November 2011 – Volume 4, Issue 9

orthotown

exclusively for orthodontic specialists

OrthoSynetics, Inc.
Realizing Your Full Potential
page 34

Practice Management
The Truth About Income
by Jay M. Geier, page 54

According to Dr. Wo
Remembering Steve Jobs
page 10

Office Visit
Meet the Developer and Sole Provider of "Incognito Lite"
page 40

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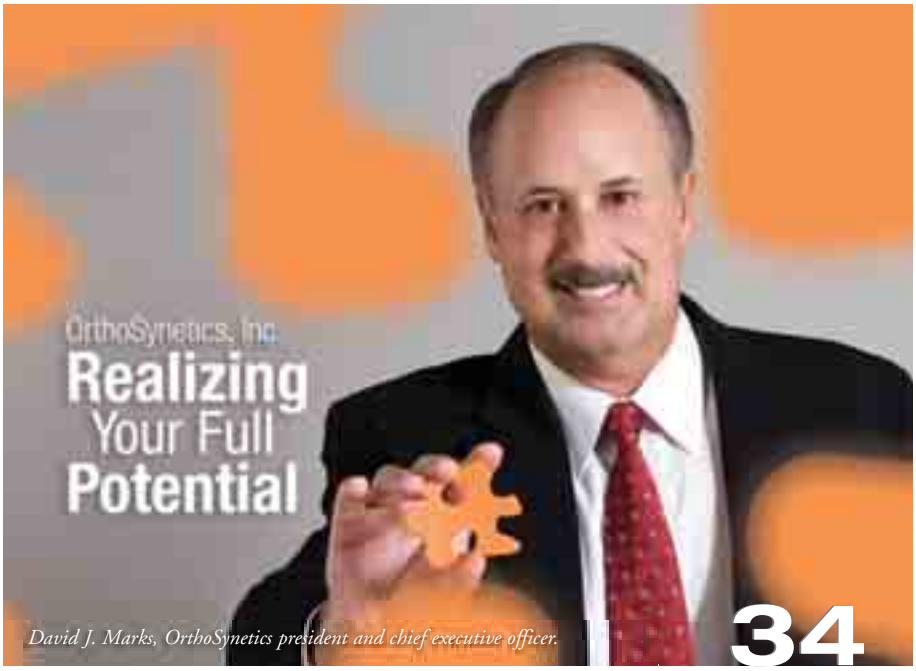


David J. Marks, OrthoSynetics president and chief executive officer.

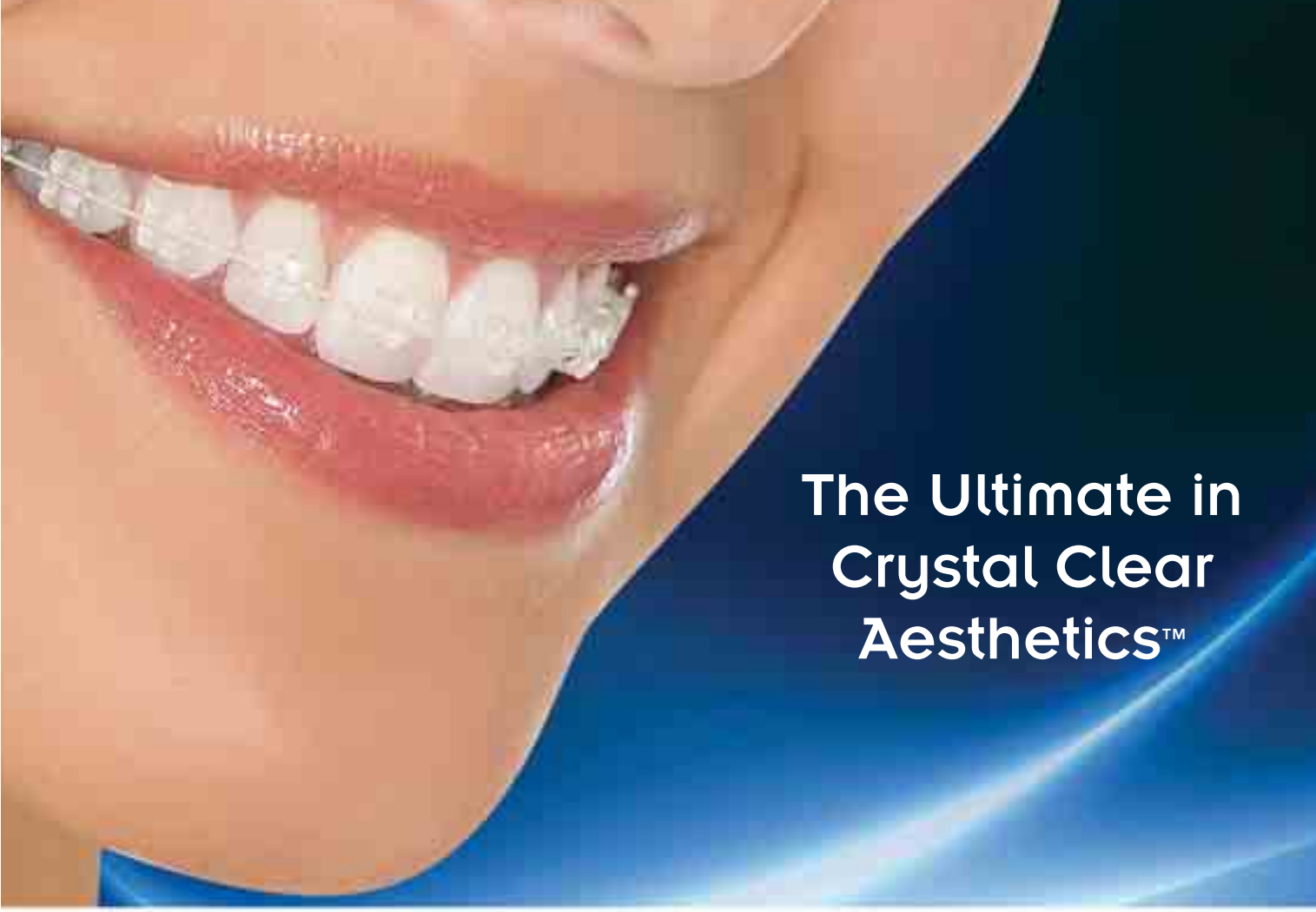
Articles

Message Boards

Townie Clinicals

In This Issue

Correction: *Orthotown Magazine* indicated the wrong contact information for Dentaurum USA on page 50 of the October 2011 issue. Dentaurum USA can be contacted by calling 800-523-3946 or visiting www.dentaurum.com. *Orthotown Magazine* regrets this error.



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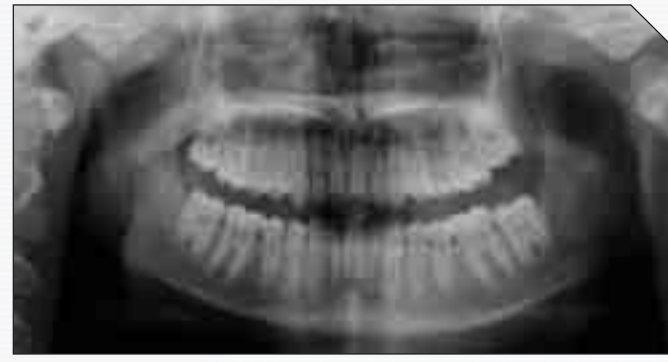
160905 Search



MESSAGE BOARDS

Lower Incisor Extraction Criteria

What factors do you take into consideration when deciding whether to extract lower incisors?

Lower Incisor Extraction Search

What's The Right Ratio of Front/Back Staff?

How many people do you have working as front staff and back staff?

Front/Back Staff Search

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Collecting Your Fee: Legal, Ethical and Practical Considerations
– Eric J. Ploumis, DMD, JD

This course explores issues that impact on fee collection efforts from legal, practical and ethical perspectives. The legal nuances associated with fee collections and the process for terminating non-paying patients from your practice will be discussed.

continued on page 6

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continued from page 4

11 11

Message from the Online Community Manager

Sharing is Caring

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If you have questions about the site, call me at **480-445-9696** or e-mail me at **kerrie@farranmedia.com.**

See you on the message boards,
Kerrie Kruse
Online Community Manager

HELPCENTER

Feature of the Month

Orthotown.com has made it easier to get feedback from Townies by adding a Poll feature on the message boards. Check out the Help Center's Feature of the Month for more information!

VIDEOTUTORIAL

How to Manage Your Message Board Subscriptions

Never miss a post from your favorite Townie within your preferred forums or within an active thread. Use your subscriptions and customize your settings so that you're never out of the loop. Go to the Orthotown.com Media Center and click on the Tutorial section to watch a short video with step-by-step instructions.

GETTAG

Throughout *Orthotown Magazine,* you can scan tag codes to access information directly from your smartphone. To scan these codes, visit http://gettag.mobi/ to download the free barcode reader to your mobile device. You can then scan every code you see in *Orthotown Magazine* to access additional information, enter contests, link to message boards, comment on articles and more!

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Nothing Stays the Same

by Wm. Randol Womack, DDS, Board Certified Orthodontist
Editorial Director, *Orthotown Magazine*

10/5/11: Today was one of those days that lead you to think, "Where was I when I heard the news about…"

There are many days in one's life that mark a significant happening, which are indelibly stamped on our memory. There are days associated with world happenings both bad and good. There are days that are associated with personal happenings that bring both tears and happiness. When things are good, we remain guarded because things can become bad. And when things are bad, we remain optimistic, because things can become good again. I'm reminded of my father's admonition to me before he passed, "Son, there is one thing in life you can always count on – nothing stays the same."

What brings me to this writing was the news of Steve Jobs' passing. Between Bill Gates and Steve Jobs, their visions have had immeasurable impact on our way of life today. But the scope of Jobs' Apple has expanded to so many aspects of our personal daily living, that we become complacent and we are inclined to take its impact for granted, until something changes.

Steve Jobs raised the innovation bar. He changed so much of the way the world has worked for the past 35 years. From the Apple computer to the Macintosh to the iPod to the iTouch to the iPhone, the penetration into our daily lives is almost inconceivable. I even observed most of the lecture slides in today's orthodontic presentations are being generated mostly by Macs! Apple will never be the same without him, and what happens going forward remains to be seen.

A couple years ago at an orthodontic meeting in Arizona, Vince Kokich announced he was retiring from the lecture circuit soon after that meeting. His lectures had a great influence on me professionally. Now Vince has moved into a different position of influence as editor-in-chief of the *American Journal of Orthodontics and Dentofacial Orthopedics*. Then, most recently at the Pacific Coast Society of Orthodontists meeting in Vancouver in late September 2011, Jim Hilgers announced his exit from the lecture circuit. Jim's presentations were the epitome of efficiency and effectiveness. I bought my first diode laser a number of years ago after one of his presentations. Again, nothing stays the same…

Orthodontics is certainly changing, thanks to the innovators who have brought us to today's level of diagnosis and treatment. Not staying the same, in orthodontics, has created the growth and the progress that has changed our profession for the better. Those who have had visions and who worked to perfect them and teach them have had their impact on our profession, just like Gates and Jobs. Some of them have passed but there are so many others, today, who are carrying on this tradition. They are the Steve Jobs of orthodontics and we are so grateful for them and for those who preceded them.

Nothing stays the same… ■

Steve Jobs Commencement Speech

The 14:24 minutes it takes to watch this video will not only impress you but will encourage you. Life lessons learned through other people's experiences are so valuable and can be life changing for anyone. I urge you to have all your patients, Facebook fans, their friends and their parents, as well, spend a few minutes really listening to this message delivered by Steve Jobs. It might change your life, no matter your age!

- To scan this code, visit: http://gettag.mobi/ to download the scan app and acces the video

(You can also find Steve Jobs' speech when you search for "Steve Jobs Stanford Commencement Speech" on Google.com)

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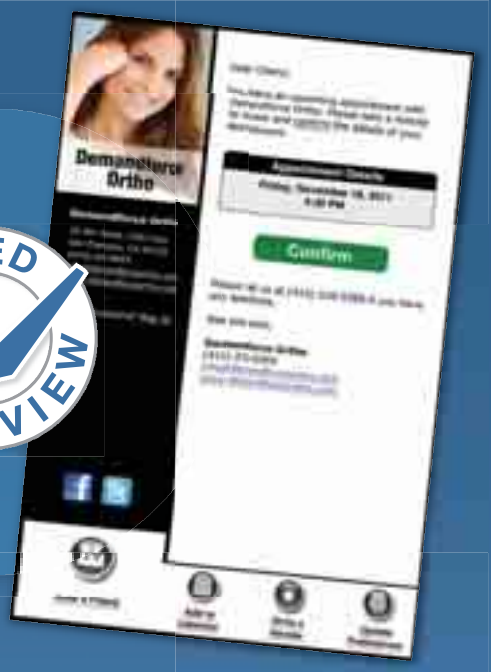

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Ortho News in Brief

The Industry News section helps keep you informed and up-to-date about what's happening around the dental profession. If there is information you would like to share in this section, please e-mail your news releases to ben@farranmedia.com. All material is subject to editing and space availability.

AAO Foundation 2012 Awards Funding Proposals

The AAO Foundation (AAOF) has announced that 2012 AAOF awards materials are posted on the AAOF Web site. Proposals for funding requests must be received by the AAOF at its St. Louis, Missouri, office no later than December 15, 2011 at 5:30 p.m. (CST). Proposals may be submitted for the following AAOF funding awards: Orthodontic Faculty Development Fellowship Awards (OFDFA), Biomedical Research Award and Education Innovation Award Planning Grant. Proposals that address the specialty's concerns with respect to craniofacial anomalies and special care patients are encouraged in all categories. To find out more information, visit www.aaofoundation.net/AwardsProgram/Fundingfor2012.aspx.

OraMetrix Makes *Inc. Magazine's* List Of Fastest Growing Companies

Inc. Magazine ranked OraMetrix #2,003 overall and #163 in the health sector, on its 29th annual Inc. 500/5000 list, an exclusive ranking of the nation's fastest-growing private companies. OraMetrix, maker of SureSmile braces, had 127 percent sales growth, 2007-2010, with annual revenue of $22.1 million in 2010. The 2011 Inc. 500 is ranked according to percentage revenue growth when comparing 2007 to 2010. To qualify, companies must have been founded and generating revenue by March 31, 2007. For more information about OraMetrix, visit www.orametrix.com.

Ormco Corporation Announces Open Registration its 11th Annual Damon Forum

Ormco Corporation announces that registration is open for its 11th Annual Damon Forum, the largest privately-sponsored orthodontic event in the world. Integrating cutting-edge research with interactive clinical workshops, the unique conference highlights the latest treatment mechanics and most advanced technology across the orthodontic profession. The clinical educational and practice-building conference – designed specifically for orthodontists, clinical staff, treatment coordinators, office managers and front office staff – will take place January 18-21, 2012, at the JW Marriott Phoenix Desert Ridge Resort & Spa in Phoenix, Arizona. For more information about the 2012 Damon Forum conference, visit www.ormco.com/forum.

ImageWorks Promotes Kevin Dillon to Vice President – NewTom Division & Corporate Accounts

ImageWorks has promoted Kevin Dillon to vice president of its NewTom Division. Dillon, previously director of sales for ImageWorks' Midwest Sales Division and a veteran of the dental imaging marketplace, brings a strong track-record of sales growth with Henry Schein and Danaher, selling digital dental imaging products, including cone beam CT imaging systems. Dillon will continue to work closely with existing sales personnel to expand the team throughout the country and implement strategic corporate objectives. For additional information, visit www.imageworkscorporation.com.

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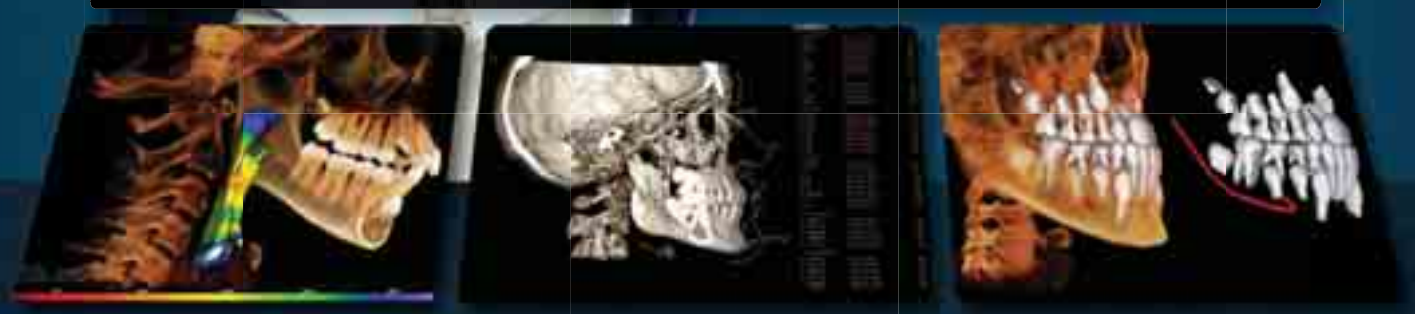

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Preventing Light NiTi Wires From Slipping Out

Light NiTi wires often slip out and poke the patient's cheek. How do you handle this situation?

Str8edge
Posted: 8/17/2011
Post: 1 of 22

I would love to know how people prevent light NiTi wires from coming out of the terminal molars. This is probably my most common emergency, particularly in the lower, so I am in search of the best way to prevent this. I love using very light wires for a long time in many cases (not a Damon guy, but I think this particular concept is sound).

I have tried:

- Cinching back – not totally predictable with very light wires (lighter than .014) – a cinched back round wire can break, unravel or still irritate since it can roll around.
- Crimped-on wire stops – again, the wires still sometimes come out with very light wires, especially lower.
- Only connect to the bicuspids during the light wires – too many rotated second bis not aligning; also, inefficient for me since I like to stay in light wires for a long time and it is amazing how much light wires will do when you let them cook.
- Leaving a bit of extra wire and putting a dab of flowable on the end – always comes off.

I would love to hear other ideas about this.

Thanks! ■ LJ

Like reading about wires? Then check out these other message boards discussing wires.

Arch Form
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Fill Those Slots! And What's Your Finishing Protocol?
Search: Fill Those Slots

zxzxzx
Posted: 8/18/2011
Post: 2 of 22

We don't go into the 7s in anything lighter than an .018 super elastic. As you stated, they always have problems with light wires. So .014 goes into the 6s and we use a bend back plier and it seems to work. We 90-degree bend with the bend back. ■

dhmjdds
Posted: 8/18/2011
Post: 3 of 22

To answer your question, in the lower arch small NiTi archwires will pull out of the 7s in certain patients no matter what, it seems. We often cut the wires at the distal of the 6s, as Charlie suggests, but when we need that wire in the 7, we add crimpable tieback hooks to the wire just mesial of the 7 bracket and tie with an elastic. Still comes out occasionally. These little crimpable hooks are also handy to use for true tiebacks on NiTi wires that we are using in space closure cases.

But I agree there's no perfect solution. ■ Diane

ucla98
Posted: 8/18/2011
Post: 4 of 22

Because of these emergency problems, I don't like to keep the patient in the light wires for a long time. I jump to .018 SS as soon as I can (usually after second or third visit). For rotated teeth, I just bypass them and then use the open coil springs to create space. Once the spaces are created, I move back to .014 NiTi to engage these rotated teeth.

continued on page 16

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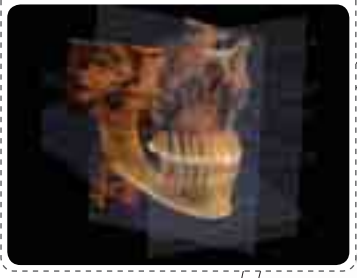

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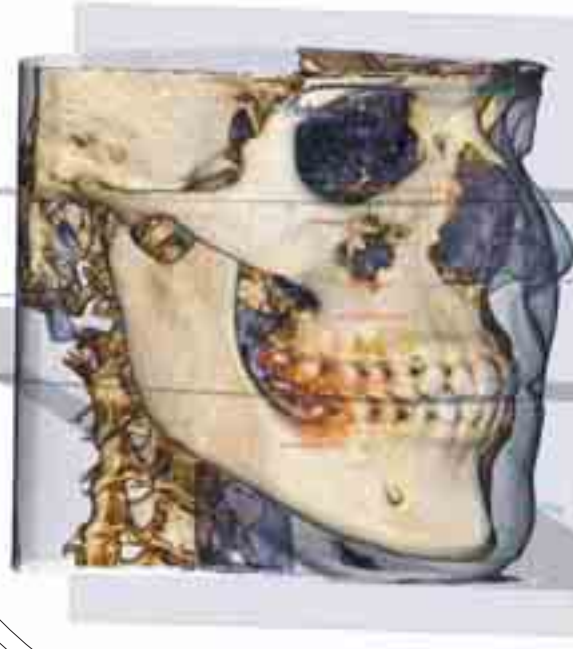

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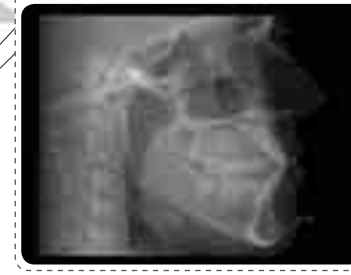

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continued from page 14

I don't like bonding the 6s either (I band all 6s) because I don't like having to deal with the wire poking the patient's cheek when the bondable molar tubes come off. ■

BracesDude
Posted: 8/18/2011
Post: 5 of 22

I noticed my newest two assistants cinching back the lower .014 NiTi with a Matheiu pliers or hemostat. They orient the plier vertically behind the lower 6s with the beak closed. They consistently can get a hairpin bend to curl almost 180 degrees back against the tooth surface. We have to cut these out. I thought this was a nifty trick. Also works for loose cinches because of the common emergency of open coil spring coming off over lower 5s – when they need space – when we used to cut the wire flush. Maybe you should try it. Funny… I learn some little trick from every assistant I hire. ■

nysent
Posted: 8/18/2011
Post: 6 of 22

A large portion of my patients live quite far away from one of my associate offices. When I first started working there, I sent patients home with .014 NiTis with a crimp in the middle as the initial wire. I had scores of patients calling and returning with complaints of "poking wires" and blaming us for not doing a good job cutting the wires before they left the chair. I thought about the issue and decided to make my initial wire an 18x18 NiTi wire in 70 percent of the patients. The amount of complaining went down 99 percent.

For the remaining patients where I do start with a .014 NiTi, I have been instructing patients to try to cut the wire with a large fingernail clipper or with a small wire cutter sold at Home Depot or any craft store if the wire starts poking. I show them what a ligature cutter pliers looks like to give them an idea of the wire cutter to buy. Most of them seem to be able to do it.

We just got a "whale tail" pliers yesterday and I tried it on a few people where I inserted the NiTi wires from 5- 5. I had a 12-year-old girl who we bonded yesterday return today complaining of a poking wire. I was quite confused how she could have a poking wire as she has quite a few rotated teeth engaging the .014 NiTi wire that should have held it in place at least longer than the first day. Turns out, the assistant used the pliers to bend the end of the wire about a mile from the distal of the molar band without telling me so of course it was going to poke the poor girl. ■

flybywire
Posted: 8/18/2011
Post: 7 of 22

BracesDude, I do this too, but I make a 90-degree bend in toward the tooth. No catching on the cheek or poking the gums. A slight tug gets it out every time so you can reuse it if you need. ■

Str8edge
Posted: 8/18/2011
Post: 8 of 22

Thanks – there are some good suggestions here that I'm going to try.

Nysent, using an 18x18 as an initial wire? Doesn't seem like it would get rotations out very well and have you seen complaints of severe soreness go way up as well? ■

amalgamator22
Posted: 8/18/2011
Post: 9 of 22

I use NiTi "hammerhead" cinching pliers on every small NiTi and they almost never come out. Mine are from Orthopli. If they are all dirty I anneal the wire and cinch it. ■

continued on page 18

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continued from page 16

Braces101
Posted: 8/18/2011 ▪ Post: 10 of 22

Diane, what brand/product of crimpable hooks do you use? My crimpable hooks are too big to stay secured on a .014 NiTi. Any pictures would be much appreciated! ■

dhmjdds
Posted: 8/19/2011
Post: 11 of 22

Braces101, 3M Unitek split round tube hooks .016. Part number 536-610.

Put them on and do the initial crimp with a sturdy Weingart. Then pinch them with the tip of a birdbeak to get them to stay on a .014 NiTi.

Some out there would say "those are too expensive." But, if you can avoid extra appointments due to wire pokes, they are worth every cent. Sondhi said years ago that he calculated each extra appointment costs about $100. ■ Diane

nysent
Posted: 8/19/2011
Post: 12 of 22

Str8edge, the patients who present with a lot of rotated teeth start with a .014 NiTi. If they are rotated or blocked out incisors, I will start with the 18x18 but skip those teeth. Later I'll use the .014 NiTi when there is enough space to align those teeth. At this point, the patient has been coming to the office for six to eight months and is more experienced with handling life with braces. We tell them we are switching to a very "flimsy" wire to straighten out their rotated teeth and that this wire might slip out and poke because it's so flimsy. We seem to get less heat it if happens in the middle of treatment than when it was happening in the beginning.

For some reason, a number of the cases in that office present with fairly well-aligned teeth but the chief complaint is spacing. The .014 NiTi was literally spinning in the brackets (we use In-Ovation R) but since the teeth are all aligned, the 18x18 is not hard to insert so I switched. Patients don't seem to complain about severe soreness, we tell them they will be sore for up to a week when they get home and they are.

Also, many of these patients are adults. They seem to be able to handle soreness and the liquid diet (some of them love that they are losing weight!) but the poking wire drives them crazy. ■

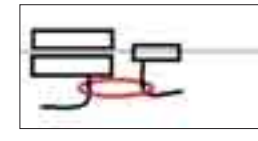
umngmc
Posted: 8/22/2011
Post: 13 of 22

Like some other replies, I don't engage 7s unless I'm in a 16x16 NiTi or greater. At our initial bonding, the assistants will flame the terminal 2mm of NiTi wire and then curl them in behind the 6s. If it's a case that has a lot of crowding and requires a lot of unraveling then I don't do the cinch backs. I almost never have a problem with light wires traveling or "pokey wires" in the beginning stages of treatment. Note, I'm .018 In-Ovation/Empower and first wire is .014 NiTi. ■

str8wire
Posted: 8/23/2011
Post: 15 of 22

I do what Diane does – especially for young kids with 2x4s.

I made a crude line drawing on my computer to illustrate – hope it makes sense. ■



ahayes
Posted: 8/23/2011
Post: 17 of 22

The way I see it, in light wires I'm not really leveling anything and not moving molars anyways. Oftentimes I just go 5-5 with the .014 NiTi initially (cinched long).

If you treat any lingual cases, you have these problems on a large scale because the initial wires are really small (.010 or .012) and the

continued on page 20

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continued from page 18

patients feel anything. In journals I remember seeing cases where people would have composite on the end of the wires. Someone mentioned previously that always comes off and it used to for me too. I've found that it works well if you turn the wire first before adding the adhesive. I've had good luck doing it this way. You just have to make sure the flowable makes its way around the 90-degree bend so it doesn't pull out. ■

ooddx
Posted: 8/29/2011
Post: 18 of 22

We start virtually all our 18 conventional labial cases with .012 NiTi SE to the first permanent molar bonded tubes. After realizing that nothing holds the wire in the tube, we just cut the wire behind the tube and tell our patients not to worry too much if the wire jumps out of the last tube, but just let the wire stay under the tube. That way it doesn't poke, provided it is not cinched.

Second best solution we have tried was to cinch the wire with hammerhead pliers leaving some distance between the tube and the cinch. That way I believe that subsequent bending of the wire between 5-6 during chewing will not be "enough" to bring the cinched portion to the tube and through it.

We use three types of hammerheads, my favorite from IV-Tech, second the one from Hu-Friedy, third from Ortho Technology.

Sometimes I give our hammerheads a light blast with the sandblaster to remove polished areas in the inside of the concave beaks. Common problem being that thinner and shorter wire ends will slip from the hammerhead and refuse to be bent.

We always place an elastic ligature in cross/figure-eight pattern on the most rotated tooth. That stops the first wire from migrating and effectively derotates that tooth. ■ dimitris

hclburnzu
Posted: 8/29/2011 ▪ Post: 19 of 22

If you definitely have to get to the 6s with a light wire, you can always laceback from the lower 6-5. ■

ddestang
Posted: 9/12/2011
Post: 20 of 22

A simple way of solving this is to keep cigarette lighters around! Heat the ends of the wires for a few seconds (not too long or else the wires will become brittle).

After heating, the NiTi can be bent as easily as stainless steel. Use a Weingart to bend the ends into a curved loop that doesn't pop out the terminal molars. ■

Wired
Posted: 9/12/2011 ▪ Post: 22 of 22

Count me as one who does not include the 6s or 7s until I get to at least a .018 NiTi. ■

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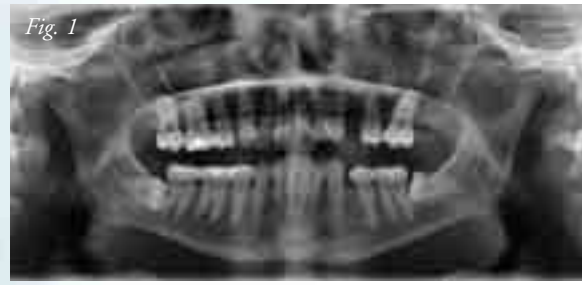
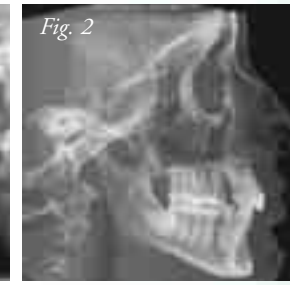
Trouble Closing Extraction Space?

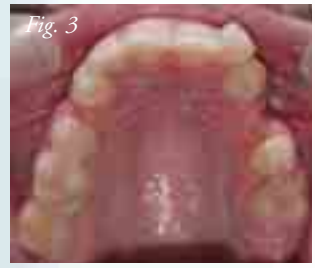
A botched extraction ends up in an orthodontist's chair for space closure.

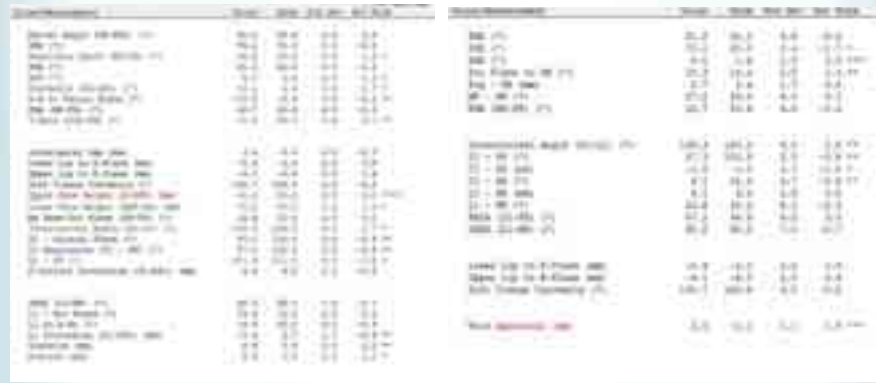
flourcity
Posted: 8/18/2011
Post: 1 of 13

Has anyone tried closing an extraction space like this?









For a clearer view of this chart search "Trouble Closing" on Orthotown.com.

Patient had treatment started by another dentist, who extracted U/L 4s and started ortho treatment, but dismissed the patient before completion. He appears to have created a large defect in the UL4 space during extraction. I referred to perio, who said he could not successfully graft the vertical defect at UL3-mesial, and suggested I close the space then have the patient undergo regular perio maintenance of UL3-mesial pocket. This pano was taken by us, and is about 12 months

Want to see more message boards regarding space closure? Then check out these message boards online.

Space Closure
Search: Space Closure

Space Closure with Short Roots
Search: Closure with Short Roots

after the extraction. Just out of curiosity, I had the patient request records from the previous dentist, since I was curious why left canines were still in full Class II, and right canines were Class I (not pictured). I found out the previous dentist did not take initial models or photos. He also did not take a lateral ceph, which was somewhat alarming especially since he chose to extract teeth. I did get a copy of the pre-extraction pano and treatment notes/chart. The patient said she was never informed that the extraction had created a defect, nor informed of any complications it might cause in space closure. Two sides to every story though, I guess...

I do recall hearing/reading somewhere that a space like this could be closed, but it would take exceptionally long, and would likely lead to root resorption of the teeth as I am trying to move them into the space. My thought was to inform the patient of these potential complications, and if unsuccessful we will have to explore the option of an implant/bridge; or propose the use of mini-screw anchorage to help with space closure. Your thoughts/advice on the feasibility of space closure would be appreciated. ■

How old is this patient? Any medical history? I think this is an interesting case, made even more so by the previous treatment. I find the missing left second molars of interest. I am leaning toward a TAD to help retract the left cuspid as the anchorage from the left side is minimal (and the molar is in crossbite) and an end-on Class II. I would not hesitate to attempt the space closure, but informing the patient before proceeding is foremost. ■

ajbortho
Posted: 8/21/2011
Post: 2 of 13

Is there a radiolucency UR3-6? ■

mkbark
Posted: 8/22/2011 ▪ Post: 3 of 13

She is 25 years old. Looking at the records I obtained, the other dentist reported 10mm of crowding in upper and lower arches. The chart also says he extracted LL5, but in the other quadrants extracted the 4s. ■

flourcity
Posted: 8/23/2011
Post: 4 of 13

This patient and her current malocclusion looks like one I saw in residency – one who had four bis extracted by a resident two years before me but disappeared after he treated her for a year. Three years later, she showed up in my chair one day wanting her braces off. I asked her why she stopped treatment and resurfaced. She answered, she had lost her Medicaid so she stopped coming for treatment but she was back on Medicaid because she was pregnant. However, she would lose it again after the baby was born so she was here to get her braces off while she had the coverage.

Not that this helps you close the spaces, but your back-story reminded me of it. ■

nysent
Posted: 8/24/2011
Post: 5 of 13

Wow this is an interesting and tough case. From those photos it looks like she might be in the dental or medical field – obviously consent will be hugely important here.

Str8edge
Posted: 9/5/2011
Post: 6 of 13

continued on page 24

continued from page 23

I have closed spaces similar to this (with large defects), but not one with a defect quite this big. When the patients were young, it closed, but it took a long time and I had a heck of a time keeping it closed, so you will want carefully consider your retention protocol. I would probably recommend a fixed retainer to span that UL space. It will probably close part of the way and then suddenly not want to close anymore and at that point you might need to increase the forces to get that last bit of closure – use closing loops or something similar.

Another thought that I had was the possibility of using corticotomy-assisted movement (Wilckodontics) in this site. I have never actually used this technique, but have read about it and have heard claims that it is helpful for these situations. I'm sure there are others here that are more qualified to weigh in on this possibility.

Do mind sharing what type of camera you use? I really like the contrast in your photos.

Thank you! ■

like2drill
Posted: 9/6/2011
Post: 7 of 13

My treatment would be to close all the space on the right, open space for a full tooth on the bottom left and close space on the top left for a single premolar (pre-graft, regardless of prognosis).

I realize that there are two sides to every story. Unfortunately, given the lack of records the GP has, he or she doesn't have a side (from a legal standpoint). I usually meet with people one on one and explain this. With a litigious patient, sometimes helping teeth get replaced from a financial standpoint with a signed release form is cheaper than the unpleasant alternatives. ■

str82th2
Posted: 9/11/2011
Post: 8 of 13

Thanks for posting!

That is one massive defect. Apparently the prior dentist is as good at exodontia as he is at orthodontics.

I have closed large spaces such as this, but it takes a lot of time. You should warn the patient to expect 30 months of treatment, minimum. In the meantime I wouldn't hesitate to place mini-screws (at least on the left side) to aid space closure or you aren't going to be able to charge enough for the amount of appointments this will take. I would suggest retracting with labial and palatal mini-screws together (a double-cable retraction) until the UL3 is about Class I and then switch to reciprocal space closure on chain to finish getting a Class I canine and some protraction of the UL to close the remaining space and hopefully drag some bone with the UL5-6 into the defect site. Unfortunately correcting the crossbite will add even more space.

I totally agree that you need a bonded wire to retain the U/L from 5-5. I always do these indirect and transfer them to the mouth. Bending 5-5 is hard but instead of using one long wire try using one piece from 3-3 and then two other short pieces from the 3s to the 5s. Use the resin bonding pad on the 3s to cover the ends of both wires in one. Make sure you open her bite as much as possible or you won't be able to get the wire on the U3s without it being in occlusion.

Because her profile and lip posture are so nice you really could consider opening space and replacing the four missing bicuspids but you probably would have to move the UL5 into the UL4 space bringing bone with it since there is no bone for an implant at the UL4 site. Implanting the UL5 would look better anyway since nothing beats the natural tooth. Try using a Locatelli spring from the UL6 to the UL5 on the lingual to help move the UL5 forward. They work great.

Good luck and thanks for sharing. ■ Larry Levens

I'd love to hear from the original dentist why he or she discontinued treatment. Poor patient cooperation or dentist just gave up? Does he or she have documentation that the patient was told that treatment was not complete (of course not – doesn't even have initial records). What does the patient say she was told about her treatment? ■

mkbark
Posted: 9/12/2011
Post: 9 of 13

The alveolar atrophy of the extraction site UL4 is a minor problem compared to the asymmetry caused by missing UL6 and LL6.

One can note that the lower midline is significantly deviated to the left and if one attempted to close the space of UL4, the maxillary midline will shift to the left as well.

Therefore, I would recommend to open a space between UL5 and UL7 (UL6 is missing). As the second premolar moves mesially it will bring bones with it and solve the alveolar bucco-lingual atrophy. Don't worry and believe me I have done it several times.

In the lower arch, I would do the same. The impacted third molar will stop the lower 7 and minimize distalization.

So it is a two-implant case... if the patient can afford it.

Otherwise micro-implants will be needed to protract everything forward on upper and lower left side. It will take a huge amount of time. The total treatment time will be more than 36 months or so. The prognosis will not be better.

Good luck. ■

SylvainChamberland
Posted: 9/12/2011
Post: 10 of 13

The patient obviously had a LL4 extracted and not the LL5 like the dentist supposedly planned. Looks like he didn't read his own extraction plan or wrote down a false note after realizing that an U/L4 extract on a Class II side leaves you Class II. ■

dondiego2000
Posted: 9/12/2011
Post: 11 of 13

Just close the upper space. It will happen slowly. In the lower arch you need to advance to the left canine to help with your lower arch asymmetry, which will help with midline and will help with not over retracting the upper canine.

This would be fastest by opening up LL4 space, but I think you've got a bit of a defect there for implanting, so I like what someone else said about opening up LL5 space. TADs would help here since you need to not only mesialize the LL5 to close space but also to correct the arch asymmetry. ■

st8nup
Posted: 9/12/2011
Post: 12 of 13

Not really too worried about closing this space. Kokich has shown molars being advanced through bone years after forward molar is lost. I would place full fixed appliances and a TAD between upper L5 and 6. I would tie upper left 5 to TAD and "ankylos" it. I would disarticulate with composite on L6s and slowly retract upper canine by chaining to the 5. Replace chain every four to six weeks. Once upper canine is back, remove lower composite and fully level. Proceed with looped upper wire to retract 2-2. I would say 24 months. ■

nistadel
Posted: 9/15/2011
Post: 13 of 13

How Do You Handle Broken Fixed Retainers?

Do you charge when patients need to have their fixed retainer rebonded or replaced?

hoodortho
Posted: 8/30/2011
Post: 1 of 14

I have a love/hate relationship with fixed lingual retainers. They are so good at keeping the teeth straight, but annoying when they come loose/debond.

For my current retention protocol, I usually give parents and patients the option of a fixed lower lingual retainer and I'll also go ahead and make upper and lower Hawleys. My assistants also let them know that the lingual retainer doesn't always last forever and like shoes, toothbrushes, clothes, etc. will wear out over time, especially in the oral environment and might need to be replaced. I will repair loose fixed retainers for free for a year, but have been charging patients after a year should they become loose or debond. I work in a corporate group practice, so I don't feel (too) guilty about doing this. But I am human, and a part of me certainly does feel like I'm overcharging the patient. Yet, I also do not want to have a life-long retention patient who I am indebted to simply because mom wanted a fixed retainer.

What protocol do you use for handling your broken fixed retainers? And what composite do you use? I'm thinking maybe my flowable isn't as robust as it could be.

Thanks! ■

Dr Van Halen
Posted: 8/30/2011
Post: 2 of 14

I agree with your frustration. We always make a clear overlay retainer for patients to wear at night, so they have a backup if the bonded retainer comes loose. We include a year of retention visits as part of their fee and charge an office visit after that, although I will admit I have waived the office visit several times.

We find the flowable composites do wear quickly. We are trying some restorative composite from Ivoclar (also starting to use for Invisalign attachments) as it supposedly is more durable. I am about to order some of the mini-molds to use for placing the composite.

Our practice is near a university and we get several calls a month to repair bonded retainers that were placed in the students' hometowns... so you are not the only one with these issues. ■

thesmiledoc
Posted: 8/30/2011
Post: 3 of 14

Communication of your retention protocol (by your office manager) at the time of retainer placement goes a long way to staving off frustration, fee, no fee, costs and options. ■

dhmjdds
Posted: 8/31/2011
Post: 4 of 14

It depends on whether you are talking about upper or lower fixed retainers.

In my opinion, lower fixed retention is absolutely the way to go in 99 percent of cases. Lower front teeth move. Always. Forever. In everyone. Of course, that is not strictly true, but no one has any way of determining in advance who has teeth that will move and who has teeth that will stay stable.

On the other hand, upper fixed retention is very rarely a good idea. They are a hygiene nightmare, they come off monthly, you have to bond every tooth, they are hard to form properly, etc.

So our policy for lower fixed retainers is:

1. If they come off within the first six months and the patient brings back the wire, the retainer is rebonded at no charge.

2. After the first six months, if the retainer is only off on one side, we will rebond it for free for a lifetime. We want to encourage them to come back immediately once they notice it is loose.

3. After the first six months, if the retainer is off on both sides and the patient brings back the wire, we charge $49 for the rebond.

4. At any time, if they come back without the wire, it is $104 (in one office) or $175 (in the other office) for a new bonded retainer. Then the clock resets.

For upper fixed retainers, I will do 1-1s for stubborn diastemas at no charge. If they knock them off, the policy is the same as for lower lingual retainers.

Any other fixed upper retainer is only when a patient/parent insists on it; we try to talk them out of it. Then it is $250 for the retainer and $100 for any rebonds, which happen all the time.

The key is to inform patients and parents of these facts all along. You should not feel guilty about charging for these things. Almost everything in life requires maintenance; retainers are no exception. ■ Diane

amalgamator22
Posted: 8/31/2011
Post: 5 of 14

Diane, on your lower do you bond every tooth or just 3s? If you are just bonding to 3s, do you find some rotations/relapse on the incisors? If you bond every tooth, do you get one tooth debonded without the patient noticing until it moves significantly? What wire do you use? Do you make an overlay Essix?

I feel that there is a million ways to approach retention and if one way was best we would all do it, so I like to hear about what others do. ■

hoodortho
Posted: 8/31/2011
Post: 6 of 14

Generally, I offer patients upper and lower Essix retainers (day of deband) and Hawleys (a few weeks later). I will bond 1-1 or 2-2 if there was a diastema to begin with. If parents request a bonded 3-3, I will do those in addition to the Essix and Hawleys – and my assistants inform parents that after a year, broken fixed retainers will be charged a fee to replace.

In the past, I bent a TMA wire and bonded to just the 3s on the lower, but found that despite that, incisors would often rotate facially. I do agree that finishing with proper overbite and overjet helps keep the upper and lower incisors somewhat in alignment, but let's face it, a lot of cases don't finish ideally due to lack of compliance, poor oral hygiene (and you have to get out), etc.

While we're also on retention, I am having a tough time keeping extraction spaces closed on adults. Regardless if patients wear their Essixs/Hawleys 24/7, it seems that a millimeter or two of space is always opening up. I've also used wrap-around upper and lower Hawleys to address this problem, but the fit is never spectacular and the contacts are still very light, if that. Any suggestions or tips? ■

dhmjdds
Posted: 9/1/2011
Post: 7 of 14

Hoodortho, So they wouldn't brush their teeth or wear their elastics, but you think they will wear a removable lower retainer for the rest of their life? I find that to be unlikely.

continued on page 28

continued from page 27

Obviously what you are saying is that if you give them a removable retainer, and they don't wear it then it is "their fault." Then their teeth get really crooked again and they need to be completely retreated. But if they had a bonded retainer, then the teeth would only be able to move a little, and the fix would be relatively cheap and easy. And somehow the movement of their teeth is their fault in the first example, but your fault in the second example? I don't really think that is true.

On your lower do you bond every tooth or just 3s? If you are just bonding to 3s, do you find some rotations/relapse on the incisors? If you bond every tooth, do you get one tooth debonded without the patient noticing until it moves significantly? What wire do you use? Do you make an overlay Essix?

We bond only the 3s. Yes, the incisors might move slightly. Bonding them to the wire seems to help only a little, since as you pointed out, they can't tell if they come loose and they always come loose from the incisors. If a tooth rotates, I IPR both sides of it slightly (with the wire in place) to free up the contacts and 90 percent of the time, it will move back into alignment just from lip pressure. I only make overlay Essixs if they are otherwise needed (bruxers); not routinely. They are not going to wear them. ■ Diane

hoodortho
Posted: 9/1/2011
Post: 8 of 14

I feel that at some point during treatment patients have to take responsibility for their teeth and the alignment of them. I prefer Hawleys, due to the ease of cleaning, longevity of use and for keeping the teeth aligned. We inform our patients that if not worn their teeth will likely get crooked. I can't babysit them for the rest of their lives. These kids will be adults someday and I feel at some point should be held accountable. So yes, I do feel less responsibility should I see relapse in cases where removables were not worn. Which is why I also give patients Hawleys to overlay bonded lingual retainers. Should they come loose, I want them to have another back-up retainer to keep those teeth straight.

My problem with using bonded linguals (and I have since switched to bonding each tooth), is hygiene and maintenance and, really, not every patient or parent wants it. I certainly don't mind rebonding those loose areas, however I don't like hearing parents gripe about the cost to do it. As I posted earlier, we inform parents that like most things in life, these bonded linguals require maintenance and might become broken – and we charge a fee to fix/replace them. Of course, many of them don't remember that or still gripe about it anyway.

When I did previously just bond to the 3s and noticed relapse, I would IPR the tooth and found that it didn't really help with the rotation correcting. Maybe it was just my technique. And I do find that patients are cognizant of when a single bond becomes loose on a lingual wire that is bonded to each tooth.

The bottom line is, I hate seeing relapse and I want to do everything I can to prevent it. ■

NWOrtho
Posted: 9/2/2011
Post: 9 of 14

I bought a practice two years ago. As a result, I am not overly confident in what the previous doc explained to patients and parents at debond, so I have eaten a lot of relapse and retainer costs over the past few years. I wish I could have bought everything but his retention patients.

This morning I have a mom with her daughter whose braces were removed three years ago. Her lower fixed retainer broke two months ago with slight relapse. She went to the dentist who recommended she have a removable retainer as her hygiene was not good and fixed retainers could break and were tough to clean around. Mom

was irate we did not give her a removable one to begin with as the teeth have shifted and the dentist told her she could not keep it clean. So I give a lower spring retainer with resets at no charge.

I move to the next chair and there is an irate mother whose daughters braces were removed three years ago. Her lower anterior teeth have shifted since braces were removed as a result of zero compliance with wearing her lower spring retainer. She tells me all her friends kids have fixed wires and never have to worry about retainers. I said I would align the lower teeth and place a fixed at no charge.

I pulled the two moms aside and asked them to tell each other why they were in the office. After five minutes of talking, the first mom asked for a permanent fixed again and the other mom asks for a new removable spring. I couldn't believe it.

Fixed or removable... damned if you do and damned if you don't.

One of the best things I did when I started in the practice was implementing a retention agreement. The parents and kids sign this at debond and take it home after it is scanned into their chart. It also covers information about late jaw growth.

Parents and patients pick either a lower fixed or lower spring. I review the positives and negatives of both and inform them either way retention is for life since those lower teeth will shift. I much prefer the lower spring and I would say we use it 80 percent of the time. With this being their choice I don't feel bad charging $100 when they come in a year later with a spot off and I don't feel bad when the lower anteriors are crowded and need retreatment if they didn't wear their spring. If there is ever an upset parent I pull up the agreement and ask if there is anything different we should have done on our end. They usually do not have much to say then. ■

Read more about broken fixed retainers in these message boards at Orthotown.com.

How Do You Repair a Broken Fixed Retainer?
Search: Repair Broken Retainer

Fixed Retainer Wire
Search: Fixed Retainer Wire

drmariana
Posted: 9/2/2011
Post: 10 of 14

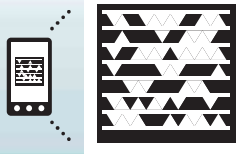
Anyone have a "retention informed consent" in the office? I have been thinking of developing one and making it be signed by the patient or guardian before the brackets come off. So we are all clear on:

1) Retainer wear
2) Post-treatment checkup protocol and what happen if it's not followed
3) Consequences of not wearing retainers
4) Financial responsibilities for retainer repair/loss/not fitting
5) Patient discharged

Any one heard of one? ■

natpar
Posted: 9/5/2011
Post: 13 of 14

We place fixed lower retainers in 99 percent of our patients, poor oral hygiene being the primary reason we do not prescribe one. Ours are placed indirectly using Anoop Sondhi's technique. We have very little failure. We guarantee them for three months, after which there is a charge for repair or replacement if they lose it. We do give them an Essix overlay if they started with a severely rotated incisor. After one year, we also charge for a post-treatment visit. We do not have them sign an agreement but we do hand them a retention brochure and review it with them and the parents. This seems to be very effective. ■



Find it online at www.orthotown.com

Backtrack or Plow Ahead?

Retreating a previously failed treatment is often more stressful than treating a new patient.

charlestonbraces
Posted: 8/2/2011
Post: 1 of 15

A 21-year-old female who moved here one year ago had orthodontic treatment started at 16 years old, but discontinued shortly thereafter for financial reasons. Had all 4s removed. About 9-10mm space per arch remaining, but current incisor angulation looks good as well as lip aesthetics. Patient wants spaces closed. I advised her that her options were (in no particular order):

A) Close all spaces orthodontically which will most likely cause a problem aesthetically with retroclined incisors and loss of her current nice lip aesthetics.

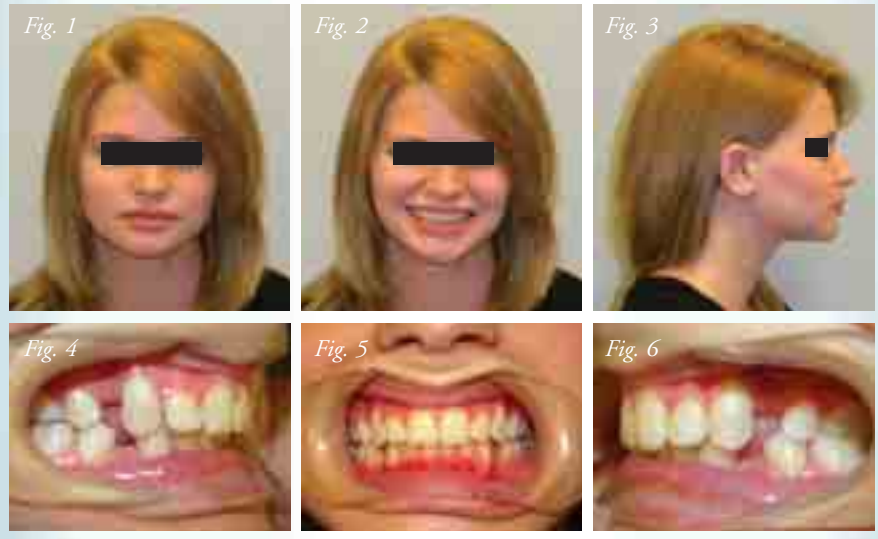
B) Open space for prosthetic replacement (most likely implants) which will be costly outside of my office.

C) Close spaces with TADs (temporary anchorage devices) which will keep aesthetics much like they are now, but will incur additional cost outside my office.

I tried to carefully glean from her the reason for extractions. She said the doctor said he thought she might be too toothy. She said she understands but did not really want the extractions. When she inquired, I told her I could not comment on the extractions because I did not have the benefit of seeing what the other doctor saw.

I have called for the initial records and will post them as I get them for additional diagnostic information.

My gut tells me option B – open space, but that's easy for me as I am not shelling out the money for implants. I could do C – TADs for posterior forward closure, but it will still cost and will drag treatment out a long time. I really can't feel comfortable with A – close 'em and kick her out!



Figs. 1-6: Complicating all of the above is the fact that her bony ridge is certainly narrowed on the lower arch (whether for space closure or implant placement).

Figs. 7-9: Mirror image (not flipped)

Check out these other message boards that debate closing spaces or opening spaces for implants.

Avulsed Lower Canine – Close Space or Plan for Implant?
Search: Avulsed Lower Canine

Open Spaces for Implants or Attempt Closure
Search: Attempt Closure


Fig. 7


Fig. 8


Fig. 9

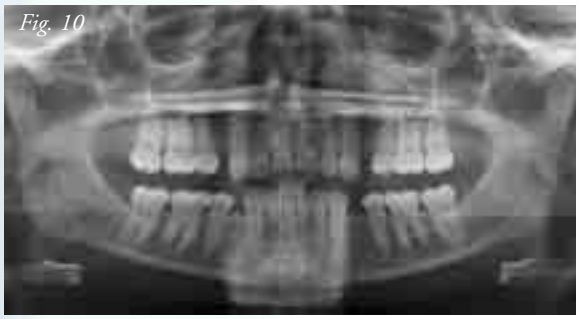


Fig. 10

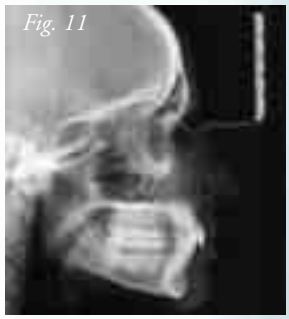


Fig. 11

Figs. 10-11: Another view of the bony defects and the less than desirable gingiva.

When I receive the records, I worry that I might have come to a different opinion regarding extractions. Would you call the original doctor? ■

vraj
Posted: 8/2/2011
Post: 2 of 15

I would plow ahead... I think the maxillary incisor angulation can be maintained by using high torque brackets and filling the slot in the maxillary arch, backed up with Class II elastics to maintain lower incisor position. Another option might be to use a dual-geometry wire (kind of like bi-dimensional). ■

sharperdds
Posted: 8/2/2011
Post: 3 of 15

I'm not saying that I would have extracted in this case, but the lower incisors do look proclined on the ceph. If you close the spaces and try to burn posterior anchorage, you will probably end up with about a 90-degree IMPA. If you use high torque U incisor brackets and try to keep facial crown torque on the upper, you should be able to finish this pretty nicely without TADs.

Sometimes when I have a crowded case and extract and align the teeth, it seems like I have this result (i.e., roughly half a premolar width residual space in each quad). I can't think of a time when after I closed the spaces that the patient had a caved-in face.

Not seeing the starting records, I wouldn't pass any judgment. And after seeing them, unless there was gross negligence (which I doubt), I wouldn't worry about the previous doctor's decisions. There are a lot of successful ways to treat a case. To some people an IMPA greater than 95 degrees with crowding is a justifiable reason to extract. This case looks like it would fit that description. I know most of us now treat to the profile, not to the IMPA, but others might. And this is not necessarily wrong, just a treatment preference.

If this were my kid, in this situation I wouldn't hesitate to close the spaces without TADs, aim for an IMPA of around 90, and try to maintain torque. I certainly think TADs could improve the case, but I wouldn't insist on them. ■

continued on page 32

continued from page 31

charlestonbraces
Posted: 8/3/2011
Post: 4 of 15

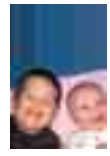
The incisors are tipped out past 90, but considering her facial type (brachy with a low MPA), I think 90 would actually be retroclined (since the incisor angulation is measured not on the facial surface, but from a line that bisects from incisal tip to root apex). ■

DrBThomas
Posted: 8/3/2011
Post: 5 of 15

Suggesting opening up the spaces for implants might be opening a can of worms. Once she gets the estimate from the dentist and/or surgeon, she's going to be really upset with the first orthodontist. Then it will become a question of your treatment plan vs. the first orthodontist.

Like others have suggested the IMPA is close to ideal. Your challenge will be to close the remaining spaces without retracting the anteriors or dishing in the lips. You will need anchorage. How about a few TADs in the maxilla along with Class III elastics? ■

pnwortho
Posted: 8/4/2011
Post: 6 of 15



I agree with Sharper and BThomas. TADs would be ideal, but closing the spaces at this point with attention to torque is not unreasonable. Might be a good case for American Ortho's new self-ligating brackets with active clips in the front and passive clips on premolars and molars to encourage anchorage burning. ■

petertphan
Posted: 8/5/2011
Post: 7 of 15

One thing I noticed on the ceph was the lip ratio affords the lip to stay there with some (read minor) anterior retraction. Really, how long do you think it'll take to close the spaces orthodontically? This is an adult with long standing spaces (bone quality), so I'm going to assume space closure is going to be a bear to accomplish (TADs or no TADs). ■

charlestonbraces
Posted: 8/5/2011
Post: 8 of 15

Petertphan, you are right on. Those alveloar ridges are going to make things tough for closure (or implant placement if space is opened). ■

ahayes
Posted: 8/5/2011
Post: 9 of 15

My thoughts exactly. This is complicated by the fact that in spite of the absence of the first bis, it's hard to even justify any orthodontic treatment. She's got a nice smile line, good lip support with no strain, and no crowding. The only treatable thing for me is probably iatrogenic in nature. Sorry to say it, but I see no logical reason to have extracted there other than gross caries or agenesis and I've never seen multiple missing 4s (without 5s gone too), and the girl doesn't have a filling in her skull. ■

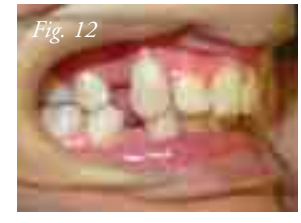


Fig. 12

charlestonbraces
Posted: 9/9/2011
Post: 10 of 15

Well, I got the initial records from the original orthodontist on this case. From the photos, she looks full in the lips, but the original ceph and even the progress ceph don't suggest overly full lips. The original ceph actually looks pretty balanced with

minimal maxillary crowding, although, as I mentioned, the original photos look full in the lips, but this could be due to tightening lips. Thoughts?

Fig. 13

Fig. 14

Fig. 15

Fig. 16

Fig. 13: Initial photos from original orthodontist
Fig. 14: Initial ceph from original orthodontist
Fig. 15: Progress ceph from original orthodontist
Fig. 16: Final photos (DOT) from original orthodontist ■

sharperdds
Posted: 9/9/2011
Post: 12 of 15

I don't think that I would have extracted in this case, but I wouldn't blame the original orthodontist for her situation. It appears she disappeared for a while and then requested to have the braces removed. It is hard to blame the orthodontist for that. I think this case could have been successfully treated by the original orthodontist, if she had followed through with the original plan.

Just give her the options you described (in your first post) and the risks, benefits, likely costs and procedures involved in each option. You can state your preferred treatment option and the rest is up to her. She might end up disappearing on you during treatment too, so be careful.

Don't promise the spaces will close or stay closed (if you try to close them). Just tell her due to her circumstances, you will do the best to your ability. If she needs multiple implants, she might balk at that. Finances certainly could be an issue (based on her previous behavior).

Retreating previously failed treatment carries more risks and potential headaches than a normal new patient. You might want to charge accordingly. ■

Realizing Your Full Poten

OrthoSynetics, Inc., is dedicated to helping orthodontists achieve business success by managing the non—

by Chelsea Knorr, staff writer, *Orthotown Magazine*

OrthoSynetics, Inc. (OSI), is a practice management/business services firm that assists orthodontic specialists with the non-clinical aspects of running their practice. The company currently serves about 300 orthodontic practices nationwide. OSI President and CEO David J. Marks is a seasoned health-care executive with more than 33 years of executive health-care management experience with an emphasis in multi-state, multi-site companies. His specialty area is in physician/group practice management. *Orthotown Magazine* spoke with Marks to learn more about the company.

David, can you please tell our readers about your career leading up to when you joined OrthoSynetics?

Marks: After beginning my career in EMS/hospital administration in 1977, leading the establishment of one of the first paramedic, helicopter transport and level I trauma/burn/spinal cord injury centers in the country, I moved to the nationally recognized emergency medicine consulting and management firm of Stern and Associates in 1983 where I served as executive vice president for 10 years.

In 1992, I accepted the role of division vice president for EmCare, a company that provides turnkey emergency and ambulatory care services to more than 3 million patients annually at 140 hospital emergency departments in 30 states. Following a successful IPO, rapid growth and expansion, I took the position of COO of USCardioVascular, a cardiology practice management company startup focused on outpatient diagnostic facility development which we grew to a multi-state and multi-faceted company over the subsequent 10 years. I took over as president and CEO in 2004.

My tenure at OSI began in October 2009 as chief operating officer and I was appointed president and CEO in July 2010.

What's OSI's mission?

Marks: Our purpose is to help doctors realize the full potential of their practice. We accomplish this by providing orthodontists with a dedicated team of business experts who are all focused on one thing – the success of the doctor. The accomplishments of our current clients speak volumes. With our suite of business services, OSI affiliated practices experience improved new patient starts, significant increases in profitability and, best of all, an overall improved quality of life. Through the implementation of our services, OSI takes the headache of managing the non-clinical aspects of a practice away from the doctor. This allows the doctor to focus on their clinical practice and patient care, while taking home more compensation and enjoying their increased "off time" with family and friends. We continuously modify our systems and service offerings to ensure OSI clients sustain their competitive advantage in their marketplace.

Tell me about the OSI team. What type of experience they offer?

Marks: OSI is comprised of many specialized departments. Each department has a director with more than 15 years of experience helping doctors grow their top line while improving their bottom line at the same time. These departments work as an integrated team delivering quality assistance to optimize the practice's performance. Our team handles the non-clinical functions of a practice so the doctor can concentrate on providing patients with exceptional care and beautiful smiles.

continued on page 36

tial

—clinical aspects of the practice

Dr. Michael Delgado (left) and David J. Marks, OrthoSynetics president & CEO

continued from page 35

"We not only provide the doctor the solution to his/her business challenges, but we also execute the solution. Our services are fully integrated with one another to ensure success."

What types of services do you offer orthodontists?

Marks: Our suite of fully integrated services include: practice development and enhancement consulting, revenue cycle management, purchasing, practice accounting, business insurance, practice and equipment financing, marketing, real estate/construction/facility management services, human resources management, patient insurance/benefits/eligibility verification, recruiting and practice transition planning and implementation. We basically can do everything except put braces on patients.

How do you group these various services into packages?

Marks: Our service packages are fully customizable. Our strategy is to perform an initial assessment of the practice operations and identify opportunities for potential growth and efficiencies. A business development consultant then provides service package recommendations that are tailored to the needs of that doctor. We often find that it is the combination of all services together that result in the greatest success.

What are the resources OSI offers?

Marks: OSI has a team of more than 100 professionals who are all experts in their respective areas. With the vast amount of talent we have in-house we are able to provide hands-on guidance in all key areas of practice operations. Our skill set includes expertise for newly-in-practice doctors, doctors in a growth stage of their career as well as those planning retirement or a sale in the next five years. We have the equivalent of a full-service marketing firm "in-house" to develop practice branding and marketing campaigns to increase patient starts and build brand awareness. We also offer the benefit of in-house legal counsel for HR issues, loan or sale closings and general legal questions regarded to everyday business matters. OSI can also recruit employees and associates for practices. Practice-operation experts bring a variety of "best practices" to our clients. We also enjoy key partnerships with industry suppliers, leveraging our 300 practice locations, to provide clients with ideal products at the best possible price.

How are your services appropriate for each newly in-practice, growth mode, practice in transition and mature practice life stage?

Marks: Service needs vary depending on the practice life stage. A newly-in-practice doctor is facing many important decisions that will have significant impact on the practice for years to come. Typically these doctors come to us for our "Newly-In-Practice" program which provides the services a new orthodontist needs to begin a successful practice while saving the orthodontist approximately $110,000 in their first year in comparison to market rates (after including our nominal fees).

A growing practice can also benefit from our sophisticated marketing, practice consulting, purchasing, real estate, recruiting and equipment financing services. The mature practice often looks to us to kick-start growth, recruit associates, tune up "best practices" and begin to look at a transition plan in the future. The practice in transition can benefit from our legal departments expertise on practice sales as well as recruitment of buyers.

How do you support orthodontists during their engagement with OSI?

Marks: During our partnership, an orthodontist can expect to typically have a team of 30 individuals working together to ensure success for the practice. We follow a proven system that ensures timely and successful execution of all best practice recommendations. One of our strongest features is that we dedicate

a practice account executive to each practice. Their role is to oversee all facets of the business from an operational and financial perspective, ensuring all service expectations and financial returns are on plan each month.

David, what interactions do you personally have with orthodontists on a daily basis?

Marks: My typical day is filled with discussions with our orthodontists regarding industry trends, new initiatives at OSI and strategic planning for their practice. There are a lot of new and exciting improvements we are rolling out to the practices that will further increase the service levels we provide clients.

What separates OSI from its competitors?

Marks: There are no other nationally focused (38 states, Puerto Rico and soon to be Canada) full-service, turnkey, orthodontic practice management companies in the industry today. OSI offers a comprehensive set of business services all under one roof. We not only provide the doctor the solution to his/her business challenges but, unlike external consultants that leave a practice with a plan the practice has to implement, we also execute the solution. Our services are fully integrated with one another to ensure success.

Can you share a few examples of success stories with our readers?

Marks: We have many success stories. The most telling and current one I can share with you is that on average, our affiliated practices have continued to grow their patient starts as well as their net income over the last three years in a very difficult economy while the average orthodontist has declined in both, some at double-digit rates.

How did you measure these results?

Marks: We measure our results by the individual doctor's level of satisfaction on OSI's achievement of the goals we initially set together when he or she became a client.

How can a doctor integrate OSI into his or her practice?

Marks: Simply by calling our new business phone line at 877-OSI-1111. We will have one of our new business specialists and a practice consultant discuss the doctor's goals and analyze where OSI could assist the practice. Doctors will also see us exhibiting at many of the national and regional orthodontic trade shows.

What does the future look like for OSI? Any plans in the works?

Marks: The future is bright for OSI – we are adding new affiliates, providing new services and improving our existing services on a monthly basis. This trend will continue and significantly improve as the word spreads on the value of our services and the ability of OSI to meet or exceed our doctor's stated goals.

To learn more about OrthoSynetics, Inc., visit www.orthosynetics.com, or call 877-OSI-1111 or 888-622-7645. n

David J. Marks, OrthoSynetics president & CEO (left) and Dr. Michael Delgado.

New Products

Perforated Diamond Finishing Strips

Perforated Diamond Strips are designed for complete control during interproximal reduction, shaping and contouring. The strips allow easy access and precise manual enamel reduction resulting in a smooth, natural finish. The perforated strips are stainless steel to resist breaking and stretching and are color-coded for grit selection; blue for medium, red for fine and yellow for super-fine. For more information, call 800-355-5063 or visit www.axisdental.com.

Diamond Finishing Strips

GC Tri Plaque ID Gel

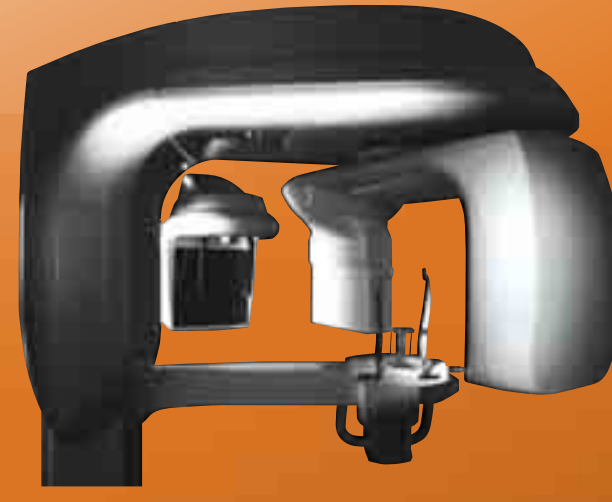
Innovative new disclosing gel promotes patient motivation for enhanced oral care. GC Tri Plaque ID Gel identifies new, mature and acid-producing biofilms in three colors; pink indicates new plaque, while dark blue/purple points out mature plaque and light blue shows the extra high-risk plaque areas. GC Tri Plaque ID Gel is a chairside motivation test which helps educate patients on plaque that remains on the teeth after brushing. For more information, visit www.gcamerica.com.

GC Tri Plaque ID Gel

CS 9300C

The CS 9300C's cephalometric imaging enables orthodontists and other oral health professionals to perform a wider range of diagnoses and treatments from their own office, without the need to refer patients to other imaging centers. In addition to 3D and panoramic imaging, the CS 9300C offers formats from 30cm x 30cm to 18cm x 18cm. The CS 9300C's cephalometric module addresses any orthodontic diagnostic and tracing need and even provides an exclusive full cranial option. The CS 9300C is also certified by OraMetrix, Inc., for use with its SureSmile technology. Also included with the CS 9300C are three automatic orthodontic enhancement filters that enable practitioners to improve image clarity and outline soft tissue with just one click. For more information on the CS 9300C or to request a product demonstration, call 800-944-6365 or visit www.carestreamdental.com.

CS 9300C

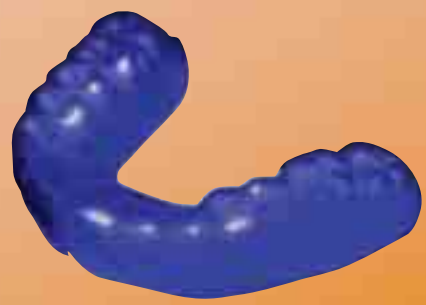


You are invited to visit Orthotown.com to ask questions or post comments about the following New Product Profiles. If you would like to submit a new product for consideration to appear in this section, please send your press releases to Assistant Editor Marie Leland at marie@farranmedia.com.

Fierce Mouthguards

Fierce mouthguards from DDS Lab meet the needs of any athlete, from gymnasts to MMA fighters. Fierce mouthguards help prevent lip, cheek and chin lacerations, broken teeth, displaced teeth, fractures of the facial bones and injury to the jaw joints. Fierce mouthguards are 100 percent customized to the specific needs of each case and are available in more than 27 colors and designs with six levels of sport-specific protection. For more information, call 877-337-7800 or visit www.ddslab.com.

Fierce Mouthguards



MicroLine Flip-Ups

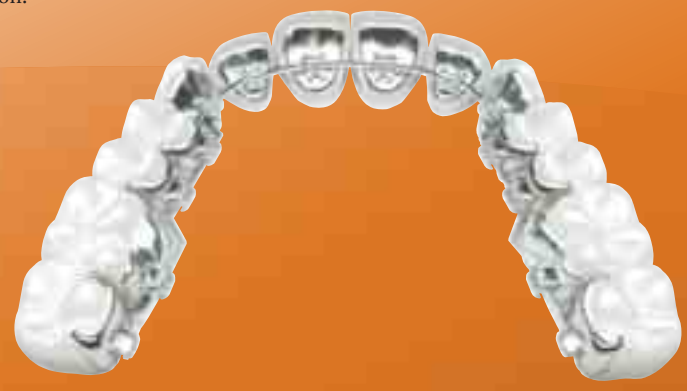
At one-third the size and weight of competitive loupes, the MicroLine Flip-Ups are so comfortable you won't notice you're wearing loupes. The Flip-Ups are individually adjustable using the patented Optilock design which ensures a perfect fit. Once you've set your interpupillary distance, your optics are automatically locked into place. Available on Adidas sports frames which come in multiple color choices. Prescription lenses can also be added with an optional insert. For more information, e-mail info@perioptix.com, call 888-360-0033 or visit www.perioptix.com.

MicroLine Flip-Ups

Harmony

Harmony is a digitally customized self-ligating lingual system. Using proprietary CAD/CAM and digital scanning technologies, a highly accurate bonding pad is created for the lingual surface of each tooth. Harmony also includes digitally customized, robotically formed arch wires, which deliver light, continuous forces that correct even the most severe malocclusions and deliver the optimal, biologically correct force levels at every phase of treatment. Using a combination of proprietary scanning, treatment planning and CAD/CAM software, as well as robotically formed arch wires, technicians at the Harmony Technical Center work closely with orthodontists to design a perfectly customized smile for every patient.
Visit www.myharmonysmile.com for additional information.

Harmony



Tailor Made

by Benjamin Lund, Editor, *Orthotown Magazine*

Welcome to the newest installment of Office Visit, where we visit a practicing orthodontist's office and profile his or her equipment, design or unique practice philosophy. If you would like to participate or nominate a colleague, please e-mail ben@farranmedia.com.

This month we paid a visit to Dr. Adam Schulhof and his practice in Oradell, New Jersey. Dr. Schulhof, the developer and sole provider of the "Incognito Lite" system, is a strong proponent of individualized treatment, pushing past his own "orthodontic biases" and ensuring the end result for each patient is tailor made for their needs. We discussed his reasons for entering orthodontics, his practice philosophy and what the orthodontics profession means to him.

Photography by Michael Benabib

Office Highlights

Bonding Agents
- 3M Unitek SEP(self-etching primer)
- Reliance Assure

Brackets/Wires
- Incognito
- Unitek Clarity SL

Cements
- 3M Unitek IDB
- 3M Unitek Transbond

Class II Correction Appliances
- Forsus

Class III Correction Appliances
- Tandem traction appliance

Hygiene
- WaterPik as patient gift with each bonding

Patient Financing
- ChaseHealthAdvance

Technology
- Macs
- TOPS

Dr. Schulhof, to begin, why did you choose orthodontics as your career path?

Schulhof: I sought a profession that helped people feel better about themselves. I majored in psychology and had first-hand experience with how a person's appearance can affect self-esteem. I also wanted to work with my hands and always be challenged. Orthodontics seemed like a perfect fit.

What is your practice philosophy?

Schulhof: Individualization. Each person is unique and we customize treatment for each individual. It's important to look at the whole package, not just the malocclusion. We need to take into account everything about this individual, from motivation and chief complaint to lifestyle.

How do you cultivate this philosophy in your practice?

Schulhof: By spending the time at each consult to really listen to each patient. As orthodontists we tend to push our "orthodontic biases" onto our patients, it's extremely helpful for some of us to stop and listen to what this patient truly wants. It helps to understand a patient's lifestyle and to then tailor a treatment plan toward his or her unique needs.

continued on page 42

Name: Adam Schulhof, DMD

Graduate from: University of Medicine and Dentistry of New Jersey (dental school); Columbia University (orthodontics)

Practice Name: KinderSmiles

Practice Locations: Oradell, New Jersey

Year when new office opened: 2003

Practice Size: 3,600 sq. ft. **Staff:** 14

Web site: www.kindersmiles.com

continued from page 41

What is the orthodontic competition like in your area?

Schulhof: It is extremely crowded, as is usual for a metropolitan area.

How have you weathered the current economic storm? Have you made any adjustments to your business or your clinical practice?

Schulhof: We have been fortunate in that our business and practice model was always one of differentiation. When a patient experiences our office they can't possibly continue "shopping" as they can't compare it to anything else around us.

What sets KinderSmiles apart from the other orthodontic practices in your area?

Schulhof: There's really so much. The newest 1,200 square feet that we've added was designed to instantly calm and soothe the patient. It combines cutting-edge design with the best of new technology.

Clinically, our niche is "customized orthodontics" with a concentration on aesthetic appliances. Every treatment plan is accomplished with either Clarity SL or Incognito Lingual braces. Incognito is 100 percent customized. If the patient opts for Clarity SL we customize using Variable Prescription and three different arch forms tailored to each patient.

What piece of technology has the biggest "wow" factor for your patients?

Schulhof: The biggest wow factor is Incognito. Patients are always wowed by the customization and about being able to treat any malocclusion truly invisibly. We constantly hear during our consultation, "You can do that?"

How do you market your practice to new patients?

Schulhof: Internal marketing, Internet, social media and local high-end magazines. With a product like Incognito there's a clear differentiating factor, so it's easy to market.

Dr. Schulhof's Top 3 Products

	Incognito	OrthoLase soft tissue diode laser	TOPS Software
When did you start using it?	2004	2006	2010
Why can you not live/ work without it?	It allows me to treat every patient and any malocclusion invisibly.	It saves a lot of chair time and allows more accurate placement of brackets earlier in treatment.	It is the heart of my practice management, my schedule, treatment record and imaging.
When do you use the item?	Daily	Daily	Daily
How do you market it to your patients?	Internet, social media, in office, print ads	In office	I don't, but it markets itself as patients are wowed by the Macs and the images.
If you could change anything about it, what would it be?	Quicker lab turnaround, lower lab cost	The newer upgrades of this product have resolved any changes I'd make.	Cost

continued on page 44

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continued from page 42

You are the developer and only provider of what you call "Incognito Lite" braces treatment – can you tell our readers more?

Schulhof: Allow me to clarify... We developed the term "Incognito Lite" to use amongst ourselves in the office to describe a new treatment type using Incognito, and pretty quickly – much to our surprise – we had patients walking through the doors asking for Incognito Lite!

After using Incognito to treat many patients, we were so thrilled with the results and noticed that Incognito has wonderful torque control as well as extremely rapid leveling and aligning of crowded teeth. Many of the adults walking through our doors needed a more limited treatment to relieve moderate crowding or spacing in the anterior but had a relatively good occlusion. I had used many clear aligners and "social 6" type treatments but was very disappointed with the lack of control and the results. With aligners we found ourselves constantly "rebooting" the case to achieve our treatment goals. This all resulted in frustration and took up a lot of additional chairtime, which is expensive to the practice.

Together with a wonderful team at 3M Unitek we quickly set up protocols to use Incognito only on the anterior 3-3 or 4-4 allowing for beautiful results. With this product we have wonderful three-dimensional control of the teeth. Most cases are finished to perfection in four to six months!

KinderSmiles staff from left: Michele Arencibia, RDA, head dental assistant; Angelica Cruz, DA, dental assistant; Joyce Giron-Papa, treatment coordinator; Dr. Schulhof; Nicole Simpson, orofacial myologist; Buseon Kim, RDH, hygienist & dental assistant and Anafaye Vandenberg, RDA, dental assistant.

Patients love it as it completely addresses their concerns and does so aesthetically, comfortably and in a timely manner. I like to call it "Limited Treatment" without the limitations.

continued on page 46

Clear Choice Alignment Trays

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per tray

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continued from page 44

In your practice, what is a typical day's schedule?

Schulhof: We see anywhere from 75-90 patients.

What is the most unique treatment plan you've put together?

Schulhof: As a lingual practice grows, it is only natural that the percentage of adult patients grows. Adult treatment is very fulfilling as well as extremely challenging. Many adults present with worn teeth and prosthetics and so many treatment plans are interdisciplinary. It is not unusual to lead a team of general dentists, periodontists and oral surgeons all working together to achieve a great result for a patient. With this in mind, almost every adult treatment plan seems unique.

What is the most rewarding experience you've had as an orthodontist?

Schulhof: When treating adolescents, a majority of them are in the chair because mom or dad dragged them there. With adult treatment, patients have made the time to come seek our help, putting aside their fears and concerns, so obviously their smile – or lack thereof – is really affecting them. On a weekly basis we see tears of joy and appreciation from patients. Successful doctors, lawyers, actors and powerful businessmen are reduced to tears telling us that we can't imagine what a change their new smile has brought about in their lives. To experience this is really powerful. In our office we are fortunate that we experience it so frequently.

In your opinion, what is the biggest problem orthodontics faces today and what do you think should be done about it?

Schulhof: The public is still not educated to the fact that orthodontics is a lot more involved than slipping an aligner into a patient's mouth. There are some general dentists who are good orthodontic clinicians, however there are many more that truly do not understand the intricacies of a proper orthodontic treatment plan. It seems that as the years go on I am seeing more and more "please fix this patient for me" cases from GPs.

How has Orthotown benefited you and the way you practice?

Schulhof: It is extremely helpful in keeping me abreast of what's new in the field and in seeing how others deal with some of the obstacles I run across daily.

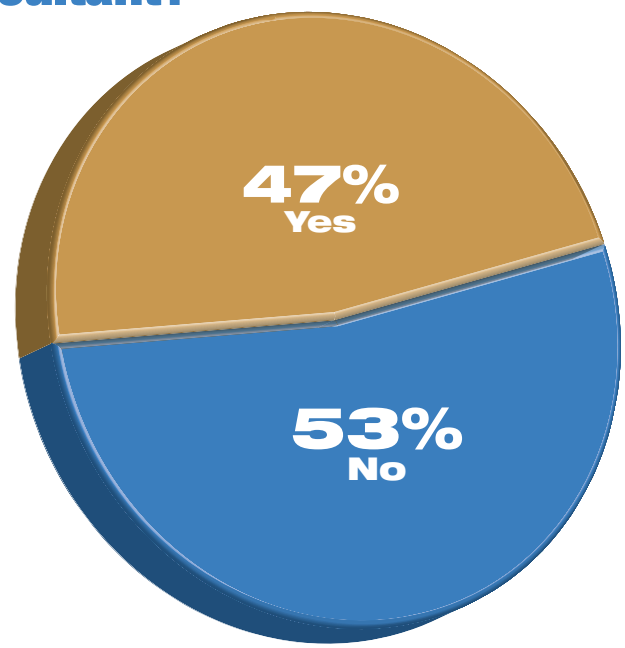
What advice would you give someone who is thinking about entering orthodontics?

Schulhof: It's hard work but extremely rewarding. Spend a nice amount of time in an orthodontic office to really get a taste of the day to day. If it's to your liking work, work, work until you realize your dream. n

Orthodontists' Opinions About Practice Management

Keep reading to see what other orthodontists are doing in terms of practice management in this poll conducted from August 26, 2011 to September 30, 2011. Don't forget to participate in the poll on Orthotown.com each month. The more opinions you can provide us, the most statistics we can supply you.

Have you ever used the services of a dental consultant?



Would you consider moving to a cloud-based practice management software platform?

75% Yes
25% No

Are you hiring?

27% Yes
73% No

Has the economy forced you to let staff go in the last six months?

23% Yes
77% No

Either or: what do your patients prefer?

68% Low cost of treatment
32% Speed of treatment

How many total hours is your practice open each week?

Average: 31.65 hours per week

Answers ranged from 16 hours per week to 42 hours per week.

An online poll asked, "What have you done in the last six months to lower your overhead?" Some of the most popular answers were:

Eliminated staff members
Reduced number of hours worked by staff
More in-house lab work
Changed brackets/other supplies
Cut back on expenses
Increased fees
Merged with another practitioner
Nothing

What practice management software are you currently using?

20% Dolphin
16% Ortho2
4% Orthoease
25% OrthoTrac
7% PracticeWorks
8% TopsOrtho
20% Other*

*** Townies also listed the following practice management software systems:**

Advanced Ortho Systems
Dentisoft
Desco Dental Systems
DOX
ICE Dental Systems
IMS
KODAK OPMS
MacBraces
MacPractice
New Horizons Software
Oasys
OrthoChart
Patient Care Suites

essentialitems

You Need to Know If You Sponsor a Qualified Retirement Plan

by Larry Mathis, CFP

On April 1, 2012, the U.S Department of Labor (DOL) regulation, ERISA Section 408(b) (2) will go into effect. This new regulation brings with it a variety of rules that will directly affect what are generally referred to as "qualified retirement plans." Although most of the regulations directly affect service providers it is important that plan sponsors know what their responsibilities are as well. This article is designed to help you understand what your obligations are as a retirement plan sponsor and fiduciary.

The 408(b) (2) regulation will require plan sponsors to receive and review certain disclosures from various plan service providers. As such, service providers must make certain required disclosures to plan sponsors by April 1, 2012. Essentially this regulation is designed to require retire-

ment plan service providers to disclose the fees (direct and indirect) that they charge for their services so that plan sponsors (as fiduciaries) can determine if the fees being charged are reasonable and at the same time identify any potential conflicts of interest that might affect the quality of the services being provided.

What does this mean to you as a sponsor of a qualified retirement plan?

The new disclosure rules will allow plan sponsors to get a true picture of the fees they are paying in their existing plan, which are often difficult to understand or for that matter even see at all. This will enable plan sponsors to make apples-to-apples comparisons when evaluating multiple plans, in regard to the services being offered by service providers and the associated costs of those services. I believe this will ultimately help plan sponsors make better decisions on behalf of the plan participants. In addition I believe this will lead to the reduction of plan fees, which could increase investment returns for participants.

What are your risks as a fiduciary of your retirement plan?

Fiduciaries who do not meet their obligations might be held personally responsible. ERISA Section 409 provides that "any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations or duties imposed upon fiduciaries by this title shall be personally liable to make good to such plan any losses to the plan resulting from each such breach…" The criminal and monetary penalties are severe, not to mention the attorney fees, taxes and possibly other costs.

You might be saying at this point, "I probably don't have too much to worry about. I doubt the government is going to be concerned with our plan, it's too small and they have bigger fish to fry." I caution you to not think this way. Instead I encourage you to go to www.dol.gov/ebsa/newsroom/main.html and take a look at some of the recent violations of fiduciaries that the U.S. Department of Labor is pursuing. It's not just the big fish that the DOL is looking to catch, so it is imperative that you are diligent to make sure you are following the regulations.

As an employer sponsoring a retirement plan, you should recognize the fact that you will always be considered a named fiduciary. As a fiduciary it is essential that you act in the interest of the plan participants and their beneficiaries. You must act in a prudent fashion, taking special care to diversify the plans investments, while at the same time being diligent to keep plan expenses reasonable. Furthermore you need to be sure you are acting in accordance with the plan document. Remember your loyalty to plan participants starts at the inception of the plan and continues through the ongoing monitoring of the plan operations and investments.

I would argue that you might want to be more concerned about what you *don't* know when it comes to understanding ERISA's fiduciary standards. It's important to keep in mind that ERISA laws were enacted to protect the plan sponsor as well as the employees who participate in the plan.

On page 50 is a list of questions that will help you determine what you do and don't know about ERISA compliance. This is not designed to be a substitute for a comprehensive compliance review, but it will give

Need to Know

ERISA

The acronym for the Employee Retirement Income Security Act. This federal law was enacted in 1974 and it established guidelines for the administration of and investment practices within defined benefit and defined contribution plans.

Qualified Retirement Plan

A plan that meets the requirements of the Internal Revenue Service and as a result, is eligible to receive certain tax benefits. These plans must be for the exclusive benefit of employees or their beneficiaries.

There are generally two types of qualified retirement plans; defined benefit plans and defined contribution plans. Examples of qualified retirement plans are: pension plans, 401(k) plans, money-purchase pension plans and profit sharing plans. SEP-IRAs, simple IRA plans and IRAs are generally not considered qualified retirement plans.

Plan Sponsor

A designated party, usually the employer, who sets up a retirement plan for the benefit of the employees. The responsibilities of the plan sponsor include determining participation and eligibility requirements, investment choices and, in some cases, providing contribution payments in the form of cash and/or stock.

Fiduciary

A fiduciary is someone who is entrusted to make prudent decisions on behalf of, or for the benefit of another. For a qualified retirement plan, a fiduciary is someone who:

- assumes discretionary authority or control over the administration of the plan
- exercises any authority or control over the management or disposition of plan assets
- renders investment advice to the plan or its participants for a fee or other compensation, whether direct or indirect

Service Providers

These are generally third parties (individuals and/or companies) whose services are contracted by the plan sponsor. Service providers generally include, but are not limited to investment professionals, insurance companies and plan administrators.

continued on page 50

continued from page 49

you some idea where you stand. In addition, the Department of Labor has a great resource on their Web site entitled "Meeting Your Fiduciary Responsibilities" at: www.dol.gov/ebsa/publications/fiduciaryresponsibility.html.

If you answer "No" to any of the questions below, you should review your plan's operations, because you might not be in full compliance with ERISA's requirements.

- Have you communicated to plan participants that the plan is intended to be a 404(c) plan?
- Do you manage and maintain reasonable plan expenses?
- Have you provided plan participants with a Summary Plan Description (SPD) and Summary Annual Report (SAR)?
- Do you maintain copies of the plan documents at your office for examination by plan participants and beneficiaries?
- Do you respond to written participant inquiries for copies of plan documents and information within 30 days?
- Does your plan operate in accordance with the plan/trust documents?
- Do the plan fiduciaries periodically monitor and evaluate plan investments and maintain adequate documentation of investments reviews?
- Are the plan's investments diversified to help minimize the risk of large losses?
- Have the plan fiduciaries determined that the investments are prudent and solely in the best interest of the plan participants and beneficiaries, and evaluated the risks associated with the plan investments before making the investments (or making available to the participants if participant directed)?
- Is your plan covered by a fidelity bond against losses due to fraud or dishonesty?
- If your plan permits participants to select the investments in the plan accounts, has the plan provided enough information to make informed decisions?
- Does the plan provide and track ongoing employee investment education?
- Are the service provider arrangements reasonable, and is the cost and quality of those services in line with the industry?
- Do the plan fiduciaries meet regularly and keep well-documented minutes of those meetings?
- Is there a prudent fiduciary decision-making process, and is there sufficient documentation to support their decisions?
- Does the employer send participant contributions to the plan on a timely basis?
- Does the plan pay participant benefits on time and in the correct amounts?

If you answer "Yes" to any of the questions below, you should review your plan's operations because you might not be in full compliance with ERISA's requirements.

- Has the plan engaged in any financial transactions with persons related to the plan or any plan official; for example has the plan made a loan to or participated in an investment with the employer?
- Has the plan official used the assets of the plan for his/her personal interests?
- Have plan assets been used to pay expenses that were not authorized in the plan document, were not necessary to the proper administration for the plan, or were more than reasonable in amount?

Is it possible to reduce your risk as fiduciary?

Section 404(c) of ERISA diminishes the plan sponsor's exposure to investment performance liability by placing the burden of investment decisions on plan participants. However, to shift this responsibility to employees, you must comply with the following 404(c) requirements for the plan:

- Explain that the plan is intended to be a 404(c) plan
- Offer a diversified range of investments (minimum of three core asset categories) with different risk and reward characteristics
- Provide participants with the ability to control their investment accounts by allowing them to move between plan investments at least once every quarter

- Give employees the option to make independent investment choices
- Educate plan participants about available investment alternatives
- Manage and maintain reasonable plan expenses

By following 404(c) guidelines, you reduce the likelihood that employees can hold you responsible for disappointing investment returns. However, as a fiduciary, you still hold the responsibility for selecting and monitoring the investments offered in the retirement plan. Remember, your fiduciary responsibilities center on several functions.

Following the steps outlined below will help to keep you on the right path as a plan sponsor and plan fiduciary.

Adopting a Plan/Trust

Although ERISA provides some latitude in how you design your company's retirement plan (subject to coverage and discrimination requirements imposed on qualified plans by the Internal Revenue Code), your plan must include:

- a written description of the benefit structure and operational guidelines
- a trust fund to hold your plan's assets
- formalized documentation to track the flow of money
- plan documents available for review by participants and the government, such as a Summary Plan Description (SPD), Summary of Material Modification (SMM) and Summary Annual Report (SAR)

Maintain Records

Scrupulous records of your fiduciary functions – including the filing of plan documents and reports, meeting minutes and written records of any other activity related to the administration or monitoring of the plan and plan assets – should be held for a minimum of six years.

Assign Other Plan Fiduciaries

Determine who will share in the fiduciary responsibilities. Typically, the plan sponsor and board of trustees share in this effort. Once fiduciaries have been assigned, delegate authority and document it in writing. Be sure to include investment selection, oversight of plan operations and trustee appointments.

Develop an Investment Policy Statement (IPS)

This document establishes the objectives for the management of the investments in the plan. It details the investment selection, monitoring and performance evaluation processes. Even though ERISA doesn't require an IPS, this documentation will show evidence of fiduciary due diligence in the event of an audit by the Department of Labor.

Analyze the Needs of Plan Participants

Assess your employees' investment knowledge, ability to balance risk and reward, their proximity to retirement and their current and potential investment needs.

Evaluate Investment Providers

Choose the best fit for your plan. Compare investment providers based on the quality of diversified options with full asset class coverage and the services offered. Identify the optimal provider to fulfill the needs of employees.

Select Diversified Investment Options

The investments selected for the plan should meet the needs of the workforce. A fiduciary is responsible for pursuing a breadth of options among asset classes in support of the participant criteria, including age, risk aversion and financial knowledge. The initial selection should include a review of performance, fees, investment style and risk. Choose "core" investments that are diversi-

continued on page 52

continued from page 51

fied and have a broad range of risk and return characteristics. The investments should provide diversification within these categories:

- Asset classes, such as bonds, equities and cash
- Investment categories, such as growth funds and emerging market funds
- Potential risk and return

Inform Employees of Their Investment Options

It is essential that you communicate with your employees. As a fiduciary, it's your responsibility to explain the plan to them and provide them with enough information to make informed investment decisions. Participants who understand the plan are more likely to appreciate the benefits and make regular contributions. Be sure to:

- explain the benefits of the plan
- provide an overview of the financial planning process
- rely on asset allocation support from materials to help individuals determine their retirement income needs
- review the risks and rewards associated with various investments
- provide prospectuses, financial statements and reports, and other information – as appropriate for product/program

Keep Participants Apprised of Investment Performance

Investment features that can help participants keep track of their investments include:

- Periodic account statements
- Phone and Web-based account access
- Investment information via newsletters, inserts, etc.

Allow and Inform Participants on How to Move Among Plan Investments

Participants should be able to provide investment transfer instructions at least once every three months. The plan should accommodate migration frequency between investments, based on the market volatility of each investment. In today's Internet world most plans easily allow for online fund transfers.

Though all of this might seem a bit overwhelming, the right tools, resources and professional guidance can provide a clear and practical approach to complying with your fiduciary responsibilities. This article is designed to help you understand what your obligations are as a retirement plan sponsor and fiduciary. If after reading this article you feel that perhaps there are areas in your plan that might require some attention, I suggest you schedule a joint meeting (for a comprehensive review of your plan) with your plan administrator, your investment professional, as well as anyone else who you believe might be considered a fiduciary on your plan. On the other hand, if after reading this article you feel you are doing everything required as a plan fiduciary, I recommend you follow the above suggestion. ■

Author's Bio

Larry Mathis is a Certified Financial Planner professional. He operates a personal financial planning practice in Phoenix, Arizona, with clients throughout the U.S. Larry works primarily with dental professionals and is the author of *Bridging the Financial Gap for Dentists – What Every Dentist Should Know About Managing Money.* Larry has spoken for numerous dental organizations, including the American Association of Orthodontists, the Western Regional Dental Conference and the Arizona School of Dentistry & Oral Health at A.T. Still University.

Larry Mathis is registered principal offering securities and advisory services through United Planners' Financial Services of America - A Limited Partnership - Member: FINRA, SIPC.

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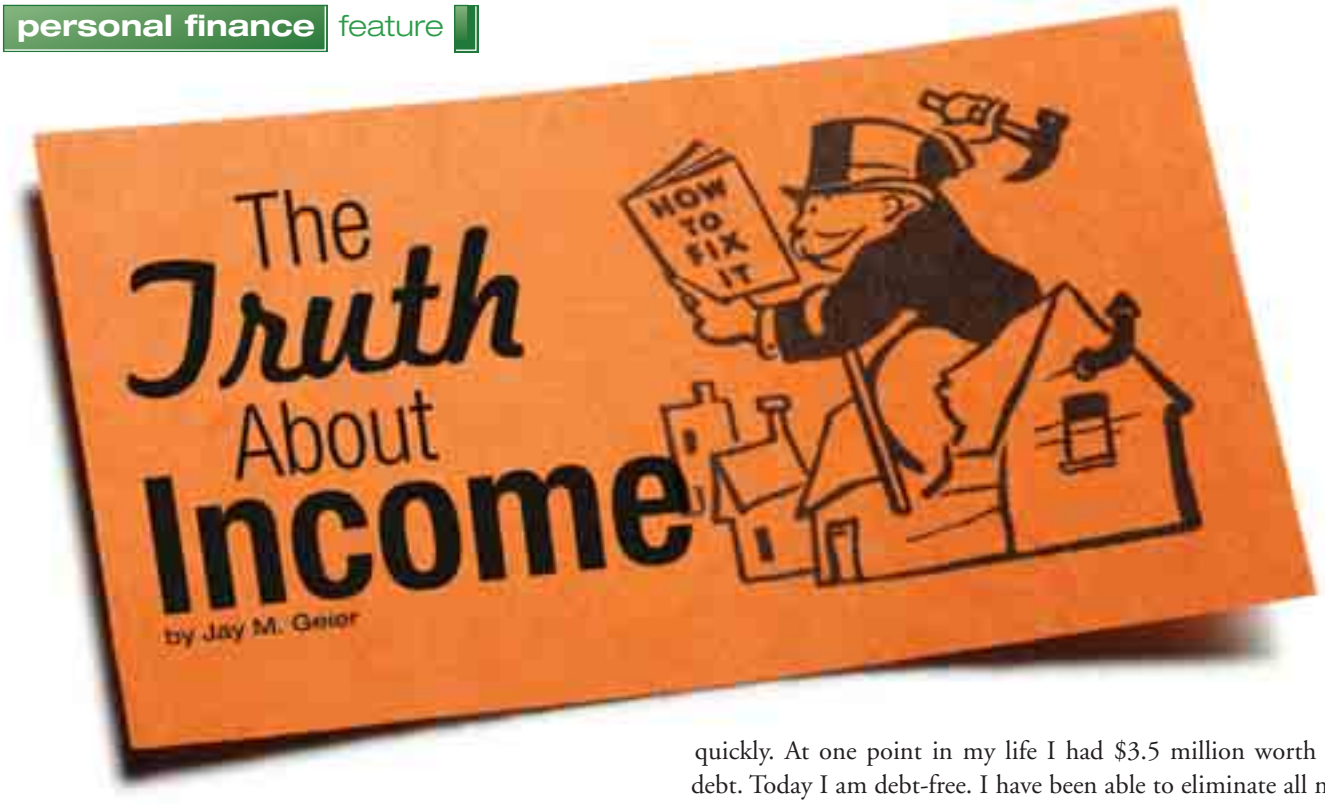
The Truth About Income



by Jay M. Geier

If you're a business owner it's important for you to realize most of the advice you hear in the world today is not designed for business owners, but for employees. If you're taking advice from people who make less money than you, it's hindering your net worth. If you're taking advice from people who are not focused on net worth you're not going to be focused on net worth. A client recently said to me, "My accountant tells me I'm paying off debts too aggressively." I replied, "Sounds like it's time to get a new accountant!" Do not let advisors derail you from increasing your net worth.

Net worth is very important to your future and it isn't just about knowing your net worth. It's about increasing it. If you don't already know your net worth, figure it out in the next 24 hours (there are charts included to help you). Then craft a plan to begin increasing it and pay close attention to it on a regular basis.

As you know, net worth is the total of all your assets minus liabilities, or debts. I find it helpful to break this into three groups. First is your personal value. This is the total of all your savings, investments, valuable items (significant content in your home, jewelry, vehicles, boats, etc.) minus your personal debt (not including real estate). Second is your real estate value. This is the total of your real estate value minus your real estate debt. Third is your practice value. For a formal valuation you should get your practice appraised, but you can use 50 percent of gross revenue minus debt as a starting place.

When setting values for assets, do not inflate the values. Set them realistically based on what they would sell for at the present time. Some things drop in value over time and you should adjust accordingly every year. It's better to show them being worth less than more than they're really worth.

Debt should be paid off aggressively and you should only take on new debt if you have an aggressive plan to pay it off quickly. At one point in my life I had $3.5 million worth of debt. Today I am debt-free. I have been able to eliminate all my debt by taking the steps I'm sharing with you in this article.

Use net worth as your measurement. If you pay close attention to this number on a regular basis it will become very clear how much progress you're making toward increasing that number. The fastest way to increase net worth is to pay down on debt. Every dollar paid to debt is a dollar added to net worth.

Step 1 – Manage Cash Flow

Every day you should know exactly how much money comes in and goes out of your practice. Don't spend hours on it; just a few minutes. If someone else in your office knows these numbers, require them to give you a daily report summarizing what happened financially. Being consistently aware will prevent financial surprises.

Step 2 – Get in the "Black Zone"

Your practice should be profitable. You should be collecting enough money every month to pay all the expenses and still have margin. If it's not profitable, or you have very little margin, there is a problem. The one asset you have that most people don't have is the value of your practice. It's shameful to spend your life working in your practice and at the end not have any value in it. Be focused, but be patient. It usually takes six to 12 months to turn a practice around.

Step 3 – Follow the "Checkbook Strategy"

This strategy will support your efforts to get in the black zone. List all your debts smallest to largest including every single person to whom you owe money. You'll probably be surprised by how many debtors you have. Then go to your business checkbook and pay off that very first debt. Once that first debt has been paid, you must continue down the list systematically and intentionally work toward paying off every debt. A debt

doesn't have to be completely paid off at once, but you must be actively paying down on debt at all times. If you plan to wait until your income goes up or you want to save before you start paying debt, you're making a huge mistake. Remember, every dollar paid to debt is a dollar added to net worth.

Step 4 – Set Aside Cash

If you don't already have accounts for these purposes set them up and move money to them frequently. The idea is that you move money out of your checking account because if it sits in your checking account it will get spent. You only need enough money in your checking account to cover expenses plus a little buffer.

- Your savings account should hold just enough money to cover emergencies.
- Your tax account is important. The more distributions you do, the more important it is to set aside money for taxes. Bottom line is, you must pay your taxes so make sure you're planning ahead for this.
- Have a large purchase account. This is the antidote to getting lines of credit when you need to make a large purchase – like buying a new building/office space, adding a treatment room or redecorating the office. Don't wait until you need something to start saving. Move money to that account frequently so when you go to make that purchase you can pay cash rather than take on debt.

The bottom line is income is irrelevant if you spend it all and none of it goes to your net worth. You should have a very intentional impact on your net worth. It's about focus, time commitments, the structure and process and your habits and discipline. Unfortunately there are no shortcuts. For every financial decision you make each day, you should know exactly how it's impacting your net worth. Get engaged in the process. When you see your progress, you're going to be amazed. n

Author's Bio

Jay M. Geier is a speaker, consultant and the president and founder of The Scheduling Institute. He helps his clients reach new levels of success and create a lifestyle they dream of, using their practice as the vehicle. He has a unique ability for getting results in a practice by leveraging its current resources with a primary focus on the staff. The Scheduling Institute currently offers several on-site training courses that focus on telephone training, marketing and creating the ultimate new patient experience. The strategies in this article are the basic strategies the Scheduling Institute clients are implementing. For more information and special Townie pricing, call 877-215-8225 or e-mail info@schedulinginstitute.com.

Retention: What's the Right Answer?

by Dr. Ed Lin

In my 12-plus years as a clinical orthodontist, I have seen several trends develop in my practice with the management of my patients. In my opinion, orthodontics today has really become a childhood rite of passage. Our adolescent patients are typically incredibly excited and nervous on the day we move them into treatment with their braces. At the appointment following the placement of their braces, either the patient or the parent will make a comment in regards to how incredibly impressed they are with the positive changes that have taken place with their treatment in such a short period of time. As we move through the course of their orthodontic treatment, we always get asked the question, "When will my braces be coming off?" And finally, one of the happiest days in a child's life is the day they get their braces removed. However, all that joy and elation is then tempered when they find out retainers are also required as part of their treatment.

One of the most difficult challenges we have always faced in orthodontics is with the management of retention for our patients. In our profession, there is really no general consensus in regards to what type of retention is better: removable vs. fixed. A recent study published in the *AJO-DO* concluded that the two most commonly used retainers in the United States are: maxillary Hawley retainer (58.2 percent) and mandibular fixed retainer (40.2 percent).[1] As we all know, there are pros and cons to both types of retention.

Without a doubt, the greatest advantage of the removable retainer is for hygiene. Regardless of the design of the removable retainer, it can be taken out of the mouth to allow the patient to floss and brush without any interference. The removable retainer will also help to maintain the arch form that has been developed during the course of orthodontic treatment. The biggest disadvantage with the removable retainer is with compliance of wear. Other negatives include its affect on speech and the appearance of the patient with the removable retainer in the mouth. Both of these factors will also impact the compliance with wear of the removable retainer. Obviously, if patients are non-compliant this will result in tooth movement.

In contrast, the greatest advantage of the fixed retainer is that it removes compliance from the picture. The fixed retainer has an aesthetic advantage, as it sits on the inside surfaces of the patient's anterior teeth. However, the biggest disadvantage is hygiene, especially over a long period of time. We all hear this complaint from the general dentists and hygienists in our communities and sometimes even from the parents or patients. Failure with the bonding of the fixed retainer can also result in tooth movement especially if the patient is unaware this has happened.

As a result, there really is no right or wrong answer when the decision needs to be made in regard to what type of retainer to use. The choice for retention really is the individual clinician's and patient's choice. My standard retention protocol involves giving the patient two removable Essix Ace retainers in the maxillary arch and bonding a mandibular fixed retainer. For my fixed retainer, I utilize a braided wire that has been heat treated to anneal the wire resulting in a very malleable and passive wire that can be adapted and bonded to every single tooth from canine to canine. If a patient makes a specific request for a certain type of retainer, I will give them that option.

Whatever the choice for retention, we must remember that stability with retention can only be accomplished if the forces that are derived from the periodontal and gingival tissues, the orofacial soft tissues, the occlusion and post-treatment facial growth and development are all in balance.[2,3,4] We must remember to reinforce to our patients that management of retention is a lifelong commitment. The only way to ensure stability with retention is to educate patients and give them options. ■

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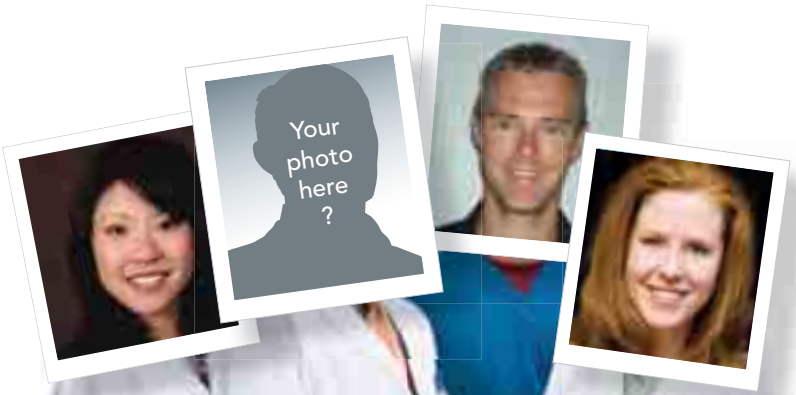

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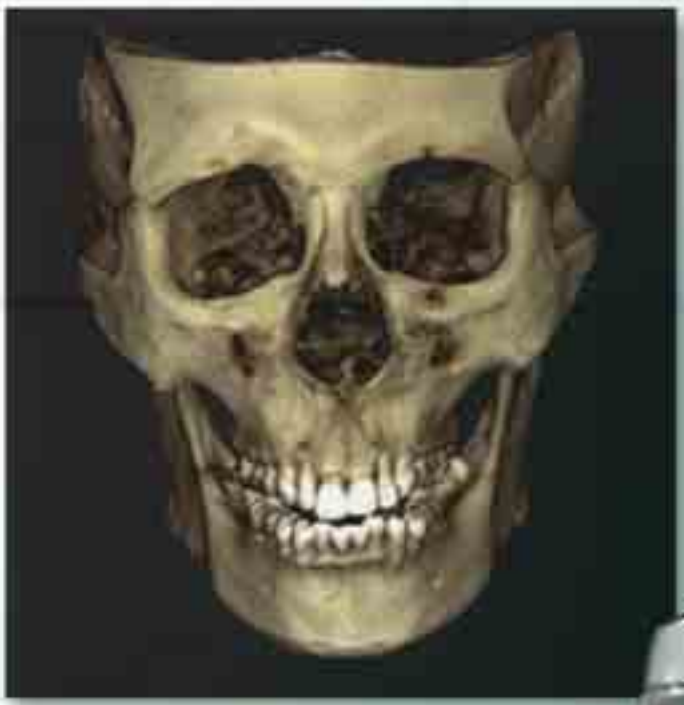

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