make him as comfortable as possible.

TISSUE CONTOURING

Before prepping and placing the temps, Beau needed some tissue contouring—mostly on his laterals and one of the centrals. I did that with a laser, which is my preferred method because it ablates cleanly and simply. CO2 lasers are particularly useful for soft tissue, so that is what I used on Beau. In my own office, I typically use an Erbium-YAG laser.

On prep day, while Beau was numb, I used the laser to probe his gingival tissue and ensure that we had an adequate zone of biologic width. I then ablated the lining along the gingival margin to widen that area. The goal was to make the gingiva more symmetrical and to perfect the gingival zenith.

HANDS-ON COURSE

I gave Beau some medicine to help him relax and then I prepped his upper teeth, following the protocol that I learned from Dr. Downs (leaving posterior stops, prepping the anterior teeth, and then realigning the bite). I didn't really need to open up his bite because, although he had lost a small amount of vertical dimension of occlusion, Beau still had a healthy Shimbashi. The plan was to rebuild the structure of the teeth and upper arch that had been lost due to erosion and damage.

1. Using the reduction guide, I prepped all of his teeth, with adequate reduction for the planned restorative material.
2. On his upper arch, I prepped twelve teeth, leaving his second molars untreated because there wasn't really any noticeable damage there. I prepped from first molar to first molar.
3. The biggest challenge was that his gums bled quite heavily. He was also a bit of a mouth breather, so I was careful around his gingival tissues to minimize bleeding.
4. I used a Sil-Tech® matrix that Arrowhead had worked up with a White Wax-Up to fabricate his provisionals using the "shrink wrap technique" that I learned from Dr. Downs. The result was beautiful.

After prepping and seating the temporaries, I emphasized to Beau the importance of a consistent home care routine during the interim between temporary and permanent restorations. ›

Good home care would ensure that his gum tissues stayed as healthy as possible. Fortunately, he was a very compliant patient.

PLACING THE TEMPS

After prepping his teeth and placing the temps, Beau was thrilled with his smile—especially once the numbness wore off. He was beaming and smiling because he was happy with the aesthetics of his new smile.

In Beau's case, having the diagnostic White Wax-Up was very helpful. It let me know where I was going in terms of the dentistry.

The next day, Beau returned to the office and we made a few minor adjustments using a T-Scan® to help remove any interferences. He wore temporaries for about a month. I gave him instructions to use his Waterpik®, mixing peroxide and water with a drop of soap to help keep the gums healthy. As noted earlier, he was diligent in using his Waterpik® and taking care of the temps.

In Beau's case, having the diagnostic White Wax-Up was very helpful. It let me know where I was going in terms of the dentistry. Even though I was not opening his vertical, Beau had plenty of erosion damage. The reduction guide helped identify a clear starting point so that I knew where I did and did not need to remove tooth structure. This way, I avoided doing more work to the teeth than was necessary.

SEATING THE RESTORATION

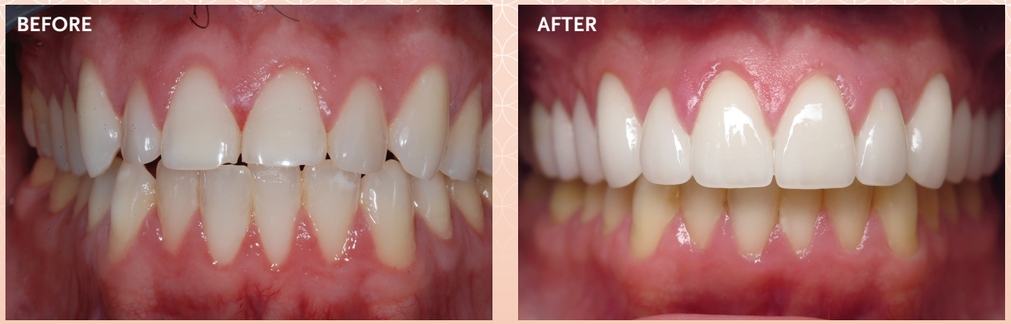
To deliver the permanent restorations, Beau and I returned to Denver for the second half of the Hands-On course. When I removed the temporaries, everything fit beautifully. I didn't really have to make any adjustments. I planned on cementing the permanent restorations with a warm shade because they were fairly bright, which is what he wanted. I was able to deliver the permanent restorations in one appointment, again following the protocol from Dr. Downs.

1. I tried the permanent restorations in first, to make sure everything fit.
2. I administered the numbing agent, and Beau said he didn't feel like he needed additional sedative medication.
3. I got the temps off, tried everything in, and then cemented it all with a couple of light adjustments afterwards.
4. On his anterior six, we placed Elite Empress crowns. The premolars were Elite E.max crowns, and the molars were zirconia.
5. He didn't have any trouble with bleeding until we cured and I was starting to get the extra cement out of the interproximals. Then the blood flowed like it usually does with him. But other than that, everything went smoothly, and nothing was too difficult or complicated.
6. The following day, we slightly adjusted the bite. There was a little bit of interference on the upper left on tooth number 12, so we made a minor adjustment.

After the permanent restorations were seated, Beau smiled continuously. I had never seen him smile so much. He remarked that he couldn't believe how nice the permanent restorations looked.

After the permanent restorations were seated, Beau smiled continuously. I had never seen him smile so much. He remarked that he couldn't believe how nice the permanent restorations looked. He was thrilled with the color, the shape, and everything about it.

We set an appointment for the following week at my office to check if he needed any additional refinements. We made a couple adjustments using the T-Scan® to help eliminate protrusive interference from his upper left canine with lateral excursive.



(Above) Before and after biting images.

Beau's case boosted my confidence in providing full arch restorations and gave me more insight into how life-changing dentistry can actually be.

We plan to restore the lower arch as soon as Beau is ready. Because of acid erosion on the lowers, we need to at least take care of his posteriors. Beau is currently considering whether to do his lower anteriors first and then his lower posteriors, or just do another full arch on his lowers.

REFLECTIONS

I haven't been doing full arch dentistry very long, and have done only five cases in the last three years—three of them since working on Beau's case. I had only done one full arch reconstruction before Beau, and that was about three years earlier.

Beau's case boosted my confidence in providing full arch restorations and gave me more insight into how life-changing dentistry can actually be. It is a satisfying feeling to contribute to someone's quality of life in such a positive way.

After seating the temporaries, Beau realized what a difference his new teeth would make, and he was beaming for hours.

The only true surprise was how much Beau loved his smile when we were done. After seating the temporaries, Beau realized what a difference his new teeth would make, and he was beaming for hours. Beau was thrilled that we were able to create a symmetrical, brighter, and more aesthetically-pleasing smile for him.

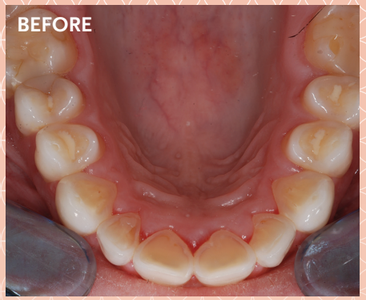
Working with Arrowhead Dental Lab to learn the process and have everything prepared ahead of time was surprisingly smooth. Case-planning with the lab and seeing everything beforehand on the models made increased my confidence for the appointment.

The reduction guide was very useful in preparing the teeth exactly like I wanted without too much or too little tooth being removed. The Sil-Tech® matrix made the provisional process simple and efficient.

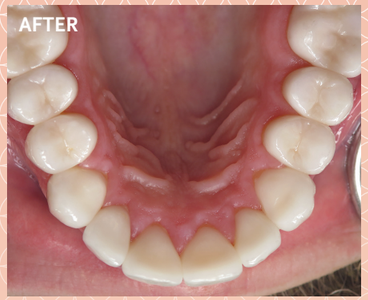
Full arch restorations shouldn't intimidate anyone who's willing to take the time to learn how to do multiple same-day restorations and plan ahead to prepare for success. The benefit to those patients who need it is truly amazing. ■

Dr. Blake Cameron received his D.D.S. degree from the Ohio State University College of Dentistry in 2012. He currently practices dentistry at Aspen Dental of Cache Valley in Logan, UT, where he provides a wide variety of dental services. His goal is to simplify dentistry for patients by providing a wide variety of services in one convenient location.

Since graduation, Dr. Cameron has received a Fellowship in the Academy of General Dentistry and the Academy of Laser Dentistry, as well as a Diplomate from the International Dental Implant Association. He currently chairs the continuing education committee for the Utah Academy of General Dentistry, where he shares his passion for learning with fellow dentists.



(Above) Maxillary arch.



(Above) Maxillary arch.

(Above) Left view, biting.

(Above) Left view, biting.

The Patient Perspective

by Beau Nicoll

As an auto shop instructor, most of my days are spent in a school full of teenage kids. One reason I grew a beard and mustache was that it covered my smile. It hid my teeth and my face really well, so no one really saw problems with my teeth.

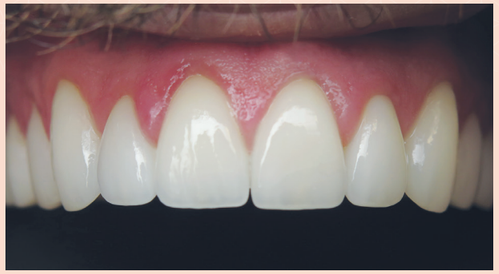
In the past, I had bad acid reflux, and the acid was wearing down my teeth pretty significantly. Occasionally, I also had toothaches and minor pains when I'd chew. My wife, Jordan, who is a dental assistant, encouraged me to start going to the dentist and getting regular cleanings and checkups. After visiting the dentist regularly, I learned that I had some extreme erosion happening on my teeth. Even after just six months, there were significant changes in my teeth.

After visiting the dentist regularly, I learned that I had some extreme erosion happening on my teeth.

Eventually, my teeth were painful every day. At that point, I was ready to do something serious. I visited with Dr. Cameron and we decided that a full arch reconstruction was my best option. He did a full upper arch reconstruction, minus the second molars.

The first appointment was on a Friday. I was in the dental chair for four or five hours. Most of the prep work was done in one sitting, and on Saturday the follow-up was quick—just a final touch-up to make sure I didn't have an extreme bite on one side or the other. Dr. Cameron also wanted to make sure I wasn't in any discomfort. That appointment only took about an hour. He adjusted the temporaries to make sure I had a decent bite and sent me home for a month.

At the seating appointment, I was again kind of surprised at how quickly he finished all the dental work. I assumed that seating a full upper arch was a really big thing and that I would be in the chair all day. When Dr. Cameron told me I was done, I thought, 'It's not even noon yet—we can't be done!'



(Above) Upper arch, after reconstruction.

As with the initial appointment, we didn't run into any problems during this visit. Everything went really fast for me, which was great because sitting in the dental chair is not exactly a fun experience. It was great to have it all done so quickly!

Afterwards, pretty much all of the pain I had been feeling in my mouth was gone. I've noticed that the sensitivity in my mouth has gone way down too. I have nice teeth now that I'm not embarrassed to show in front of people.

It was a real confidence boost for people to notice and compliment me on how nice my teeth looked.

When I returned to work, I had a bright white smile peeking through my mustache and beard. Lots of people at work noticed, as well as neighbors, friends, and family members. It was a real confidence boost for people to notice and compliment me on how nice my teeth looked.

Before getting my teeth done, I was nervous about the procedure, but now I'm very happy with the results. Everything went better than I expected. I knew that my teeth were going to be a big improvement, but the entire process exceeded my expectations. I could not be happier with my teeth. ■

Q&A: Communication for Implant Success

Strategic Planning for Implant Cases.

Ray LeGendre, part of Arrowhead Dental Laboratory's technical support team, recently talked with Aesthetic Dentistry *about communication between dental labs and dentists—particularly with regards to implant cases. Ray emphasized the importance of effective communication for the overall success of implant cases and gave several tips for doctors when submitting them. Here are highlights of that conversation:*

AD: HOW CAN EFFECTIVE COMMUNICATION WITH A DENTAL LAB CONTRIBUTE TO IMPLANT SUCCESS?

RL: To ensure that each implant case is successful, communication between the doctor and the dental laboratory is key. When the doctor makes plans for a case from the beginning with an overall case plan in mind, a more predictable result can be achieved.

With this article, my goal is to address a few items that are sometimes overlooked, forgotten, or otherwise not always considered when a doctor submits an implant case to a dental laboratory. A solid plan leaves little open to interpretation.

AD: WHAT DO YOU NEED FROM THE DOCTOR WHEN YOU RECEIVE A NEW IMPLANT CASE?

RL: The most important thing is to have the proper information. This includes six key pieces of information, which are:

1. **Aesthetic level of the restoration—Elite, Bella, or Traditional.**
2. **Crown material—E.max Press, Zir-MAX®, PFM, Zircrown.**
3. **Implant information—surgeon's report, X-rays.**
4. **Custom abutment milling—in-house options, abutment emergence.**
5. **Shade photos, stick bite, study model.**
6. **Case plan—future treatment that may impact the current plan.**

When a case arrives at the lab, the doctor can finalize all details with a member of the technical support team. This ensures that the case moves forward quickly and smoothly. When questions inevitably arise, technical support representatives are available to answer them—everything from questions about filling out the prescription to questions about full mouth reconstructions.

Years ago, only a few implant systems were on the market. Today, we work with numerous implant systems and we continually evolve and adapt to these new innovations. As technical support representatives at Arrowhead Dental Lab, our goal is to guide dentists through all the changes in the industry.

AD: IS ALL THE INFORMATION THAT YOU NEED LISTED ON THE PRESCRIPTION FORM?

RL: It is helpful if the prescription includes a few notes about the doctor's and patient's expectations. A section is provided on the prescription form for the doctor's case plan. That's a great place to put notes about the case, including any plans for future treatment.

Sometimes we receive cases in which the doctor is only planning on restoring the upper arch, but the dentition is broken down on the patient's lower arch. If we build the upper restorations based on a broken-down lower arch, then the opposing dentition can be problematic.

> When the doctor makes plans for a case from the beginning with an overall case plan in mind, a more predictable result can be achieved.

In each case, lab technicians ask what the plan is for the lower arch, because instead of a doctor placing restorations against opposing dentition, we can offer alternatives. Such alternatives may include a White Wax-Up, to show what's possible with a full mouth restoration.

If a patient needs to segment out treatment due to financial or other concerns, we can suggest Snowcaps (long-term Radica® temporaries) that a patient can wear for up to two years. That way, patients are set up for success.

AD: WHAT IS TYPICALLY MISSING WHEN DOCTORS SEND THEIR FORMS TO YOU?

RL: When a case is submitted, the items that are most often missing include photos, X-rays, brand of implant to be used, and size of the implant.

When we don't have all the information that we need, we call the doctor and ask him or her for it. We realize that some things may not be available, but the more complete the prescription, the smoother the process for both the doctor and the lab.

AD: CAN THE SURGEON'S REPORT BE ATTACHED TO THE PRESCRIPTION?

RL: Yes, a copy of the report is usually mailed with the prescription. This information will help identify the implant so we can

mill the correct abutment. Attaching a surgeon's report is helpful because it is information from the placing surgeon to the dentist. It outlines the results of the surgery and if the patient is ready for the implant.

It also includes implant information and any recommendations or concerns the surgeon may have. This is valuable information to keep in the patient's chart for future reference.

AD: WHAT ELSE CAN DOCTORS DO TO ENSURE THEIR CASE HAS THE BEST POSSIBLE OUTCOME?

RL: Today's dental practices are very busy and patients' expectations are high. A complete case plan will increase success and invite patient referrals.

AD: WHEN DOCTORS SUBMIT PHOTOS WITH A CASE, WHAT DO YOU RECOMMEND TO ENSURE THAT THE PHOTOS MEET YOUR SPECIFICATIONS?

RL: Taking photos correctly makes a big difference in the success of the case. The "Social Six" (tooth numbers 6 through 11) can be the most challenging (*for more information, see my story in* Aesthetic Dentistry *magazine, November 2015, "Q and A on the Social Six"*). Tooth characterization is unique to every patient due to hypo-calcification, striation marks, and halos. When we receive photos with shade tabs and proper lighting, it helps lab technicians achieve the requested shade. ›

INFORMATION CHECKLIST

- ☑ **Aesthetic level of the restoration—Elite, Bella, or Traditional.**
- ☑ **Crown material—E.max Press, Zir-MAX®, PFM, Zircrown.**
- ☑ **Implant information—surgeon's report, X-rays.**
- ☑ **Custom abutment milling—in-house options, abutment emergence.**
- ☑ **Shade photos, stick bite, study model.**
- ☑ **Case plan—future treatment that may impact the current plan.**

For example, if there is fluorescent lighting in the office, the shade tab may come across a little more yellow. Color-corrective lighting makes all the difference when taking a case photo. Predetermine an area in your office for photography. Send photos with the following angles: non-retracted, retracted, frontal, and lateral.

Focus on the specific tooth or shade tab you would like to match. Using a shade tab in the photos helps to compensate for the surrounding light in the dental office. When a crown shade needs to be adjusted, take a photo with the crown in place or at least next to a tooth the doctor is trying to match.

Photos can be used as a reference for horizontal plane. It is imperative that the patient is standing up with his or her head and shoulders leveled. I recommend having a Symmetrigraf® posture grid in the background or a solid horizontal reference.

If an office can designate one operatory to have proper lighting for photography, it can save a lot of time in capturing accurate shades for the restorations.

AD: WHEN YOU HAVE A LARGE CASE, WHAT ARE THE MOST IMPORTANT THINGS FOR DENTISTS TO COMMUNICATE?

RL: The first step is to take a great impression. When taking an impression, the phrase "quality in, quality out" is apropos. Good margins that are clear in the impression or scan lead to good results with the implant case.

We realize that some information is not available, but the more complete the prescription, the smoother the process for both the doctor and the lab.

The horizontal plane is also key. Mounting the models to the correct plane of occlusion is important because it determines long-centric, cant, curve of Spee/Wilson, etc. A facebow sent on a transfer table and or a stick bite helps with proper mounting. Most popular articulator brands offer a transfer table for lab use.

Impression copings or transfer copings are used for implant-level impressions. When the impression coping is placed chairside over the implant, tissue and bone must be evaluated to ensure a flush seat. It is important for the doctor to X-ray verify to make sure that the impression is not being held up by bone or surrounding tissue. When the impression coping is not fully seated, it can result in height differences and rotational discrepancies.

Using closed tray impression copings as the manufacturer suggests means not using it as an open tray. Depending on the system used, this can greatly affect the working model pour-up. Open tray impression copings are great for implants that are at a severe angle. They disengage at the interface facilitating a smooth removal of the impression tray. Taking the time to make sure an accurate impression of a correctly placed impression coping will be time well spent.

AD: WHAT ARE OTHER WAYS THE LAB CAN HELP DOCTORS WITH IMPLANT SUCCESS?

RL: At Arrowhead, we offer surgical guides for implant placement. If a doctor uses guided surgery to help place an implant, it becomes more predictable. A CBCT scan and models can start the process of planning for guided surgery. We work directly with doctors to help dial-in each case using TeamViewer screen-sharing software, so that doctors can easily see what's going on with their case.

Implant case success is a joint effort between the lab and doctor. The greater the communication, the greater the success.

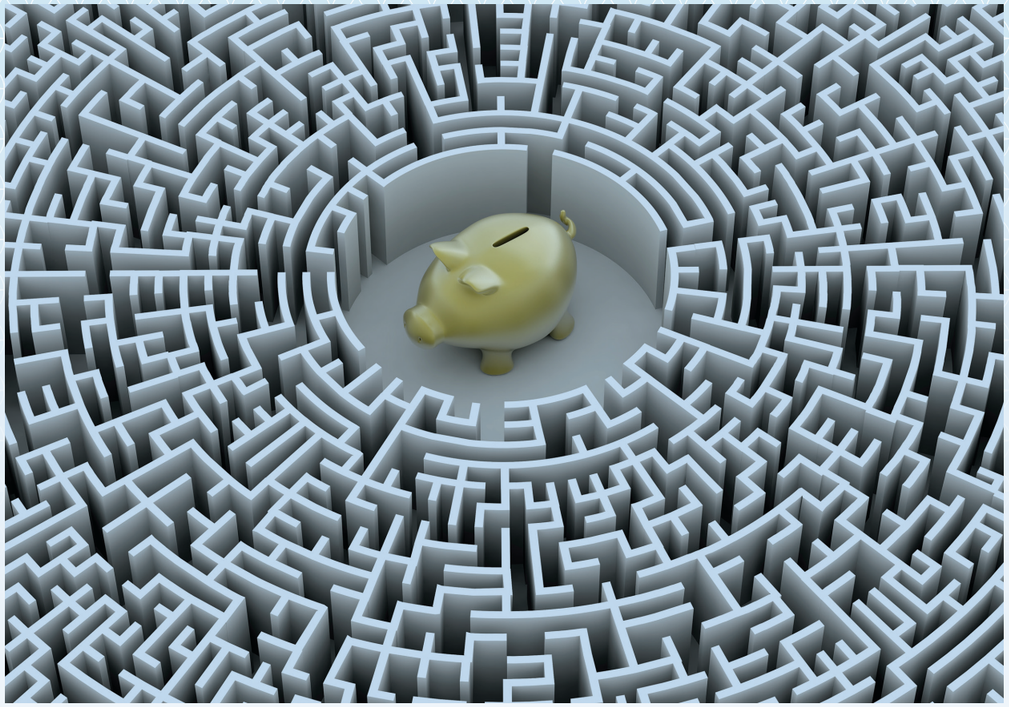
Additionally, doctors may not be aware of all the possibilities that the lab can create. For example, in-house abutments can be customized with a gold hue to add more warmth through the tissue in areas where the patient may have thin bio-type. When there's thin tissue, there's a tendency for the color of the titanium to shine through and cause a gray halo. When a gold hue is added to an abutment, it creates warmth through the tissue. It's just one of many possibilities!

Implant case success is a joint effort between the lab and doctor. The greater the communication, the greater the success. ■

Ray LeGendre has worked at Arrowhead Dental Lab for 10 years and is part of the implant team. Originally from New York City, NY, Ray has spent more than 25 years in the dental field. His experience includes orthodontics assisting, oral surgery assisting, and every phase of dental lab production. He enjoys spending time with his family, including biking and running. Ray said, "I have a passion for dentistry and enjoy seeing the change in people's lives. The newfound confidence in their eyes is inspiring."

Finding the Money

Part 1: Helping Patients Pay for Dental Treatment.



When a patient accepts the treatment that a doctor has recommended, it's an exciting time! It's exciting for the patient because he or she has caught the vision of improved dental health. It's exciting for the dentist because he or she has effectively communicated to the patient the importance of treatment. Soon, the dentist will be able to help the patient improve their dental aesthetics and/or function.

Instead of waiting until the day of treatment for payment, make all financial arrangements (whether cash or other methods) in advance of scheduling treatment. Always find the money first and then schedule patients for treatment.

Sometimes, patients and dental teams get caught up in the excitement of accepting treatment without realizing that the next step of finding the money is often challenging. Most dentists will tell you that it's rare to find a patient who accepts large cases and has unlimited financial resources to pay for it.

Why is finding the money the responsibility of the dental team? Isn't it the patient's responsibility? Of course, it's the patient's responsibility to pay for treatment. However, patients are not always aware of the many financial options that may be available to help.

Don't put your practice in the position of becoming the bank for the patient. Your practice should not take the financial risk if a patient can't come up with money for dental treatment. Instead, train your team members to help patients find ways to pay for treatment.

THINGS DO HAPPEN

Unexpected events are a part of everyday life. Sometimes it's a car that requires money for repairs. Sometimes a roof starts leaking and needs fixing. Sometimes it's the opportunity for a trip with a dear friend. Whatever the reason, things happen and when they do, patients either scale back on the treatment or they cancel altogether.

Years ago, when I was working for a dental office in Arkansas, we discovered that we could be proactive and help patients find money for treatment—even if they didn't think they could. And guess what happened after patients found the money? They didn't cancel their appointments!

Guess what happened after patients found the money? They didn't cancel their appointments!

Recently, I spoke with a financial coordinator in a dental office who told me that the doctor she works for had a big case that went off the schedule at the last minute. The first thing I asked was, "How was the patient paying for it?" If the patient was bringing in cash on the day of the appointment, he or she probably got buyer's remorse and changed their mind, or had a life's unexpected event happen. When that happens, the office will have up to three or four hours in a doctor's schedule to try and fill at the last minute.

Instead of waiting until the day of treatment for payment, make all financial arrangements (whether cash or other methods) in advance of scheduling treatment. Always find the money first and then schedule patients for treatment. That way, dental teams can count on patients showing up. Finding the money in advance of treatment is one of the best ways to stop "no-shows" in the schedule.

In the practice where I worked, after a patient had been diagnosed I would say, "I can tell you're so excited. If you'd like, we can take care of this today and then we can get all your appointments scheduled." I made this comment to everyone because I learned never to judge a patient's pocketbook.

CASH PAYMENTS

Cash payments are great but if financial coordinators wait to collect payment until the day of treatment, any number of unexpected life events can happen between the time a patient agrees to treatment and the day he or she shows up for the appointment.

Some dental practices ask about paying half down and half at completion. I don't recommend this strategy because things happen and when it comes time for completion, patients sometimes don't have the rest of the money. By that time, the practice has already incurred expenses such as salaries, supplies, utilities, and lab bills. That's one reason it's better to find the money before scheduling treatment.

ASSESS THE SITUATION

How do you know if your patients need help finding the money? The subject usually comes up after quoting the fee to the patient. Once a dentist outlines the clinical plan, it's best if he or she can quote the fee to the patient.

Don't put your practice in the position of becoming the bank for the patient. Your practice should not take the financial risk if a patient can't come up with money for dental treatment.

Dr. Dick Barnes always says, "Be firm in principle, flexible in procedure." Someone does have to quote the fee, but there's flexibility in who quotes it—whether it's the dentist or the financial coordinator.

Whoever quotes the fee should wait three seconds afterwards to let the patient absorb the information. Then, if he or she doesn't respond, the financial coordinator can follow up with the following scenario:

Financial Coordinator: "Did that surprise you?"

Patient: "Yes." ›

Financial Coordinator: "Help me understand . . . is it the treatment?"
Patient: "No, it's the money."
Financial Coordinator: "So that I understand you correctly, this is the treatment that you'd like to have if we can fit it into your budget. It is, isn't it?"
Patient: "Yes."

With the confirmation of a desire for treatment and a concern for finances, the financial coordinator can start to help the patient find the money.

Here's another secret to finding the money: do it while the patient is still in your office. Don't simply send the patient home with a brochure about CareCredit, LendingClub, or any other financing options or they probably won't follow through.

The next part of the conversation goes something like this:
Financial Coordinator: "Some companies that we work with offer no sign-up fees, no annual fees, interest-free money, and you pay no money down. You get to keep your cash. It has worked well for a lot of our patients. Perhaps this is something that you'd like too?"
Patient: "That sounds great."
Financial Coordinator: "Will you share with me what fits into your budget?" (the financial coordinator is trying to assess whatever monthly payment the patient can afford.)
Patient: "I think I can do two hundred dollars per month."
Financial Coordinator: "If you can afford two hundred, do you think you could stretch to two hundred and fifty dollars per month?"
Patient: "I think that would be okay."
Financial Coordinator: "Two great companies we use are CareCredit and Lending Club [healthcare financing organizations]. When using them, you get to keep your cash. You pay it out over time. In fact, you would not have to pay any money down and you would assume monthly payments."

At this point, I always brought out a repayment schedule from the lending company, and then I could see how much treatment patients could get. For example, if they paid $250 per month on interest-free money for a year, they could get $3,000 worth of treatment. If they financed payments for 36 months, it would no longer be interest-free, but they could get up to $7,500 worth of treatment for that same $250 per month payment.

If patients financed for 60 months, the payment would drop to $166 a month and they could get up to $10,000 worth of treatment. Furthermore, there's no pre-payment penalty for paying off the loan early.

After checking the repayment schedule and offering different scenarios to the patient, the financial coordinator then says:

Financial Coordinator: "If you've got just a few minutes, we'll get this taken care of and then we will get you scheduled."

MAKE IT EASY

Here's another secret to finding the money: do it while the patient is still in your office. Don't simply send patients home with a brochure about CareCredit, LendingClub, or any other financing options or they probably won't follow through. If financial coordinators help patients submit their applications for financing—whichever financing option they choose—it takes just a few minutes and then you can get them scheduled.

Years ago, CareCredit called and asked me what we were doing because our practice had a high patient approval rate. In fact, our practice was in the top 5 percent of approval ratings of any office in the United States. After I explained our process, they learned that there were two primary reasons for our success. First, we presented financing to the patients while they were in the office and helped them with the process.

Financial coordinators should never judge a patient based on their finances. Instead, it's important to offer alternatives that may work for patients in such circumstances.

Second, I developed relationships with patients, so they felt comfortable sharing their financial information with me. If for any reason a patient would probably not get approved for financing, he or she would tell me about it before I submitted their name for approval. I did not submit names for financing if the patient disclosed that he or she had poor credit. Hence, our approval rate went way up.

Sometimes financial coordinators hesitate to proceed with this financing option because they think their patients will not get approved. They use this as a last resort instead of a first resort. Financial coordinators should never judge a patient based on their finances. Instead, it's important to offer alternatives that may work for patients in such circumstances. When patients share their concerns about obtaining financing, here's a scenario that I suggest:

Patient: "Healthcare financing is probably not going to work for me. I don't have a good credit score."
Financial Coordinator: "Thank you for sharing that and for being honest with me. You obviously have a good reason. But still, is this the treatment you would like to have if we can find a way? It is, isn't it? So, let's do this. Would there possibly be anybody who could help you? Is there anyone who could co-sign with you?"
Patient: "Well I think my father-in-law might help."
Financial Coordinator: "Would you like me to call him? If you'd like we could call right now."
Patient: "Oh gosh, would you call him?"
Financial Coordinator: "Of course!"

One time, a young lady came into our dental practice and needed a root canal, a crown, and some other dental work. The dentist told me, "Tawana, this girl doesn't have any money. She doesn't even have a car. But it's important to get for her to get this dental treatment done and I want you to see if you can help find some money for her."

After I presented the financing options, the young woman said, "I don't have good credit." I asked her what amount of money fit into her budget and she responded, "fifty dollars." And just like in the previous scenario I said, "Is there anyone who can help you?" She replied, "My boyfriend's mother has offered to help me finance a car. She might be able to help. Would you call her?" I did, and the woman agreed.

Soon afterwards, the woman came by the practice with the money for treatment. She couldn't afford both the car and the dental treatment, so the young woman made the decision to get her teeth done. She realized the importance of keeping her teeth and chose her teeth over a car, even though it meant she had to walk everywhere in the cold and snow where she lived. Eventually, the young woman married her boyfriend and became part of the woman's family.

OTHER RESOURCES

Success with finding the money is much higher if financial coordinators can obtain financing while the patient is in the practice. However, patients occasionally go to their own credit union or another resource to obtain money for treatment.

I've also watched patients' circumstances change when they inherited money, postponed vacations, or sold personal items. I've seen all sorts of things happen. They've done such things because there was value created for the dentistry.

When a patient leaves the practice to find other financing resources, it's important to stress the urgency of the treatment for the patient. The following scenario is often useful:

Financial Coordinator: "So may I presume that you're excited about this recommended treatment [aesthetic]?" Or, "Do you see the urgency in getting treatment done [functional]?"
Patient: "Yes, I understand."
Financial Coordinator: "Could I presume that you're going to pursue those resources tomorrow? ›

Patient: "Yes"
Financial Coordinator: If so, what is a good time tomorrow afternoon for me to call you?"

I responded, "Well, let's see if we can find a way." And then I went through the scenarios to see if we could find some money to do all of the treatments together.

Sometimes, patients will say that they have to discuss it with a spouse or significant other before they make a decision. When that happens, the financial coordinator's next question would be:

Financial Coordinator: "Is it the treatment?"
Patient: "No, it's the money."
Financial Coordinator: "Could I presume that you're so excited, you're going to discuss this tonight? If so, what would be a good time tomorrow for me to call you?"

After each conversation, I literally made an appointment card and called the patient at the appointed time. *Never, never tell patients, "Oh just get back to me when you can."* I was proactive because I understood the recommended treatment for the patient. I knew it was either was something that he or she really wanted, or it was something important because he or she was in pain. Either way, getting treatment done was a priority.

TIME IS MONEY

Another time, a patient in our practice was given a diagnosis for four crowns. The patient said to me, "I know the doctor recommended four crowns, but I can only afford to do one right now."

It's important never to argue with patients. So instead of arguing, I just looked puzzled and said, "Okay." Then I continued with, "I know that your time off work is important to you and a big consideration. If we single out the work, it's going to take eight appointments to prep and seat each crown. However, if we could find a way to get everything done at the same time, you would only have two appointments."

TAWANA'S TIPS

1. **Don't put the dental practice in the position of being the bank.**
2. **Be firm in principle, flexible in procedure.**
3. **Find money in advance of treatment.**
4. **Never judge a patient's pocketbook.**
5. **Help patients with financial applications while they are at the dental practice.**
6. **Make appointments to follow up with patients regarding financing.**
7. **Always leave patients with hope.**

The patient said to me, "Yes, but I don't have that money." And I responded, "Well, let's see if we can find a way." And then I went through the scenarios to see if we could find some money for him to do all of the treatments together.

By doing multiple crowns at once, I have seen practices double and sometimes triple their per-hour production. Combining treatments together saves chairside time for practices and patients.

ALWAYS HAVE HOPE

Occasionally, despite everyone's best efforts, it's sometimes impossible to find money for treatment. The patient can't get money or financing on their own or through healthcare financing, and they don't have a friend or relative who can help them. It's agony!

In those circumstances, I would look at the patient with endearment and say,

Financial Coordinator: "You know Bob, none of these financing options *so far* have worked out for you. One last time, I want to ask you this question for my own understanding—if we could have worked this out, this is still the treatment you'd like to have. It is, isn't?"
Patient: "Yes it is, but as you see, right now I'm having everything in the world happening to me, and I cannot do anything."
Financial Coordinator: "Well Bob, please be patient with us. We will get there."

And then I would say, "It's kind of like going from Fort Smith, Arkansas to New York City. Sometimes we go on a jet airplane, and we get there quickly, and sometimes we go in an automobile and it takes a lot longer. Ultimately, however, we will get there."

Then you have to start giving the patient hope. Tell the patient the following:

Financial Coordinator: "We're going to keep you in our recall schedule because we want to make sure you come here every six months." In other words, don't make any patient feel like they don't belong in your dental practice because they don't have the money at the time. And close with the following:
Financial Coordinator: "Because Bob, you never know when your circumstances are going to change!"

Financial coordinators must always give patients HOPE and make them feel welcome in the practice, regardless of present circumstances.

That last phrase is so important because it gives patients HOPE. And it's the truth—you never know when a patient's circumstances may change. I've watched people leave the practice, get second jobs, and return to the dental practice with the money several months later.

One woman walked into our dental practice, asked for me and said, "Tawana, I've brought you $3,000 today. I got a second job at an upscale restaurant and I've saved all this tip money." Not only that, her husband detailed cars at night and on the weekends. Together they accumulated the $3,000 for treatment.

I've also watched patients' circumstances change when they inherited money, postponed vacations, or sold personal items. I've seen all sorts of things happen. They did those things because there was value created for the dentistry.

LIFE-CHANGING DENTISTRY

I've witnessed patients get treatment after finding the money even though circumstances seemed dire. And I've watched dentistry change lives.

One young man came to our practice who had made poor choices in his young life. He needed a full mouth reconstruction. He was just a teenager. We tried everything to find money for his treatment and nothing worked out. I called his mother every couple of days as she tried to find financing options. He wanted desperately to smile in his senior pictures.

You never know when a patient's circumstances may change. I've watched people leave the practice, get second jobs, and return to the practice with the money several months later.

Eventually, his parents made the choice to re-finance their house in order to get the money for his treatment. It was an extreme situation. I'd never recommend this option as a first choice for finding the money—in fact it's the very last thing I'd ever recommend. But the family placed a high value on getting this young man's teeth fixed.

Dr. Dick Barnes always taught that Value = Benefits greater than the cost. For this young man, the value and benefits of getting treatment greatly outweighed the cost. Today, years after getting his treatment done, this young man who never had a girlfriend or the confidence to interview for a job, is married and has a productive career.

Recently, I ran into a woman who had been to our dental practice years ago. She heard me talking and said, "I know that voice. Tawana, I can't believe it's you! You helped me out more than 15 years ago. I will never forget how much you helped me."

Finding the money is important because it helps patients get treatment that truly can change their lives.

Finding the money is important because it helps patients get treatment that truly can change their lives. It's thrilling to know that years later, patients are still grateful for such assistance. When financial coordinators help patients, it in turn helps the dental practice, and it's gratifying for everyone. I hope you'll help all your patients find all the options that are available for them. Start today. ■

For Part 2 on "Finding the Money," check out the February 2019 issue of Aesthetic Dentistry. *The second installment of this story will be authored by Glennine Varga, a business development coach for Arrowhead Dental Lab and Total Team Training course instructor. Glennine's story will identify more healthcare financing options for patients and include an easy-to-read chart highlighting the differences in each. Coming soon!*

Tawana Coleman was a practice development trainer with the Dr. Dick Barnes Group for more than 20 years. She worked with thousands of dental practices across the United States and Europe. The structure that she taught empowered dental practices to dramatically increase production. For any questions, email Tawana at rtcoleman@cox.net.

Course Correction *(continued from page 13)*

NETWORKING

Because I had a practice partner who was willing to cover my workload, I didn't use a lot of temporary dentists to help out. However, because we had just opened our practice, my partner and I were still working part-time at other offices. In order for him to cover my workload, the dentists at his other office had to shift their schedules.

I also referred some of the cases that I was working on to other doctors. That was key in ensuring continuity of care for those patients. For dentists not working in a group practice or working without a partner, having good relationships and a network of other local dentists is critical.

PRIORITIES

I am happy to say that I already loved spending time with my wife and my young kids, and I didn't need to have a brain tumor to know that it's important to give them a lot of time and attention. Nonetheless, after my experience, it's more important than ever for me to establish more clearly when work ends and family time begins.

It's great to have a job and make a living, but life is so much fuller if you have more of a purpose than a paycheck. Putting people first—family and team and patients—just makes you a better dentist.

Another shift my wife and I have made is that material things have decreased in priority. Experiences and memories are what matter most. For Christmas last year, we didn't exchange material gifts. Instead, we took our kids to Disneyland. It's a memory we will have for the rest of our lives—time spent as a family doing something fun, enjoying each other's company, and sharing a new experience.

PERSONAL GOALS

As I mentioned, my family is extremely important to me. I also have a deep faith in God. I think these two things were instrumental in getting me through this difficult experience. Finding a bigger purpose, whatever that may be, is something everyone should consider.

One of my favorite things to do is to work with an organization that provides free dentistry to less-fortunate people. It's great to have a job and make a living, but life is so much fuller if you have more of a purpose than a paycheck. Putting people first—family and dental team and patients—just makes you a better dentist.

Patients and team members can sense if they're important to you, or if they represent dollar signs. If they feel important, they're more likely to trust you, feel comfortable in your office, and have confidence that you will work according to their best interests. Any dentist can drill and fill, but I think a lot of patients gravitate toward those dentists who consider them to be individuals, rather than just patients.

(Above) Dr. Richins practicing dentistry at a children's free dental day with TeamSmile, a charitable organization.

REFLECTIONS

I have learned much from this challenging episode of my life. I was lucky in many ways: I have an awesome partner, a fantastic team, and an amazing wife and family.

My classmates from dental school were also wonderful; I heard from nearly every one of them, along with other dentists in the area. I received encouraging letters and messages on social media on a daily basis. Patients expressed their gratitude and told me they wanted me back as their dentist. It was so gratifying—and fortifying—to realize the impact that we as dentists can have on people's lives.

I went into dentistry to help people, and I absolutely love my job because I'm able to affect patients' lives in a positive way. I intend to continue doing that as long as I possibly can. I also hope to strengthen my community and help my colleagues. I have learned how important it is to be prepared for difficulties. Prepare for the worst (and hope for the best), and you'll be better able to deal with your practice, your life, and the curveballs as they come. ■

Brett Richins, D.M.D. has been practicing dentistry since 2012. In 2015, he opened Aspen Heights Dental in Lehi, UT, with a business partner. He practices most aspects of general and family dentistry, including implants and cosmetics. He is also the founder of SureClaim dental billing. When not practicing dentistry, he loves to spend time with his wife and four kids or go mountain biking. He is constantly pursuing opportunities to further his training, including completing the New Dentist Program at Arrowhead Dental Lab. Dr. Richins graduated from the University of Pittsburgh School of Dental Medicine in Pennsylvania.

A Reason to Smile *(continued from page 9)*

of the procedure was a welcome and exciting improvement. The fact that the temporaries were all one color and weren't chipping was a benefit for me.

REACTIONS

It has been life-changing to have permanent restorations because they don't chip or break or cause me any oral health problems. A few of my siblings have also had dental issues, but nothing in comparison to what I've been through.

The fact that the temporaries were all one color and weren't chipping was huge for me, and I was excited.

For the first time in my life, my teeth are now functioning at a high level and are beautiful! Today, my gum health is significantly different too. My gums used to be red and sore and bleed often, but I've had zero gum problems since the procedure.

The reaction of other people to my new smile has been dramatic. People have stopped me mid-conversation to ask what is different about me. Sometimes they can't determine what has changed, but others specifically say that my teeth look amazing.

I didn't tell many people about my full arch restoration because I wanted to see if they would notice. And they have! They think they're admiring my teeth but I know it's my new, confident smile. ■

Diana M. Thompson graduated magna cum laude with a bachelor's degree in English from Utah State University in Logan, UT. For more than 10 years, she has worked as a copywriter and editor for the natural products industry. She has written for several newspapers and edited a variety of full-length books and booklets. She specializes in nonfiction literature, particularly for the healthcare industry. Diana can be contacted at dianamaxfield@gmail.com.

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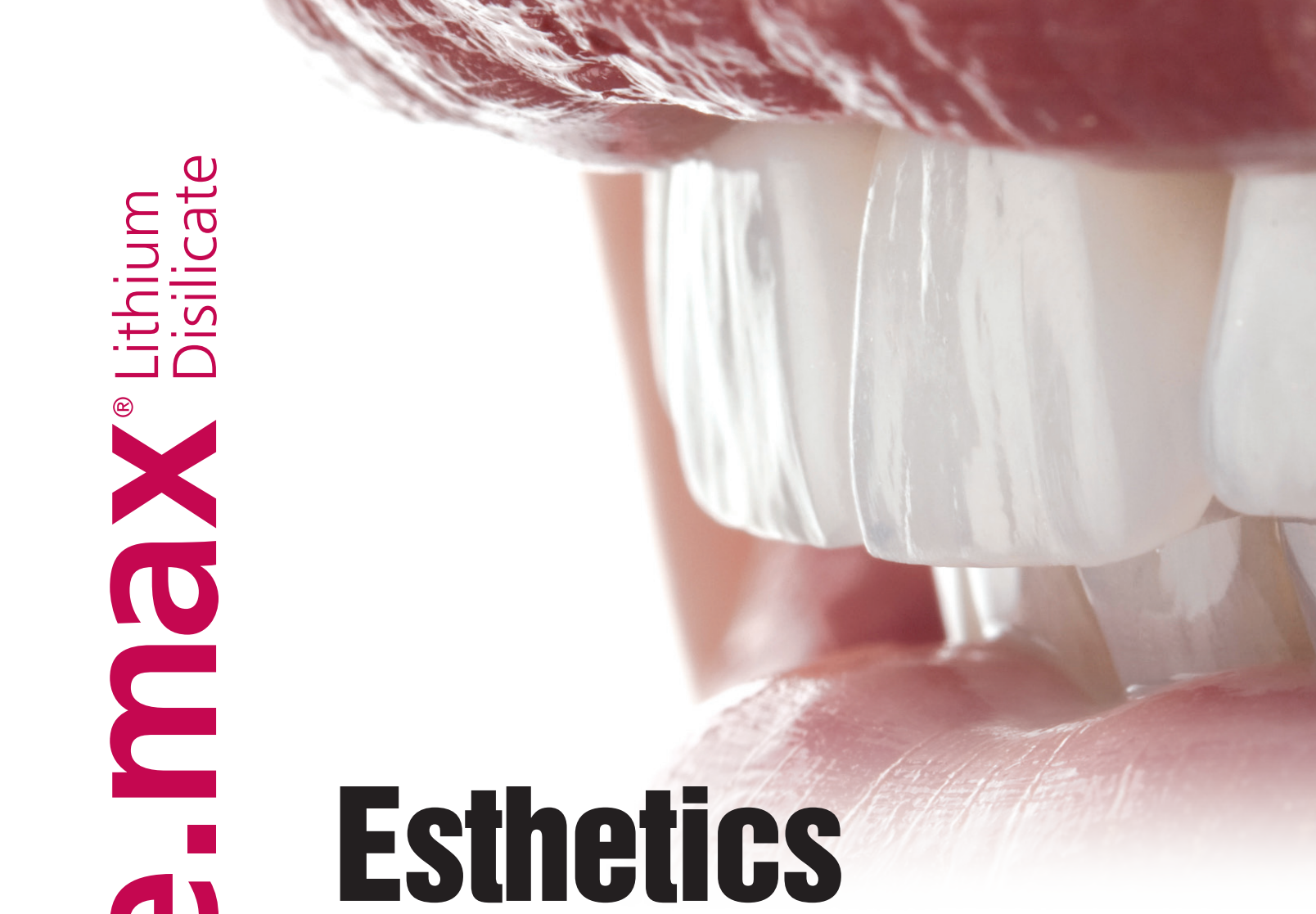

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