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.
EDITOR’S COMMENTARY  DR. DICK BARNES, D.D.S.

I
n 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.

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.

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.

Pay It Forward

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

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.

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 had to pay it forward. I hope you will too.
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Tawana Coleman
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.

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.

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...
Aesthetic Dentistry

THE LAST STRAW

In early 2017, I was chewing on a sunflower seed—both my front teeth chipped—both the tooth that was already broken and a huge piece of the tooth next to it. 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...
I reasoned that the appointment was more for my peace of mind, to confirm that I didn’t have a big problem. 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, 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 wasn’t in a hurry, even though my friend kept pressuring me. 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 didn’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.

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.

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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 hampered, 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 with...
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 plans, 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 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.

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...
Aesthetic Dentistry

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.
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 inciso-gingivally 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 predictably 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. Living 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 veryuffy and bulbous, and the patient had to sit with cotton rolls in for about 10 minutes to let everything settle.

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 muscles 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.

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When 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 healing 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.

RESTORATION

It was important to address Abby’s gingival recession first. Once the gums 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.

For Abby, we prepped and temporized everything on the same day. She was in the temples 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. We communicated back and forth with the lab, making small alterations or corrections, then the lead technicians fabricated the final restorations.

SUCCESS

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?

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.

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

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.

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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.

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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. 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.

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. To join, patients pay a monthly or yearly fee that covers certain benefits and provides a cost savings 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 maximums, patients can get as much dentistry as they need—far different from an insurance company that stops paying out at maximums.

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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.

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

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

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

PRIVATELY AND SECURELY MAKES PROGRAM METRICS EASILY ACCESSIBLE FOR TEAM MEMBERS.

The office manager lost one of the sticky notes and said, “What you do in your model is not nearly as important as what you do in your model and stopped billing the customer for the program, which is detrimen- tal to the program and the practice.”

SCALABILITY

“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 detrimen- tal to the program and the practice.”

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.”

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.

2. MAKE THE SYSTEM SCALABLE

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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 automatically and privately and securely makes program metrics easily accessible for team members. By using software, in-house membership plans are much more scalable.

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.
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, the treatment fee would be if they were part of the in-house membership 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.

Arrowhead White Wax-Ups can help by providing a stunning 3D physical model that you can use to show patients exactly what their new smile will look like.

A White Wax-Up kit includes:
• a Sil-Tech® temporary matrix
• a clear reduction guide for prepping
• a prep model

Arrowhead White Wax-Ups are the key to patient acceptance and predictable outcomes.

With Arrowhead’s dedicated support, doing full arch cases has never been easier.

FOR MORE INFORMATION CALL 1-877-502-2443
www.arrowheaddental.com/whitewax
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. 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. Not surprisingly, the front teeth were a bit chipped.

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 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.

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.

After 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 Erbrum-YAG laser.

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Tissue Contouring

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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 shen-bashi. 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.

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.

4. I used a Si-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.
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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 since 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.

**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 and 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 Emax 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 interproximal. 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.

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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.

**EXPANDING THE TREATMENT PLAN**

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 posterior. 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.

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.
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The Patient Perspective
by Beau Nicoll

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

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 had acid reflux, and the acid was eating away at 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.

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 or any discomfort. The 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!’

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 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.

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.

(Above) Upper arch, after reconstruction.
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: 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 key pieces of information, which are:
1. Aesthetic level of the restoration—Elite, Bella, or Traditional.
3. Implant information—surgeon’s report, X-rays.
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 concerns 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: 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: WHAT ELSE CAN DOCTORS DO 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.

AD: WHEN DOCTORS SUBMIT PHOTOS WITH A CASE, IS ALL THE INFORMATION THAT YOU NEED LISTED ON THE PRESCRIPTION?

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

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INFORMATION CHECKLIST

☐ Aesthetic level of the restoration—Elite, Bella, or Traditional.
☐ 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 a 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. Prede-termine 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.

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. 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.

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 the horizontal plane is also helpful. When the impression coping is not fully seat-ed, it can result in height differences and rotational discrepancies. Using closed tray impression copings as the manufacturer suggests makes 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 dia-in each case using TeamViewer screen-sharing software, so that doctors can easily see what’s going on with their case.

Arrowhead Dental Lab and the Dr. Dick Barnes Group offer a CE plan specifically designed to make new dentists more successful. Dr. Valerie Holleman was in practice for about eight years before starting the New Dentist Program with Arrowhead. Dr. Holleman said, “My advice? Do it now! It’s the best decision I ever made and the courses are life changing.”

Get the skills and support you need for success and keep your patients coming back by providing the latest in dentistry.

Sign up today for Arrowhead’s New Dentist Program by visiting our website at: www.ArrowheadDental.com or by calling 1-877-302-3443.

Arrowhead’s New Dentist Continuing Education (CE) Plan:

- Full Arch Reconstruction: Only 30 percent of dentists offer this innovative procedure in their practices—you can be one of them!
- Total Team Training: Give your entire team the tools they need to help build a more profitable practice.
- Implant EZ I: Reduce the number of patients you refer out and keep valuable revenue in your practice.
- Everyday Occlusion: Help a large number of your patients achieve improved dental health by applying these specialized concepts and techniques.
- Airway Management and Dentistry: Learn how to integrate sleep dentistry and the treatment of sleep-disordered breathing for your patients.

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 chair side 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 seat-ed, 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.

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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.”

Dr. Valerie Holleman, Broken Arrow, OK

“My practice is more successful than I could have imagined!”

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Finding the Money


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.

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.
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 organization]. 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—whether 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 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: “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 [esthetic]?”

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 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 regarding financing. 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.”

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. 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 empathy 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—did we have this worked out, this is still the treatment you’d like to have. Is it, isn’t it?”
Patient: “Yes, it is... but 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 by name, 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’S TIPS

1. Don’t put the dental practice in the position of being the bank.
2. Be firm in principle, flexible in procedure.
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.
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 importance. 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.

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 difficult situations. 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 that come your way.

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 SunClaim 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.

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 bleeding, 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 diamanmaxfield@gmail.com.

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*Based on global data.