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**Bonding U2s When U3s are Impacted?**

The controversy of early treatment comes up in this case presentation regarding impacted U3s.

**U3s Impacting?**

This Townie isn’t quite sure what to extract and what to wait on. Care to help him out?

**Practice Management Embezzlement**

Some scary embezzlement scams in these offices might make you change the way you handle money in your practice.

**Employee Training**

Andrea Cook explores the importance of a great training system for new team members.

**Look at Your Lease**

Whether you’re signing a new lease for your practice or are renewing an existing one, you are now likely to enjoy a stronger negotiating position than you would have in the recent past. Ryan Wilson details three areas in which landlords try to gain the upper hand.

**The Perfect Storm**

Dr. Ronald Roncone discusses his opinions about the major storms that have occurred in orthodontics over the past few years and what can be done to maneuver out of them.

**Easing the Concerns of Adult Patients**

Pamela Waterman touches on the subject of adult patients and what you can do to answer their questions.

**An Adult Non-Extraction Expansion-Aligner Case**

Dr. Ken Fischer presents a case of a 45-year-old woman that wanted to have her crooked teeth straightened, but did not want any of her teeth removed and insisted that she be treated with Invisalign.

**52 Weeks of Facebook Orthodontic Posts**

Rachel Mele from Sesame Communications presents a list of 52 Facebook posts your orthodontic practice can use.
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CASE OF THE MONTH

Which Ones to Remove?
Case Number: 161198
Here is a Hispanic female in her 30s with a straight profile, minimum overjet, midline shift and blocked out lower right canine. What lower teeth would you recommend to extract?

MESSAGEBOARDS

Does Anyone Have a Dedicated PR/Marketing Coordinator?
Do you have a staff member that is solely dedicated to PR and marketing? How do you compensate this person? How many days per week does he or she work?

Orthotown Magazine

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Do you use a laser in your practice?
A. Yes  B. No

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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

Message from the Online Community Manager

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Orthotown.com has added a toolbar at the bottom of the Web site to make more features just one click away. Check out the Help Center’s Feature of the Month for more information!

VIDEO TUTORIAL
Every week Orthotown sends a free newsletter with the highlights of what’s been happening on Orthotown.com. Go to the Media Center and click on the Tutorial section to watch a short video with step-by-step instructions to sign up.

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Feature of the Month
Orthotown.com has added a toolbar at the bottom of the Web site to make more features just one click away. Check out the Help Center’s Feature of the Month for more information!

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Dolphin Management 5

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  a. Text.
  b. Message

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Looking Back, Looking Ahead
by Wm. Randol Womack, DDS, Board Certified Orthodontist, Editorial Director, Orthotown Magazine

January signals the beginning of the New Year with the College Bowls Extravaganza followed by the BCS Championship and the NFL Super Bowl! But for Orthotown Magazine, January signals our opportunity to look back at the past year, through the eyes of our annual survey.

This year the responses were very interesting and also very candid. Last year there were 84 respondents to the survey and this year there were 97 respondents. We extend our sincere appreciation to those who took the time to complete this year’s survey.

I have attempted to summarize some of the responses and make a few comparisons to last year’s survey. Please note, participants were not required to answer every question.

We started the survey with “How would you describe Orthotown.com and Orthotown Magazine to a colleague?” Typical responses were:

• Every issue has a number of topics that I find to be worth the time to read. It is not the traditional journal with articles that are of little or no relevance to my practice.
• Very practical. Useful clinical resource. Only ortho magazine I read cover to cover.
• Pertinent, current, informational, clinically relevant, preferred reading, well done.
• Discusses the current issues related to orthodontics, and it is interactive.
• Great venue for discussing cases and practice management. Reminds me of the conversations we used to have as residents.
• Amazing, great Web site.

What other orthodontic-related publications do you read on a regular basis?


Have you ever posted a case or comment on the Orthotown.com Message Boards?

This is slightly down from last year (44/56).
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If you’re ready to grow your practice and improve patient care, you won’t find a better partner than DDS Lab.
If no, why not:

• Never have time but the cases are interesting to review and my thoughts on treatment have always been with the consensus treatment recommended.
• Guilty of lurking only!
• I would like to but haven’t yet. I do read every monthly issue.
• I’d rather look and occasionally comment.
• I find adequate benefit reading everyone else’s posts.

So the conclusions we can draw from this year’s survey – when comparing to the previous surveys, indicate we are meeting our reader’s needs and expectations and putting valuable content in each issue of the magazine. Our readers posting cases has remained in line with last year and we view this as a valuable feature of having the strongest online presence in orthodontics.

Practice trends are stable indicating no real upward change in 2011 from 2010. Our January/February issue is focused on practice management, which may be exactly what we all need to concentrate on as we plan our strategy for 2012. Dr. Ron Roncone recently spoke at the Arizona State Ortho meeting and his candid comments on the trends in orthodontics are featured in this issue. He has a very interesting perception of where things are going in orthodontics. Don’t miss it!

The response of preferring to obtain CE credits online indicates that our efforts to increase the variety and the value of our CE courses remain an important part of our agenda for 2012.

Bottom line is that our business model of creating an online community and publication “exclusively” for orthodontists is continuing to be widely accepted and valued by the orthodontic profession. We are grateful for your praise, comments and suggestions. We will continue to remain true to that commitment for the coming year and we will keep our focus on the issues that are of utmost importance to the advancement of quality orthodontic treatment and an economically positive practice environment.

All of us at Orthotown welcome the New Year and the opportunity to continue to provide our readers with interesting and valuable content. Our wish is for everyone to have a healthy and prosperous 2012.

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Which of the current Web site features is most useful to you at the present time?

<table>
<thead>
<tr>
<th>Feature</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Message Boards Discussions (35)</td>
<td>37.6%</td>
</tr>
<tr>
<td>Case Presentations (35)</td>
<td>37.6%</td>
</tr>
<tr>
<td>Continuing Education Courses (10)</td>
<td>10.8%</td>
</tr>
<tr>
<td>Classified Ads (2)</td>
<td>2.2%</td>
</tr>
<tr>
<td>Digital Version of Orthotown Magazine (8)</td>
<td>8.6%</td>
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</table>

This has changed from last year when Message Board Discussions was 46 percent and Case Presentations was 32 percent.

Where would you prefer to obtain the majority of your CE credits?

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Online Webinars/Presentations (34)</td>
<td>35.4%</td>
</tr>
<tr>
<td>In-person Courses (34)</td>
<td>35.4%</td>
</tr>
<tr>
<td>Conferences Lasting Multiple Days (26)</td>
<td>27.1%</td>
</tr>
<tr>
<td>Magazines (1)</td>
<td>1%</td>
</tr>
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</table>

No significant change from last year.

Have your patient starts increased or decreased within the past 12 months?

<table>
<thead>
<tr>
<th>Change</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Stayed the Same (35)</td>
<td>37.2%</td>
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<tr>
<td>Increased (30)</td>
<td>31.9%</td>
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<tr>
<td>Decreased (29)</td>
<td>30.9%</td>
</tr>
</tbody>
</table>

Last year the response was 41/28/31 percent trending toward no real change since last year.
The FROG® Appliance offers outstanding molar distalization without crown or root tipping. Find out about this innovative Class II treatment option at the DORAL 2012 meeting in Miami, FL as Dr. Walde covers the “evolution” of the FROG, proper fabrication, clinical delivery, and case selection. An additional hands on fabrication course will also be offered for anyone interested!

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Bonding U2s When U3s are Impacted?

The controversy of early treatment comes up in this case presentation regarding impacted U3s.

I typically like to not bond the U2 that is in the vicinity of an impacted U3, until I've moved the U3 out of the vicinity of U2 root. In this case though, I think I will need to consolidate U2-2 in order to open enough space to fit the U3s in. Would you guys bond U2s in this case, right off the bat? Am I overthinking my biomechanics?

By the way, my plan in this case is to either distalize UR6, or to extract UR4. Non-extraction on the upper left side.

Thanks.
How do you plan to accelerate your practice? It’s a big world with lots of possibilities. The challenge is you can only do so much at one time. You’re lacking time in some areas and expertise in others. You want to keep control without getting bogged down in the details.

OrthoSynetics is the company you’ve been looking for. We assist orthodontic and dental practices with business, marketing and administrative functions.
I'll let you know how I was taught and how I would approach this. Others might disagree, however. I would bond the upper 2s right off the bat, however I would place the brackets purposely to swing the roots of the upper 2s mesial and away from the crowns of the impacted 3s. This would allow you to start making the space you need to bring those cuspids in. I would also stay in a round wire until I was sure I had moved the 3s out of harm’s way, then progress to my rectangulars, and eventually reposition the upper 2s to fix my root angulations.

I was taught in residency that staying in a round wire will allow the roots of the laterals to “move out of the way” torque-wise if the crowns of the 3s run into them while you are bringing them in. Also, the last thing I want on those laterals at this point is buccal root torque from a rectangular wire. Seems to work for me so far, but I’m interested to hear how others approach this as well.

That’s exactly what I do. I don’t think the round wire allows the roots to bounce out of the way, but at least you’re not torquing that U2 root lingually into a palatal canine with a rectangular wire. In this case, I don’t think it would matter since the cuspid is buccal. I know docs that don’t seem to care about the 2 roots, but that bothers me.

Bond laterals, stay in round, tip incisor roots mesially, open space and apply traction.

Since the canines are buccal, would you want to expose them from the palatal, bond them palatally and pull them in a distal direction hoping to bring them through attached gingiva? Is this necessary? I’m still in residency, and I know you don’t want to pull them through the alveolar mucosa, but I haven’t had a buccal-impacted canine case yet. Could you just expose them from the buccal and bring them down after you have made space?

I think I would try to do this non-extraction just because her profile already appears dished-in – so I would like to try and distalize... but I actually don’t think taking out an upper bi would damage her profile very much because you wouldn’t be retracting much since there is not much extra space even after extraction.

Interesting observations, interesting comments.

The presented child clearly is not a stranger to dental offices. What hit me first are the grossly oversized SS crowns on mandibular Es. Why are they there? How long have they resided on her teeth? Aesthetically they look bad, anatomically they are incorrect and their margins don’t even come close to “hugging” the prepped teeth. What are they doing there now? It appears that they very effectively interfere with both eruption of 4s and mesial migration of the 6s. Get those off before you place any brackets and arch wires.

Many years ago, I posed the following challenge to my students and colleagues: show me one, (yes, only one) properly made, properly fitted, properly equilibrated SS crown and I’ll shut up on the subject. If I hear “that’s the best we have” again, then make, invent or design a better restoration, or better yet, prevent the need for these ugly restorations.
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age of canines. There is a whole bunch of teeth that need to do something before the maxillary canines are ready (or possibly not ready!) to erupt. So be careful and consistent.

Finally, your bonding dilemma. Where does it say that one has to bond the laterals (or any other teeth) in the middle of their crowns, presumably where their engagement could interfere with, or create an obstacle for a descending canine?

My advice, for whatever it is worth, is to bond the lateral, if you need to. Consider mechanics of OTM, in this case, an occlusally directed traction of usually high impacted canines. What advantages does one gain – not always, but most of the time – by skipping an attachment between the central and the canine? Certainly our archwires will be significantly less deflected, producing lower forces and providing a biologically better OTM. Of course, skipping that attachment temporarily reduces 3D control of the involved teeth (both the canine and the central) and this should be considered as the teeth start their OTM into a desired position.

I’d be happy to discuss any of these comments with whoever wishes to do so.

Are you planning to start a comprehensive case now or just future planning? She’s a long way from being in full permanent dentition; by long I mean more than a year. And, as has been said, it is very early for those canines to be erupting. That right side though has me concerned because I’m figuring that the 3 will become impacted or ectopic unless space is made, either through extraction or otherwise.

How old is your patient?
General observations: Mandibular retrognathia, hyperdivergence, missing #32 (dentigerous cyst possible), crossbite #3, blocked #5, impacted 6 and 11.
Great diagnostic X-rays (what CBCT machine do you use?)
What would I do now?
1. Surgical consult on exposure
2. Extract K and T and place space maintainer
What I don’t like to do?
1. Extract first premolars before I see the second premolar
2. Extract any premolar before I am sure the canine is not ankylosed
Imagine that the 4 is gone, the 5 comes in with a problem or is small, and the canine doesn’t move.
So, I don’t suggest jumping into full treatment right away.
Keep us updated and tell me about those beautiful X-rays.

From a veteran chrome steel crown placer – I can tell you that they are not perfect but also no reason for concern. I do think that the crown on the right is one size larger than the left but so what? Note the first bi has erupted nicely on both sides (see the photos). What you see is not what you get on a pano. A better evaluation would be a bitewing radiograph. If the crown did get in the way of eruption – just remove them and place a LLA until full eruption.

I see a significant dolichofacial patient (five standard deviations high on upper facial height) with about 14mm of available space on the upper right and a few more on the upper left. When you see a cuspid violating the lateral incisor to that extent – even though it is facial – they aren’t coming in well with time, they are coming in facial into alveolar mucosa. Note the cuspid position is no better on the left than on the right. The right side looks worse because you have lost your six-year molar position and it is several millimeters mesial of Class I.
Would anyone consider removal of both first bis and allow Class II molar position rather than distalize and open the bite further? Does anyone doubt that you could do that without affecting the incisor position unfavorably in this case? ■ Wave

Good case. I say bracket as many teeth on the upper arch as you want. Make sure to place your U2 brackets with mesial root. Once you’re on, go ahead and refer to extract the UR4 and expose the canines with bonded chains at the same time and start bringing them into place. By the time the 3s are in, you should be able to get the lower arch going and reposition the U2s to put back your distal root. ■

Does this patient need expansion? To me it looks like the right side is in crossbite and the lower midline is to the right. Would you consider waiting until the upper 4s erupt and then build an expander on the UL 6 both 4s (a three-legged expander)? If you do that you can band or bond the UR 6 and rotate it back into position with a push-coil. I would increase the arch-length slightly to accommodate the upper 3s, consolidate the space 2-2 (on a round arch wire) and have the upper Cs removed. Take X-ray to see if upper 3 positions have improved (six or nine months?). Expose them if you need to. Looks like the tips of the 3s are just above the CEJ of the 2s and might even be in attached gingiva. Also, was there a ton of improvement in canine position from the 3/14 pano until the i-CAT images were taken? Are you considering using a laser in your own office to access the 3s? ■

Great CBCT images! I’d be curious to see an updated pano since you’ve extracted the upper Cs and Ds. I’d be hesitant to jump into fixed braces for her right away until I knew for sure the canines were impacted. At the time of the pano, I would have taken out the Cs and expanded her upper arch. To me, it looks like she’s slightly narrow transverse. There’s a great article in one of the AJODOs on impacted canines and from personal experience, once you take the Cs out and get some more space for the canines, often times they start heading south. It also looks like you have some major arch length issues in the upper right quad with a full molar Class II. Since she’s pretty high angle, I would have expanded her upper arch first, serially extract the U4s (upon eruption) and monitor the U3 ectopic eruption, and wait for the L5s to erupt. Once the U5s are in, start braces with the upper arch, expose the U3s as needed and once aligned, add the lower braces to finish.

But to answer your question, I try to stay off the U2s in impacted canine cases, especially if the U2s are palatal. I can still consolidate spaces or open more space for crowded impacted canines by running open coils from the centrals to first premolars. Once I have sufficient space for the canines, then I refer for exposure and start pulling the canines away from the laterals. Once clear, then bond up the laterals to help align the U3s. Different strokes for different folks. I just don’t want any responsibility if there’s upper lateral root resorption. Plus I use the AAO informed consent on impacted and ectopic teeth. ■

Find it online at: www.orthotown.com

search  Bonding U2s
U3s Impacting?
This Townie isn't quite sure what to extract and what to wait on. Care to help him out?

The first pano is from a year ago. The second pano was taken yesterday. I can palpate the U3s labially in the vestibule, and they seem to be located directly above the apex of the 2s. Moderate crowding in the upper. Would you extract upper Cs now and wait and see? Do you think the U3s will simply erupt ectopically without damaging the U2s?

I'd definitely get the Cs out now and follow up with a new pan in six months.

I'd request the upper Cs and Ds be extracted now. Follow up with pan in six to nine months. RPE after that if little improvement. Good sign that you can palpate on labial.

I'd wait and watch a bit more. Canines are fairly vertical. Looks like normal development.

It seems U3s are up very high. I would extract upper Cs now. Space maintainer is needed after extraction. After extraction the teeth will move into the least resistant pathway. So I don’t think they will damage U2s.

How old is the patient? There was a recent article somewhere within the last six months that showed the benefit of doing Cs and Ds rather than just the Cs to allow for better eruption of the permanent 3s. My thinking would also take into account the patient’s age.

Applekor, I think that article applied to palatal canines and there were letters to the editor questioning its validity because the sample size was under the age of 10.
1. Definitely get the upper Cs out; there does not seem to be any downside to that (unless they insist on having a sedation done at the OS. Then there’s a major cost downside to the family).
2. No space maintainer is needed in the maxillary arch if only the Cs are extracted. Not sure about that if the Ds are extracted also. Opinions?
3. I agree with the above poster. I think there is no way you can palpate those babies intra-orally, so whether they are labial or palatal is still up in the air in this case. Diane

I’d wait on any extractions and follow up with another panorex in eight to 12 months. I don’t think there’s a huge advantage to extracting upper Cs at this point. U4s seems to be resorbing upper Cs and Ds pretty well. U3s are upright and very high, and there’s a possibility of U4s blocking canine eruption if the Cs are gone too early. Upper Cs are a great space maintainer in this case. As the roots on the Cs resorb, I bet those 3s slowly drop in decent position. Diane
Embezzlement

Some scary embezzlement scams in these offices might make you change the way you handle money in your practice.

OK, etaynor, you tell your story, then I’ll tell mine.

We have a primary and a satellite office. All finances and billing are kept at the main office. When a cash payment is made, a sequentially numbered, triplet receipt is issued. One is given to the paying party, one is kept in the book and one is returned that evening to the main office with the payment. Approximately once a week, the financial manager would generate the deposit slip, attach the sequentially numbered receipts and the monies. She would then give that to the doctor. He would check the receipts, tally the sums and make the deposit.

One day, at the end of a busy day, I casually asked the receptionist how it went up front today. She replied that it was very hectic when a patient paid her $850 bill with one, five and 10 dollar bills. “I had to count this mountain of small bills in the middle of the afternoon.”

With that in mind, I thought that in a day or two I would have to bring that money to the bank. So, I was kind of waiting for that lump sum. It didn’t show up. Before asking, I went to the satellite office, looked at the receipt book and saw the receipt. I then checked the account on the computer, and saw the posting. So, where was the money? In my previous deposit, all receipts were in order. In my next deposit, all receipts were also in sequential order. What I found, after one month, was that with a large sum of money she would extract one receipt between weeks. This week, I would get #1, 2, 3, 4, 5, 6 and next week I would get #8, 9, 10, etc. The book showed that all the receipts were in order and the computer would show that the patient’s statement was correct. But, I was failing to remember what the last numbered receipt was from last week.

With my labor lawyer sitting in the room, she was properly fired. I identified more than $10,000 missing over a short period of time. Lesson learned. But what I didn’t know was, regardless, she was entitled to all of her monies from the defined benefit plan. Lesson two, learned.

Did you send her a 1099 for the $10,000 or whatever the amount was? Seriously. I did that when an office manager embezzled a lot more than that. Let her deal with the IRS for a few years.

My former treatment coordinator (TC) was intercepting the insurance checks, adjusting them off the balance and cashing them. I was looking at the daily transaction reports, but not checking to make sure they were consecutive. She was coming in on weekends to cook the books. I also was not checking the report that shows ratio of adjustments to receipts.
She had left the office a few months before I found the theft. A local police officer put together an air-tight case, with the help of an auditor that I hired. She was found guilty of felony embezzlement. She hasn’t done any jail time yet, and has yet to make the court-ordered restitution.

I’ve always written all the checks (thank heavens!) but now I open all the mail, too. Don Lewis has a workbook on protecting your practice from embezzlement – a lot of good stuff.

Thanks for sharing the story. From the day I opened my doors six years ago, we have a no-cash policy. We accept certified checks, money orders, and of course, checks and credit cards.

On the bottom of every quote, it clearly states: No cash payments accepted.

Every so often we’ll get someone who pays $25 (no show fee) or retainer replacement ($150), but it’s very rare. Sorry to hear this happened!

We also found that on every rebate sent in, the checks were coming in our name with the office manager’s name also on the check. She cashed every one of those. In a big practice, everyone who orders things is asked to “shop” the item. So, from pens to toilet paper, we’re shopping the shops.

After I found out my front desk person was stealing cash, I confronted her with my partner and she confessed. She had taken around $15,000. We gave her the option of repaying the money with her retirement funds (she worked for us eight years) or calling the prosecuting attorney. She paid. We met her at her bank the day she deposited the check from our retirement plan. She didn’t go to jail and we had our money back. Figured it was better than getting $10 a month for 1,500 years.

Several years ago our front desk staff embezzled about $20,000 in a little less than a year. She was with me more than 14 years, and had recently been placed at the front where she dealt with money. Her method was mostly taking cash and giving bogus receipts and using one patient’s credit card to cover for stolen cash from another patient, then another credit card to cover for that deficit, etc. The prosecuting attorney happened to be our patient, and we were advised (off the record) to report this to the police since it involved a large amount of money and most importantly, the fraudulent use of credit cards (identity theft). I went to the police (even the police had a hard time understanding her method, but were nevertheless impressed with her creativity) and filed a complaint. They did a lot of legwork to document every patient’s account that was tampered with, and went to grand jury. She pleaded innocent, so a court date was set. After numerous continuances filed by her attorney, she pleaded guilty. She didn’t go to jail or anything, but was ordered to write me a letter of apology and pay us restitution for the whole amount stolen in the amount not less than $200 a month, but since this judgment was handed down, we have only collected $250. Financially we took a hit, as I reimbursed all the fraudulent credit card charges, or credited that to their ortho accounts if they still had balances.

There was a long list of 30-plus other things in the judgment against her, but the main thing I wanted was for her to have a record. I didn’t want this to just get swept under the
I agree, orthoangel – that’s one of the pluses of a criminal suit. I found that the other advantage is that the practice doesn’t have to pay attorney fees. In my case, it was clear from the start that restitution was a pipe dream. But the embezzler has a felony on her record, and my only costs (other than my losses) were hiring a forensic accountant to get our patient accounts figured out. Many business insurances will cover documented theft up to a certain amount. My plan through the AAO covered $25,000 of my losses.

Orthoangel, what I would really like to know is, what did you learn from this? What changes did you make to your practice to prevent this from ever happening again? ■ Diane

Diane, besides feeling angry (at her and at myself) when I first discovered the embezzlement, I felt very stupid that I did not see that this was going on right under my supposedly astute nose. And betrayed and violated and insulted. List goes on. Besides learning not to be so stupid from then on, I learned that:

1) Patients are very understanding and supportive. They cooperated 100 percent with our investigation and requests, and gave us pep-talks and not one them was angry with us (especially amazing since their credit cards were abused).

2) Patients (and people in general) are trusting. When we found numerous suspicious credit card charges made by our office on their statements, we asked them why they did not question it; they said they a) never check their credit card (CC) statements that closely, or b) assumed that whatever charges we posted were correct.

Changes made:

1) We now keep our unopened paper receipt books under lock and key. We order our sequentially numbered receipt books by the dozen, and used to keep the unopened books in our closet or storeroom. The bogus receipts our embezzler used were our actual receipts, torn off back end of the last receipt book in the closet, so we would not catch any out-of-sequence receipts until months or a year later. So now they are locked up.

2) We no longer keep credit card numbers on file. We used to do automatic monthly charges for patients who requested it (and there were many who liked that convenience) so we had their CC numbers on file. These CCs were abused. We no longer do automatic payments, and we require that the patient swipe their credit cards in person. We do not take CC payment requests over the phone. Our CC printouts do not show the entire CC number so we do not know the number. Several exceptions are for responsible parties from out-of-town who cannot come to the office; we give them CC payment authorization forms, and they fax in a request for each CC payment, and we obliterate the number after each transaction.

3) Limited access for staff to certain features in the computer. It puts more work on me, but staff can no longer print statements, post charges or post payments on the computer. Financial info is read-only for staff. My embezzler did not have access to post charges or payments, but she could print statements (we use Ortho2). She’d print a bunch of statements and neatly cut and paste numbers (actually, with scissors and glue!) to make a fake statement...
to cover her thefts, and send the patient a photocopy (so it didn’t look too much like a ransom note).

4) Locked one-way cashbox. Payments can go in but they need to come see me to open the box if they need to retrieve anything, like cash for change, etc.

There are a bunch of other changes we made here and there, but can’t think of them offhand. Basically, I’m a lot more watchful now for anything suspicious. And the staff I have now have been through this with me and don’t want to have to see this happen again.

What does everyone think of putting a camera “eye in the sky” to monitor the front desk? I mean that costs nothing and if the employees know that they are on camera, the embezzlement problem would go away. You can tell them that it’s not them that you don’t trust it’s your insurance’s and attorney’s recommendations.

Find it online at: www.orthotown.com

Lean and Mean Ortho:
Cost-saving Measures in an Orthodontic Practice?

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Harmony is the orthodontic profession’s only fully digital, customized self-ligating lingual system, developed in 2007 by Dr. Patrick Curiel. After four years in development, and more than a thousand successfully treated cases, Harmony launched worldwide in 2011 through an exclusive distributor partnership with American Orthodontics, which recently purchased Harmony in the latter part of 2011. Dr. Curiel is an innovative orthodontist with a premier private practice in Paris, France, currently starting 300 lingual patients per year. Dr. Curiel recently spoke to Orthotown Magazine about what sparked his desire to develop Harmony, and how it is changing the way orthodontists think about lingual treatment.

Describe your experiences treating lingual cases before Harmony. What were the biggest challenges you faced with other lingual systems?

Curiel: I gained valuable exposure to lingual treatment during my years studying at Columbia University, which was beneficial because many patients in Paris seek lingual treatment. The first lingual system I used had great end results, but we had to work extremely hard to get them. Plus it was very uncomfortable for patients. The second lingual system was more comfortable for patients, but was still difficult to achieve the consistent results we were getting with labial treatment. The third lingual system we tried showed great promise because it was customizable. However, the challenges with finishing and the complicated ligating methods used in this system caused a lot of frustration. After making numerous suggestions for improvements, I decided to design a new lingual system that offered efficiency and patient comfort, and also delivered a precise finish – a combination that I found lacking in all the lingual systems I had tried previously.
What were your goals when you set out to create the Harmony system?

Curiel: I always felt that orthodontists should be able to achieve the same results in lingual treatment as they can with labial appliances. When designing Harmony I strongly believed that the system should adapt to the treatment philosophy of every clinician, providing doctors with the ability to design each case to meet their individual treatment goals. I knew that a lingual system must be easy to use, so that orthodontists do not have to work like crazy to finish a case. I really wanted doctors to be able to treat cases lingually without having to change their mechanics or treatment philosophy. With the help of my friends and colleagues, I started developing the Harmony system to meet these goals. The result was the world’s first digitally customized lingual system that offered the features and benefits of self-ligating brackets and the accuracy of robotically formed wires.

Why is self-ligation more beneficial in a lingual system than traditional ligation?

Curiel: Before Harmony, we used a lot of self-ligating systems for labial cases. I have tried just about every one of them, which has given me a lot of insight into the advantages of each one. I applied the features that I liked from popular labial self-ligating systems to the lingual environment, which provided low friction and light forces during treatment. In lingual treatment, traditional ligation becomes very difficult. It’s time consuming, irritating for the patient, and often difficult to tell if the bracket is ligated correctly. In our previous experience with traditionally ligated lingual systems, we had to use time consuming tying techniques like elastomeric double overties, which led to longer appointments and longer treatment time due to the increased friction over self-ligation. So, I designed Harmony to offer the same features and benefits as the best self-ligating systems.

Why is Harmony more efficient than other lingual or labial systems?

Curiel: Harmony takes the best concepts from labial systems like low friction, low force, MIM technology and self-ligation and combines them with digital customization, which moves teeth more efficiently and more precisely than any other lingual system. Harmony offers the advantages of a passive self-ligating bracket during treatment. When the .018 x .025 finishing wire is inserted in the .018 x .025 slot, Harmony becomes a fully active system that provides consistent results. By filling the slot with a NiTi finishing wire, which is highly recommended, the customized prescription that is built into every bracket is translated accurately to the teeth. While it is possible to place offset bends in the finishing wire, it is rarely necessary. The flexibility of NiTi allows the teeth to settle in while the tight tolerances gently guide each tooth to its ideal position, which was designed by the doctor before treatment began using Harmony’s proprietary digital technology.

Harmony is the only digitally customized, self-ligating system in the world. Talk about how you digitally customize a Harmony case

Curiel: First of all, Harmony doesn’t dictate the course of treatment. It adapts to the clinical philosophy of each orthodontist. Each Harmony case starts with a silicone (PVS) impression that is sent to us by the orthodontist, which we use to create a 3D scan of the teeth. Using Harmony’s digital technology, the teeth are then moved to their ideal position following the orthodontist’s recommended treatment plan. Once the teeth have been moved to their ideal position, the doctor can go online and access the digital setup for the case and instruct the Harmony Technical Center to make changes, if necessary. The digital setup is then used to fabricate the customized lingual self-ligating system, as well as robotically formed arch wires, which are created using proprietary CAD/CAM technology. After the customized
brackets are produced, an indirect bonding tray is fabricated to ensure a precise fit with the patient’s malocclusion during the bonding appointment. So, the benefits of Harmony are derived from its ability to move teeth with a level of accuracy not seen in other lingual systems.

**Talk a little more about the robotically formed arch wires and why those are so important.**

_Curiel:_ Pre-formed wire blanks designed for lingual appliances create a lot of challenges. They can only approximate the unique lingual arch of each patient as well as the variations in tooth size and shape, so the wire is often far away from the surface of the teeth. When designing Harmony, I felt that the arch wire should adapt to the teeth instead of building up the base of the bracket to compensate for a pre-formed arch wire. Harmony’s robotically formed wires offer the clinician the flexibility of placing the wire as close to the tooth surface as possible, or, when the case requires opening or closing of spaces (such as an extraction case) the wire can be formed with straight wire sections to improve sliding mechanics. For every Harmony case, the doctor dictates the type of customized arch wire needed to achieve the best clinical results. For example, the doctor can choose to place the brackets as close to the teeth as possible, which results in many bends in the arch wire to achieve the desired finish (Fig. 1). Alternatively, the doctor can choose to make the wire straighter along the lingual arch, which results in an increase in the profile height of some of the brackets to achieve the desired finish (Fig. 2). Harmony offers an “optimized” wire, which incorporates both features into the system based on the treatment goals described on the prescription sheet that accompanies each case (Fig. 3).

**How does Harmony address debonds during treatments, and teeth that are blocked out at the initial bonding appointment?**

_Curiel:_ Harmony offers a set of positioning jigs with every case for bonding the anterior teeth (six jigs per arch). Positioning jigs are designed to slide over the occlusal surface of each anterior tooth and provide a mechanical guide for positioning the bonding pad just prior to light curing the appliance on the tooth. It is common for an adult patient to present with severe crowding where one or more anterior teeth cannot be bonded during the initial indirect bonding appointment. The positioning jig is used at a subsequent appointment when space opens up to allow for a bracket to be direct bonded to the lingual surface of the anterior tooth. If a bracket comes loose at any time during treatment, the positioning jigs provide an easy solution that ensures placement accuracy, which is highly critical for a digitally customized orthodontic system. The posterior teeth can be direct bonded at any time during treatment due to the shape of the bonding pad, which has occlusal rests that guide the appliance to the correct position for bonding.

**What happens if a Harmony case does not progress as expected?**

_Curiel:_ If the orthodontist feels that the case is not progressing as planned, the digital setup can be modified at any time during treatment and, for a small fee, a new set of arch wires will be robotically formed that follow the new treatment plan. The doctor is in complete control of the case during treatment. For example, a case can start out as a non-extraction case and then, later in treatment, the doctor may determine after meeting with the patient that premolars need to be extracted in order to achieve the desired finish. This is an easy change with Harmony. The doctor only needs to send a new prescription sheet to the Technical Center, which leads to the creation of a new digital setup, which can be viewed online. After two to three weeks, a new set of arch wires is robotically formed and shipped to the doctor.

**How challenging is Harmony for doctors with little to no lingual experience?**

_Curiel:_ Many doctors who have little to no background in lingual orthodontics have started treating lingual cases with Harmony. Because Harmony adapts to the doctor’s philosophy and is digitally customized for a highly accurate finish, orthodontists can submit their first case after taking an online certification course. However, attending a certification lecture is recommended. Harmony is designed to treat lingual cases using self-ligating brackets, which open and close very similarly to labial self-ligating brackets. Due to the ease of wire insertions, there is no need for intensive ligature and wire-tying exercises. A knowledge of indirect bonding is helpful, but this procedure can be learned using online resources as well as by following...
Harmony’s printed protocols. I recommend that doctors start their first Harmony case on the maxillary arch and use labial appliances on the lower arch. The maxillary teeth are wider, so they are easier to bond and insert arch wires. After starting a few cases, then progress to the Harmony system on both arches.

What gives Harmony an advantage over clear aligners?

Curiel: When patients want a truly invisible system, Harmony is the only choice. First of all, clear aligners are not truly invisible. Second, in order to get three-dimensional control of teeth, bonded buttons are required and do not always achieve a perfect result. Aligners also require patient cooperation and can become lost or damaged. I find most of my patients do not like having to constantly remove and re-insert aligners during the day. A lot of my patients who initially requested clear aligners have switched to Harmony just for these reasons.

A distinct advantage Harmony has over clear aligners is the range of cases that can be treated. Essentially, if you can treat a case with labial appliances you can treat the case with Harmony. The same cannot be said for clear aligners. When a patient tells me that they want invisible braces, I educate them on the advantages and disadvantages of both systems. Not surprisingly, almost every patient seeking invisible braces selects Harmony.

What is Harmony’s biggest benefit for the patient?

Curiel: Harmony offers patients an orthodontic system that is not just truly invisible, but quick and effective. I find that many patients seeking invisible orthodontic treatment have already visited several orthodontists, so I know they have already heard the clear aligner story from other dentists and orthodontists. When presenting Harmony, I inform the patient that their smile can be improved using the latest in digital technology, that they can benefit from the most efficient method for straightening teeth, that their office visits are typically 10 weeks apart, and that each office visit is only 10 to 15 minutes. These advantages are very compelling. Whether patients seeking invisible orthodontics choose to use Harmony or not, I find that by offering Harmony it really distinguishes my practice from other offices in the area.

How much time will Harmony save both the doctor and the patient?

Curiel: With Harmony, I change a lingual arch wire in about three to five minutes. A traditionally ligated lingual system takes me about 15 minutes or more per arch due to the challenges of tying in ligatures. I find appointments with Harmony to run about four times faster than with other lingual systems. Another time-saving benefit is that I do not have to spend time bending wires. This saves a lot of time and overcomes one of the biggest challenges orthodontists face with lingual treatment. Because Harmony is a self-ligating system, I can schedule appointments up to 10 weeks apart instead of every four weeks, which opens up my schedule for more patients. I find that I can finish most of my Harmony lingual cases with the same number of appointments and the same overall treatment time as my self-ligating labial cases, so there really is no downside to starting a lingual case versus a self-ligating labial case. Fortunately, patients are willing to pay a lot more for invisible orthodontics, so Harmony is a great tool for creating additional revenue for the practice.

Why did you partner with American Orthodontics?

Curiel: We realized that to take Harmony to the next level, we needed a partner who not only shared our vision, but had well-established global distribution. We found this in American Orthodontics. One factor that was critical is that American Orthodontics is a privately held company whose focus is strictly on orthodontics. They are different from other large companies where orthodontics is a small fraction of their business. Another factor that was important in building a long-term relationship with American Orthodontics is that they are like a family. They manufacture quality products and offer outstanding customer service, so we felt this would be a great fit for our two organizations. We’re excited American Orthodontics has taken over the manufacturing of Harmony and will now have their full resources and experience behind it. They are truly the company of choice as we look to move Harmony forward in the future.

For more information about Harmony and American Orthodontics, visit www.americanortho.com, or call 800-558-7687.
Employee Training
The Importance of a Great Training System
by Andrea Cook

“The most valuable asset in an orthodontic practice is the people. One of the most critical issues facing orthodontists today is how to hire, train and retain quality people to achieve and maintain excellence.” — Dr. Steven Seltzer

This statement was published more than 10 years ago. The struggle of how to accomplish this continues in today’s busy orthodontic practice. I was recently in an orthodontic office to implement their new sterilization system. They had a new team member there on her first day with the office. She was watching with eyes wide open as we went through the new system and equipment. I had a minute to ask her how she was doing and almost with tears in her eyes she said, “I am so lost.” When we got a break I asked the clinical coordinator what the training protocol was for the new team members. She replied “Well, it is pretty much sink or swim here. We don’t have time to train.” Sadly, this is the case with many busy orthodontic offices. Training systems such as this have a significantly lower success rate than offices that provide good information, proper training and clear expectations for new employees. Many great team members are lost without a structured training system and a trainer.

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The employee base of today is changing. People are much more transient than they have been in the past. It is estimated that today's students will have 10 to 14 jobs before their 38th birthday! These numbers indicate our offices will be investing more time and energy into training than in previous years. Having a designated trainer and a good training system will make this process much more successful.

Many offices struggle with the “we are always training” cycle that they can’t seem to break. I have found offices that suffer with this vicious cycle have a poor new employee training system or no system at all. Without proper care and feeding even the best new employee will fail if not given information, tools, training and set expectations needed to excel.

Not every new hire can be an all-star employee and we will have failures. There are two types of failures when it comes to training new team members. There are system-based failures and employee-based failures.

- System-based failures include:
  - Lack of a training schedule
  - The trainer is not well trained
  - Lack of written information
  - No clear job description
  - No guidelines and expectations established

- Employee-based failures include:
  - Tardiness
  - Lack of accountability
  - Failure to meet expectations

If an office loses a new team member based on a system failure, this should be a great concern to the office. The system must be improved in order to stop the cycle of perpetual training and increase the development and retention of great team members.

When a new team member is hired, he or she will move through four basic stages as the member learns the new skills. Each stage presents its own challenges. With great training, patience and care, we can help a person move through them smoothly and develop into a great team member.

There are four basic steps in the ladder of training:

1. **Unconscious Incompetence**
   You don’t know that you don’t know. This new team member does not understand or know all that he or she doesn’t know. The new member must recognize his or her own incompetence, and the value of the new skill, before moving on to the next stage.

2. **Conscious Incompetence**
   You know that you don’t know. Though the trainee might not understand or know how to do something, he or she recognizes the fact that he or she doesn’t know it. This can be a pivotal point for a trainee. There can be a level of frustration during this stage. The trainee might feel like he or she will never “get it” and give up if not given the support needed. It is critical to celebrate successes no matter how small in order to build confidence.

3. **Conscious Competence**
   You know that you know. This trainee understands or knows how to do something. However, demonstrating the skill or knowledge requires concentration. He or she can accomplish the procedure, but it takes heavy concentration. The time it takes to complete appointments might be longer than the schedule allows.

4. **Unconscious Competence**
   You don’t know that you know. It just seems easy. I finally got it! This is your new orthodontic clinician! He or she has had so much practice with a skill that it has become second nature and can be performed easily. As a result, the team member can complete procedures with accuracy and within the scheduled time.

The length of time an individual spends in any of these four stages depends on the strength of the trainer and the training system in your office.

So, let’s set our new team members up to climb the ladder quickly and most efficiently by giving them the tools, training and set expectations they need to become a valuable asset to your office.

If we expect team members to perform, we must make sure we let them know how to perform, as well as provide them with all the tools and training they need to perform those skills. All newly hired team members should receive a packet with office information included. They should receive an office manual, a clear job description, their training schedule and any other information your office provides. Make sure they get introduced to all the other employees and know who their trainer or “go to” person is. I have been in an office during the morning huddle when a new team member has started. After the huddle I heard some team members asking “who was that in the morning meeting?” The answer was, “that is your new team member.” How do you think she felt about joining that team?

Before we can start training our new team members we must determine what we are training them for. From brackets and adhesives to sterilization protocols, orthodontic clinical procedures are different in almost every office. Even when hiring a clinical assistant with 20 years of orthodontic experience, it is critical to train her on how orthodontic patient care is delivered.

“Albert Einstein once said, ‘Insanity is doing the same thing over and over and expecting different results.’”
in your office. This is not limited to the clinical area. Clear definition must be outlined for every position in your office from scheduling coordinator, treatment coordinator, records technician, lab technician, etc.

This definition should come in the form of a clear and outlined job description. Most often a clinical assistant is hired with that blanket job description “clinical assistant,” without any definition of what that means for your office. A clinical job description should include the clinical duties, infection control duties, lab duties and all miscellaneous procedures that he or she is expected to perform. Without expectations, how can you expect them to perform well and fulfill their role in your office?

Now that we have the job description clearly defined for the new member, we must give him or her all the information needed to fulfill this role. The first portion of that would be all basic orthodontic information including tooth numbering, names of instruments, a complete list of dental and orthodontic terminology, etc. I recommend this basic information be given to all team members when they join your team. This will help your scheduling coordinators triage the emergency call much better. This will also help your treatment coordinators explain treatment and appliances to new patients.

There should also be information that is specific to your office such as: what types of brackets you use, what “taking records” means to your office, what adhesives you use and what appliances you use with your patients. Offices are quick to assume that an experienced orthodontic assistant can immediately start running a column. So often this sets a trainee up for failure. For example, her bond failure rate may be too high simply because she was never taught how to bond in your office and with your products. This is a system failure and protocols must be in place to help her be successful from the start.

A new team member will also need a training outline. I hear all the time, “well, she has been here a year and still isn’t fully trained.” This failure is most often due to the training system, not the person. Clear expectations and time frames should be set up to help him or her achieve goals. Starting off with short-term goals and celebrating successes will keep him or her motivated during the training process. I recommend having a list for the trainee and the trainer to check off as goals are accomplished. There should be a time frame for 30-, 60- and 90-day goals with accomplishments to check off along the way.

Hands-on training is key to making a new clinicians’ training move quickly. Having the trainer sit with a trainee during a procedure that he or she is not comfortable with makes both parties (trainee and the patient) more confident. I remember the first time I put an archwire on a patient. I got the patient all tied in and was so proud of my success. That is, until my trainer came over and said “next time, don’t put the archwire in the headgear tube.” I was very deflated by that comment. If I had a trainer that stayed with me and gave me encouragement throughout the procedure, the result would have been much different.

I have worked with many offices who tell me they have a high turnover rate. They’ll say they have a hard time finding good people who want to work. Many times good people are hired and not provided with good training so the cycle continues. Albert Einstein once said, “Insanity is doing the same thing over and over again and expecting different results.” Continuing to hire new team members without a good training system might fall into this insanity definition. The first steps in developing great new employees are:

- Develop a complete office manual
- Develop clear job descriptions for every position in your office
- Set expectations and time frames for your new team members
- Have a trained trainer – not everyone is meant to train
- Implement a training system – not just “sink or swim”

We have implemented a great training system into the office above that previously used the “sink or swim” training method. They have successfully trained two new team members. The office, the new team members and their patients are all benefiting from this change. Making these changes in your office might stop the perpetual training cycle and keep you from falling into the definition of insanity!

Author’s Bio

Andrea Cook bases training systems on practical knowledge gained through 20 years chairside experience. Andrea works as a clinical consultant and trainer for premier orthodontic offices across the country. Since effectively training clinical team members is a critical portion to the advancement of clinical productivity and profitability, Andrea works with teams to increase efficiency, improve communication and guides the office to a new level of excellence. For more information, contact Andrea Cook at 253-332-3376 or andreacook@andreacookconsulting.com. You can also visit her Web site at www.andreacookconsulting.com.
The troubled economy has put a damper on the commercial real estate market, which ends up being good news for orthodontic practices. Whether you’re signing a new lease for your practice or are renewing an existing one, you are now likely to enjoy a stronger negotiating position than you would have in the recent past. Developers overbuilt during the real estate boom, most national retailers have cut back their store-growth plans, and some smaller, local businesses have had to close their operations. As a result of these factors, vacancies are high. Commercial landlords are motivated to approve deals in order to attract and retain good tenants, which they might not have in better economic times.

Landlords’ desire to cut deals doesn’t mean, however, that they’re giving away the farm. Orthodontists would be wise to pay close attention to the leases they are asked to sign. The following three contract sections are areas where we have found landlords often try to gain an upper hand.

**Term**

Generally speaking, the landlord’s goal is to lock the tenant into a longer term while the tenant hopes to pay as little as possible. You can frequently ask the landlord to add years onto the lease in return for lower rent or to gain other concessions like a tenant improvement allowance.

In truth, most orthodontists will have to commit to a 10-year lease. Orthodontic practices have high build-out costs for their offices, often $85 per square foot, and might need to borrow upward of $100,000 from a financial institution. Most banks require a 10-year lease before approving such a high
build-out loan. Landlords, however, typically aren’t aware of this requirement and might assume an orthodontist’s build-out costs are similar to a general dentist’s (approximately $55 per square foot). As a negotiation tactic, you can start by offering to sign a seven-year lease and allow the landlord to raise the term to 10 years in order to gain lower rent. In case the landlord actually approves a seven-year term, you can ask for three additional option years, which will give you the chance to extend the contract and meet the bank’s requirement.

Before renewing a lease, the doctor should take various factors into account such as nearby competition, the health of the local economy, any desire to relocate and the level of satisfaction with the present location. Even if you are satisfied with where you are, about a year before your contract expires you should take the time to contact other landlords and discuss the incentives they are willing to offer for relocation. Learn what your neighbors are paying. Get a sense of the market, and use your findings as leverage. If your practice already has more than one office, your position is even stronger since you have a back-up place to practice in case contract negotiations fall through.

Indemnity

Disputes between tenants and landlords will happen. Most are small and can be resolved easily, but others can concern tens or even hundreds of thousands of dollars. You might feel your landlord should pay for a new roof or A/C system. An employee or patient of yours might suffer a bad fall in an icy parking lot, and in your view, the medical costs are the landlord’s liability.

You will find it difficult to seek resolution through the legal system if you signed a lease that includes an indemnity clause. Such a clause means the tenant has waived rights, which could include rights to recovery, claims and actions against the landlord and sometimes the right to a trial by jury. Often, an indemnity clause can be a single sentence slipped into a lengthy section of legalese, and doctors will not be aware of the rights they are signing away.

Be careful of indemnifying landlords against legal action. If they are firm about such a provision in the lease, you should at least insist upon mutual indemnification, so your practice has the same protection the landlord has. For a dispute covered by a lease with mutual indemnification, the matter will go to a jury. Juries tend to like doctors and to rule in favor of the little guy. Since a jury trial is more likely to go in your favor, some landlords wish to preclude this possibility. If the lease indemnifies the landlord from a jury trial, the matter will go to a judge who might be more inclined to favor the landlord.

As a rule, keep an eye out for indemnification clauses. You might decide to waive some judicial rights because you find the property ideal or because of some other business reason, but make sure you are doing so consciously and not because of a deception or a failure to carefully read the contract.

Triple Nets

Most leases will contain a section covering the property’s base rent and a separate section covering extra costs passed along to tenants. These extra costs, called “triple nets,” consist of three items: real estate property taxes, insurance on the property and Common Area Maintenance (CAM). The first two items are typically straightforward because landlords cannot readily negotiate their own costs with the government or insurance carriers. Still, as a tenant with your own expense projections to consider, you should always request a cap on the amount the landlord can increase your costs each year. A good strategy is to ask for a three percent cap on annual increases in triple nets, and most landlords will settle for a four or five percent cap.

Unlike insurance or taxes, CAM fees are one area where landlords often try to pass off their own costs onto the tenants’ shoulders. Legitimate CAM fees will help the landlord cover direct expenses for the areas shared among multiple tenants, areas such as lobbies, public bathrooms and parking lots. On the other hand, CAM fees should not cover the landlord’s management, administrative, accounting, legal or marketing costs. Ask for the lease to explicitly state what CAM covers. At end of each year, your landlord will submit CAM expenditures, and you’ll have 30 days to review them. Most doctors are so busy, they don’t look at the list, but I have found that many landlords will try to insert illegitimate charges. If you successfully dispute any fraudulent CAM fees, you will also be entitled to reimbursement of your legal costs.

The three sections discussed above only scratch the surface of the potential traps found in leases, which can be quite lengthy and often impenetrable. You don’t have to assume all landlords are ethically challenged adversaries, but it’s a good idea to prepare for the worst by reviewing your lease carefully before you sign and enlisting the help of a good real estate agent or lawyer. The greatest leverage you can have is to always be willing to walk away from the deal.

Author’s Bio

Ryan Wilson is the real estate director for OrthoSynetics (OSI), a business services firm that assists orthodontic and dental practices utilizing a full service, management approach to address all non-clinical practice functions to gain better efficiencies and profitability. Services are also offered on an a la carte basis. For more information, visit www.orthosynetics.com or email sales@orthosynetics.com.
Most of us have seen the movie _The Perfect Storm_ where a fishing vessel in search of a large catch of fish goes to the outer banks and beyond to find them. The good part is they do find an incredible catch. The bad part is they find themselves in the middle of a convergence of multiple weather elements almost unknown in seafaring history. This convergence makes it impossible to escape in any direction. They are trapped.

I believe the last three years in orthodontics have a lot in common with that fishing boat. I have been practicing for 40 years, during which there have been choppy seas, ill winds and several “mutinies.” However, there has never been the combination of all of these events, and certainly not in the severe intensity that now exists. What is it that has created this foreboding climate for the orthodontic profession?

- Pediatric dentists have always done some orthodontics. Now, however, they are hiring orthodontists within their practices, which have in many respects, cut-off the young patient referral source. Certainly pediatric dentists have always hired orthodontists, but never in the numbers that exist now.
- The dental group practice is now intensifying to the degree that it is also creating a problem for the solo orthodontist. With more females entering the dental and orthodontic arenas, this is a perfect setting for those who wish to work at their profession and also spend time raising their children. This is not a condemnation of the problem; it is merely a statement of fact.
- For the very first time in my 40 years of practice, general dentists performing orthodontics are impacting orthodontists. We claimed it was a problem before, but it wasn’t yet. Remember how we thought the “straight-wire” appliance was going to end the specialty? It didn’t! Remember we thought MSOs were going to bring down orthodontics? They didn’t! There have been many other threats. None of them damaged the profession – at least not by themselves anyway. The advent of “aligners” to orthodontics and then to dentistry has dealt a huge blow to traditional orthodontics. Give the patient aligners (which they want) and the teeth will move. The dentist just needs to give the aligners to the patient in the proper sequence and the magic happens. This is not a bashing of aligners. They certainly have their place in orthodontic tooth movement. It is the widespread use of these appliances in the hands of those who have not been trained in tooth movement that causes the problems, and the numbers in which the cases are done! There are now at least three companies marketing to general dentists with their version of straight teeth in six months or less. The result is many fewer referrals to orthodontists.
• The great uncertainty of this current recession has created an environment which does not bode well for those in the orthodontic profession. Patients and potential patients have lost their jobs or are in fear of losing them. With that comes a reticence to call for an orthodontic consultation. Those who get consultations are not sure they should begin treatment or maybe they can obtain treatment cheaper (see GPs, clinics etc.). Add to this the fact that banks are refusing loans to qualified orthodontists and cutting lines of credit, and the fact that the recession might not have hit bottom.

• The last major area of this perfect storm is the presence of what is called Generation X and Generation Y. What does this have to do with anything? The answer is everything! Haven’t you noticed the difference in patient attitude over at least the last 10 years? Gen X was different. Gen Y is really different! Gen X has partially raised Gen Y. Gen Y is being raised by technology and the Internet. They might seem independent but are, to a large degree, followers. They don’t read newspapers. They don’t watch the news (maybe a good thing). Their lives revolve around what they can look up on the Internet – Google, Facebook, MySpace, etc. They don’t believe in the same things as past generations. Their work ethic is different. And oh yes, you cannot market to them in the same way. Logic, great service and what we use to call “value” do not move them to choose an orthodontist as they did in past generations. I am not saying any of this is bad. I am saying that it is different and that we must recognize the differences.

So there you have it. Those are the major waves, storm clouds and winds all upon us at the same time. I believe that orthodontics will never return to the way it was in the past. So what should we do? Give up? Retire? No!

Some of the things which should be done will be described. But first I would like to warn you, especially if you are over 40 and consider yourself traditional, my suggestions might not sit well with you. Also, remember not every orthodontist will be affected in the same way by this perfect storm. Maneuvering your way out of the problems previously mentioned will require a multi-pronged response.

• Everything possible must be done to quickly reduce overhead in a very significant way. Forty percent should be the target. Many of you will look at that number and think it is impossible to reach. It is not and it must be achieved very quickly. This has to be accomplished within two years.

• Incredible efficiency must be brought into the management of your practice. This is especially true in your clinical area.

• You must gain financial mastery of your practice.

• Marketing must change from what has been the norm to something that is appealing to the Gen X and Y groups.

• The Internet must play a large part in your marketing, but in a way that will not cost a significant amount of money (remember 40 percent overhead).

• Any assistance from consultants should be reasonable and measurable in ROI.

• You will be performing services which include more than just tooth movement.

• A heart-wrenching decision will need to be made concerning fees – either very high fees with a select small number of patients or significantly lower fees with large volume. Remember, many orthodontists will not have a choice. We are now dealing with different times, different circumstances and different people.

• Practices will need to have superbly trained smaller staff sizes.

• It will be necessary to develop much better diagnostic skills and determine which technological advances are necessary versus those which are just nice to have. What is best for the patient? What is best for superb diagnostics? What is best for efficient and effective treatment?

All of the items have answers beyond the scope of this article. But based on 40 years of experience, this is my opinion.

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**Author’s Bio**

Dr. Ronald Roncone received his BA, DDS and MS in physiology from Marquette University and his postdoctoral Certificate in Orthodontics from Forsythe Dental Center and Harvard School of Dental Medicine. Dr. Roncone maintains a large practice in Vista, California, and has lectured extensively presenting more than 1,000 seminars around the world and is president and CEO of Roncone Orthodontics International (ROI). ROI offers Just Short of Perfect (JSOP) orthodontic seminars starting in March 2012. The year-long program consists of four four-day group sessions covering topics clinical, financial, marketing, scheduling, and patient enrollment. To take this opportunity with significantly reduced fees only offered this year, visit www.ronconeroi.com.
For more than 50 years, a famous East Coast off-price clothing store has declared “an educated consumer is our best customer.” That statement should also be the mantra at orthodontic offices seeking win-win partnerships with today’s prospective adult patients. This growing market segment wants to know how orthodontics will impact their entire lifestyle, not just their budget, from treatment options to hygiene commitments to eating challenges.

With the reality of similar costs among practices, addressing these broader concerns can be the tie-breaker for a patient choosing between you and the practice down the street. Adults who are “shopping around” generally investigate three to five possibilities, seeking what differentiates each. Be proactive. Offer information and don’t assume adults have all the answers – they may be misinformed, embarrassed to ask obvious questions or not even know what to ask.

**Appearances Can Be Everything**

Adult patients, whether age 18 or 48, might worry even more than teens about adjusting to life in braces. Just because prospective patients have searched the Internet for “types of braces” or talked to a friend who had Invisalign back in 2008 doesn’t mean they’re aware of the techniques available right now. Today’s wide array of treatment approaches can be overwhelming, and improvements in material science need to be translated into easily understandable impacts. Of course, not all options are viable for a given case, but patients need to have a clear picture of their possibilities to be happy with the final decision.

Where is a good place to start? “Assure adults that excellent results can be obtained at any age,” says Dr. Michael Rogers, a practicing orthodontist of 38 years and member of the American Association of Orthodontists (AAO). “Then have your treatment coordinator (TC) follow up by emphasizing possible limitations of treatment, (e.g., a protrusion that could only be corrected by orthognathic surgery). I believe it is important to help people understand what orthodontic treatment can and cannot do for them on an individual basis.”

Dr. Rogers, who is also the 2011-12 AAO President, adds that his TC makes sure to discuss options for
dealing with issues such as missing teeth, as well as the importance of long-term retention with retainers or perhaps lingually bonded wires.

Adults are accustomed to kicking the tires of a potential purchase, as well as dealing peer to peer; they want to see what you have to offer and be given the chance to ask, “So what does that do?” Invest in multiple 3D dental models that demonstrate the appearance and placement of the latest bracket, arch wire, hook, ligature, aligner, etc. used in your practice. At the same time, check out using case presentation software to help explain the pluses and minuses of each possibility.

Lynn Schneider, owner of the online supply company www.dentakit.com, knows firsthand the frustrations that some adults feel. She went through the process of braces 10 years ago. She says she couldn’t find answers to many basic questions and often felt uncomfortable asking her orthodontist. Moreover, Schneider wanted to hear the experiences of others going through the process from her side of the chair. She solved the problem by founding the Web site www.archwired.com. This online community now features dozens of forums covering topics from braces 101 and lingual braces to dental products and orthognathic surgery.

“Adults don’t want to be surprised,” says Schneider. “If you’re going to be adding new hardware at some point, such as springs, don’t just put them in without discussing it; this will only make a previously happy patient resentful and non-compliant.” Another example concerning expectations is if a patient has any teeth with gold crowns, you should explain that those teeth will require banded brackets rather than the cube type, due to bonding issues.

Managing Pain and Maintaining Good Dental Health

Although the orthodontic community has made the conscious effort to use the word “discomfort” when discussing orthodontic treatment, adults are just as savvy as teens in figuring out that sometimes things are going to hurt. Key to getting past this objection is not merely to say, “You’ll feel much better after two or three days.” Even though that statement is true, you’re better off acknowledging the concern, then giving patients information and tools that will help them to feel in control.

A great forum for sharing experiences on this topic is the online professional organization Women in Orthodontics (WIO) (see sidebar). For example, Anne Pearson, WIO member and professional rela-

Top Ten TC Tips for Adult Patients

From members of the professional organization Women in Orthodontics (www.womeninortho.org) come these great tips to share with adult patients.

1. Apply moist heat around face to ease muscle soreness, and chew gum or eat a steak. (Stephanie T., Jeremy Smith Orthodontics, Rogers, Arkansas)
2. Use an oxygenating oral rinse and a rubber-tip stimulator to help decrease the hyper-plastic response to the appliances. (Paula H.)
3. Tell them that discomfort is a sign that things are progressing. (Ellen E.)
4. Assure patients that it’s better to have attention drawn to your smile because it is “under construction” rather than because it is unsightly and unhealthy. (Melissa T.)
5. Change your Invisalign tray at night before going to bed, because your teeth adjust more while you are sleeping. (Kristi L.)
6. Brush more than once a day. (Cyndie P.)
7. Dry brush! Anywhere! It’s the motion of the bristles that makes your gums healthy. (Rosemary Bray, Consultant, Carlsbad, California)
8. Follow instructions exactly as they are given; many adults want to rush the process thinking they will speed up finishing. (Carolyn Friedman, OrthoAssist, Tallahassee, Florida)
9. Fruit smoothies, milk shakes, ice cream, pudding and cold applesauce can be very soothing for aching teeth. (Lisa Anderson, Orthodontic Specialty Services, Fort Wayne, Indiana)
10. Let them know that patients in their 80s have had braces and said it was worth it! (Anne Pearson, McDonald Orthodontics, Salem, Oregon)
tions coordinator for McDonald Orthodontics in Salem, Oregon, says that for pain management, “along with over-the-counter pain relievers, many adults love the Invisalign ‘chewies’ (the soft rubber rolls patients bite on to seat their aligners).” To ensure a successful start, the practice also requires a current cleaning and requests perio charting even before the new patient exam. Another pointer comes from Dr. Natalie Parisi of Reading Orthodontic Group, in Wyomissing, Pennsylvania, a WIO member who strongly recommends that adult patients use a Sonicare toothbrush and a water-flosser system.

Fortunately, today’s adults have grown up with a vastly improved and accepted regimen of regular dental care. For a little perspective, consider the results of a recent survey by the National Institute of Dental Health: the rate of toothlessness among people ages 55 to 64 has plummeted 60 percent in the past 50 years. Knowing that one’s teeth could (and should) last for 60, 70 or 80-plus years gives new relevance to making them their best.

People are also getting the message that having a proper bite is directly related to overall dental health. Explain that teeth are easier to clean if they are not as crowded, periodontal health is improved and a well-aligned bite helps prevent teeth from wearing down.

**So, What Can You Eat?**

The new-patient packet for any age patient usually includes a classic “foods to avoid” magnet for prominent placement on the refrigerator. It’s true: hard/crunchy/sticky/chewy items are likely to cause problems. However, while the content and purpose is absolutely in the patient’s best interest, this list also operates from a sense of denial: don’t do this and don’t eat that. You can reassure prospective adult patients that just because they might feel like a kid again, they don’t have to eat like one.

Adults don’t want to feel restricted, whether they are eating at home, a party or a business function. Pass along tips such as, 1) seal freshly baked items in a lidded container with a slice of fresh bread (to add moisture), 2) use cauliflower instead of broccoli for a party dip, and 3) try microwaving an item instead of popping it in the toaster.

For the adult who has never had orthodontic treatment, how food affects braces will be a new topic. Other adults, especially if they had traditional full-band braces in the 60s and 70s, might have eaten pretty much what they wanted, never had a problem and wonder what the big deal is. The fact is that today’s small, aesthetically improved cube brackets are not as ruggedly attached as the older full-band type. Biting into apples, hard cookies or jerky might indeed have been fine for the latter, but today’s patient must be advised about the best food types, ingredients and preparation techniques to ensure continued bonding.

Arming patients with information that will help them avoid bracket/wire breakage will also directly help your business. Fewer repairs mean fewer unscheduled appointments to interfere with your daily timeline.

**Resources for Adult Patients**

Lastly, go the extra mile to find printed and online resources you can share with prospective patients. Send home a packet that will help prospective patients make an informed, pressure-free decision in the quiet of their home. Beyond the written cost and timeframe estimates, consider these additions:

- Print out color photos of the patient’s teeth (not just generic images) showing the problem areas with diagrams of how they can be corrected.
- Describe the hardware and process each treatment approach would entail (again, with pictures).
- Suggest watching the Webisode on “Adults and Orthodontics,” featuring AAO member Dr. Larry Wang (scroll through the AAO’s YouTube channel at www.youtube.com/user/AmerAssocOrtho#/p/u).
• Update your own Web site with clear visuals to help adults understand typical problems that might compare to their own situation, that they can take their time viewing. Three good examples are at:
www.berkmanshapirosmiles.com/?p=ortho
www.identalhub.com/article_choosing-right-type-of-braces-159.aspx

A downloadable AAO brochure on adult treatment is at www.braces.org/learn/Brochures.cfm.

Use the take-home packet to reinforce how much you care about the patient as a whole person by including a list of the additional items they will receive once they start their treatment. These items should further differentiate your practice and could include a braces-friendly cookbook targeted to adults, an orthodontic version of an electric toothbrush, flossing product-samples and, later, compliance awards appropriate to adults, such as gift cards for Starbucks, Jamba Juice or frozen yogurt.

This is your chance to show prospective adult patients they are “more than just a mouth” – take advantage of all the resources that will help you convert those consults to starts.

Author's Bio

Pamela Waterman is the president of Metal Mouth Media, a publishing company dedicated to “taking the bite out of braces” through specialty cookbooks, articles, Web resources and workshops. She has been a spokesperson for the American Association of Orthodontists and is the creator of the new “Braces-Friendly” Seal of Approval. Based in Mesa, Arizona, Waterman has more than 25 years of experience in engineering and writing and is the author of four books including the award-winning Braces Cookbook series. She can be contacted at pwaterman@metalmouthmedia.net
Introduction

After successfully getting her three children completely through orthodontic treatment, this 45-year-old woman (Fig. 1) wanted to have her crooked teeth straightened, but not without conditions. She did not want any of her teeth removed and she insisted that she be treated with Invisalign. Her treatment began early in 2002, only a couple of years after the introduction of Invisalign. At that time, Align Technology suggested successful Invisalign treatment should be limited to relatively minor crowding and excessive space cases.
**Diagnosis**

The patient presented with a challenging combination of circumstances: severe crowding, narrow upper and lower dental arches positioned to the fullest extent of the supporting skeletal bases, large teeth and a dolichocephalic Class I relation (Figs. 2-6). She was missing the lower left and upper right third molars, but the upper left and lower right third molars were unerupted. The health and status of the gingiva and underlying bone level was excellent and the soft tissue profile good (Figs. 7&8).

**Treatment**

A quadhelix expansion appliance (.036 stainless steel wire attached to upper first molar bands) was inserted in March 2002, and remained in place for six months until September 2002 (Figs. 9-13). At that time, PVS impressions were submitted to Align Technology where a ClinCheck was created according to the prescribed treatment plan (Figs. 14-16 & 25-29). The first of 25 upper aligners and 13 lower align-
ers were delivered in October 2002. Around October 2003, at stage 18, 13 upper mid-course correction aligners were ordered (lower correction having been accomplished, patient was continuing to wear lower aligner #13). In January 2004, the clear aligners were discontinued so the patient could begin to wear upper and lower Hawley retainers; four and a half years later, in August 2008, the patient was dismissed from our supervision, although we granted her request to continue to wear her retainers to bed a couple of nights per week (Figs. 18-24).

Discussion

There have been many published articles arguing the efficacy (and even possibility) of expanding the adult, non-growing maxilla. The threat of blowing the teeth out beyond the limits of the alveolar process with excessive forces, resulting in periodontal recession and instability, is certainly a valid concern. As a mentee of Dr. Robert Ricketts, I am a disciple of the biology-friendly light, continuous force paradigm. It is this paradigm that explains the successful expansion of the adult maxilla: the use of light, continuous pressure on the maxillary teeth results in a biological remodeling of the alveolar process as the teeth move buccally. Simply, the quadhelix translates the alveolar process laterally, keeping the teeth well-surrounded by bone and providing adequate attachment for the gingiva. As demonstrated in this patient’s treatment, her expansion was significant, resulted in healthy bone and gingiva and has remained stable for many years.

Although contemporary Invisalign treatment has overwhelmingly dispelled doubts that clear aligners can adequately move teeth and properly align roots, early in the Invisalign experience those doubts were purported by many orthodontists. The appropriately trained Invisalign orthodontist appreciates the importance of judicial use of attachments and staging to move teeth with preferred results. This patient’s treatment validates teeth, even when closing extraction spaces, can be moved and properly aligned with clear aligner therapy (Fig. 24).

The total treatment time for this patient’s correction was 21 months, six months with a quadhelix prior to 15 months of clear aligners, which included 13 mid-course correction aligners for a total of 31 upper and 13 lower aligners. This treatment period strongly suggests use of clear aligners does not prolong the typical treatment time for most corrections and, in fact, often shortens some treatment corrections.

The Invisalign appliance gave this patient the smile and appearance she desired because, she admits, she would not have had orthodontic treatment without that option available. The use of the clear aligners has expanded in today’s orthodontic practice largely due to successful treatment results like this case. The treatment plans are more sophisticated, the attachments are more technologically engineered and the plastic materials are more enduring. Patient demand continues to push orthodontists into becoming Invisalign-trained and providing clear aligners for more types of corrections. If they don’t, the public will simply go elsewhere for treatment.
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Welcome to the newest installment of Office Visit, where we visit a Townie’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 *Orthotown Magazine* travels to the Great White North to visit Dr. Michael Koropp and his team at their practice in Anchorage, Alaska. We discuss his reasons for entering orthodontics, his practice philosophy, the orthodontic competition in his area, and we find out from Dr. Koropp’s staff what it’s like working for him and how the team functions (and has fun).

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

*Koropp:* After graduating from Oregon Health & Science University I had no desire to immediately pursue a career in orthodontics, so I became an associate in a wonderful general dental practice. During this time I came to realize my personal fulfillment was tied to the enjoyment and happiness my patients experienced. At that point it was obvious that an orthodontic career would provide me with the great opportunity to provide health and happiness to virtually everyone who walked through the door. After 25 years of orthodontic practice I can confirm that time really does fly when you’re having fun.

**What is your practice philosophy?**

*Koropp:* Our practice philosophy is to provide outstanding orthodontic treatment and service in a manner that enables our patients and ourselves to be the best that we can be. Providing excellent treatment and service requires a highly trained and motivated staff. Frequent training sessions and seminars are essential if the staff is to become skilled in all aspects of delivering orthodontic care. Equally important, the staff must have a
Office Highlights

Bonding Agents
- 3M Unitek Transbond

Brackets and Wires
- 3M Unitek MBT pre-pasted brackets/.022 slot
- 3M Unitek SmartClip self-ligating brackets
- 3M Unitek wires, NiTi, Stainless Steel & TMA

Cements
- 3M Unitek Ketac glass ionomer

Class II Appliances
- Banded Herbst appliance for most severe Class II cases
- Forsus springs or Pendex appliance for less severe Class II

Class III Appliances
- Banded RPE with hooks for facemask (Henry Schien multi-adjustable)

Technology
- i-Cat 3D scanner with Anatomage software and Beamreaders reports
- Incognito lingual braces
- Paperless office with Ortho2 ViewPoint software and Dolphin Imaging
- Soft-tissue laser (BioLase – Ezlase)
- Vector temporary anchorage system
- Web design and communications by Televox

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clear vision of the manner in which patients are to be cared for, from the initial exam to their orthodontic graduation. The staff understands the importance of embracing, encouraging and empowering patients so they are capable of maintaining their orthodontic appliances and teeth throughout their life. Care cards, e-mails and texting are our most common and most effective ways of communicating with patients outside the office. We have also developed incentive programs that encourage our younger patients to be better students and citizens.

How do you cultivate this philosophy in your practice?

Koropp: It is important that your patients and referring doctors know that you embrace new technology and provide treatment using the latest techniques available. Some of the more recent technologies that we have incorporated include lasers (BioLase), 3D imaging (i-CAT) and lingual appliances (Incognito). It takes time, effort and money to add any new technology but it is very important to do so to maintain the vitality and growth of your practice.

As a team we have great respect for the time, effort and energy that the parents put forth to provide orthodontic treatment for their children. As a result we encourage them to be active listeners and participants at every appointment. In addition, we have developed a schedule which allows us to see patients in an efficient and timely manner. It is understood that our parents’ time is just as important and valuable as our own. Our two locations on opposite sides of Anchorage provide quick and convenient accessibility to almost everyone.

We keep our referring doctors involved by sending an oral hygiene “evaluation card” with patients every time they have a cleaning or examination with their dentist. This allows the hygienist/doctor to make specific comments regarding any concerns he or she might have and affords a great opportunity for direct dialogue on a frequent basis.

What is the orthodontic competition like in your area?

Koropp: There are about a dozen orthodontists in the Anchorage area, so potential patients have many choices and often “shop” for the best price. In addition, the current economic slowdown makes it increasingly difficult for many people to pursue orthodontic treatment. Our focus has always been to explain how the value of a beautiful and healthy smile is much greater than the monetary cost.

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

Koropp: One thing that sets our practice apart from others is consistency. Our parents and patients know that we don’t have up days and down days. They will receive the same level of service and care day in and day out. Our message is the same regardless of whether it comes from our Web site, automated phone messages, e-mails, staff, doctor or any other source.

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

Koropp: The technology with the biggest “wow” factor is the i-CAT cone beam scanner and the Anatomage software program. The images and information that can be presented to patients is very impressive. My partner and I are the only orthodontists with an i-CAT in Anchorage and it has been very effective in setting us apart from other orthodontic offices. Referring doctors are impressed with this new technology and we provide a scanning service to any of their patients for a nominal fee.

How do you accommodate emergency appointments (broken brackets, etc.)?

Koropp: We set specific times each day to deal with any emergency appointments. If a patient calls with a problem, we make sure it is addressed the same day. On weekends and evenings we have an emergency cell phone, which revolves between the technicians on a monthly basis so patients are able to speak with an assistant at almost any time.

Dr. Koropp’s Three Favorite Products

1. Imaging Sciences i-CAT CBCT

“I have been using the i-CAT since August 2009. It provides diagnostic information that cannot be attained with traditional 2D radiographs. It is particularly helpful in determining root positions, evaluating impacted teeth and detecting supernumerary teeth and airway problems. Parents and patients alike are impressed with this technology and its potential benefits in diagnosis and treatment planning.”

2. BioLase (Ezlase) Soft Tissue Laser

“Our practice has been using this laser since May 2008. Lasers are essential if you are extending treatment time due to partially or totally unerupted teeth. I use the Ezlase any time there is insufficient intra-oral tooth structure to place a bracket. The Ezlase is also a quick and nearly painless way to remove redundant hypertrophic gingival tissue. I only use topical gels for anesthesia and rarely have a complaint concerning discomfort.”

3. Incognito Lingu al Braces

“It is a very good alternative to aligner therapy. The aesthetics of lingual brackets are better than clear aligners and they are well tolerated by patients. The Incognito system is the epitome of high-tech with custom brackets and wires for each patient. Lingual brackets also give me an option for treating difficult cases that might not be effectively completed with aligners. The limiting factor in case acceptance is cost. Nonetheless, they are a great value.”
Meet Dr. Koropp’s Staff

Tracey Bakker, Katie Brickley, Kari Cabanski and Allison Millar – Technicians; Tracie Hales – Treatment Coordinator; Shannon Zink – Financial Coordinator; Katie Koropp – Marketing Coordinator

How do you like working for Dr. Koropp?

Cabanski: He treats all of his patients as if “they were his kids.” As an employer, he is fair, honest and provides us with the best technology and equipment to provide exceptional orthodontic care for our patients.

Brickley: Dr. Koropp is wonderful to work for. He is also a great teacher. He is patient when he is helping us learn. Dr. Koropp always treats each patient with respect; he is calm, collected and makes everyone around him feel at ease. He is a great lead to follow.

Tell me a little bit about the practice dynamic – how does your team function?

Zink: We are like a family. We truly like each other and care about each other and each other’s families.

Millar: We are a great team. We all enjoy each other and work well as a team. We all pitch in and get the job done. Most of us have been here for many years and have cultivated great personal relationships outside of the office.

What’s a usual day like in the practice?

Bakker: We always start our day with a morning meeting to go over our schedule. We end each meeting with a joke of the day. There is always laughter in our office. Our office can get very hectic at times. We work to ensure that each patient is seen on time.

Katie Koropp: We typically have three doctor days and two assistant days per week. On the days we have a full schedule it is very busy, but we work at a pretty consistent pace. We see an average of 60 or so patients on those days and the majority of them are in the afternoon after school hours. We schedule our longer appointments in the morning so we can accommodate more school-age children into our afternoon appointments.

What is the most important team-building exercise you (as a team) have undergone?

Hales: Continuing education classes are not only a great chance to be together out of the office as friends, but it gives us the opportunity to grow in knowledge. Of course, our annual Christmas shopping event is a big hit too!
What do you do for patients to celebrate deband day?

Koropp: The deband day is always cause for celebration. All the staff is involved in acknowledging and complimenting the patients on their great achievement. We use props, banners, bulletin boards and photographs to make the deband day a memorable occasion.

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

Koropp: One of the most wonderful things about being an orthodontist is the ability to make people feel good about their smiles and themselves. For me there is nothing more rewarding than providing free orthodontic treatment to a deserving person who would otherwise never be able to attain it. My involvement with Special Olympics has given me a unique opportunity to identify and treat some very special people over the last 25 years.

Tell me about your team.

Koropp: My team is the heart and soul of the practice. I encourage the staff to take ownership of the practice and develop an environment that is wonderful for our patients and us. I provide direction and ideas, but the staff is on stage every day delivering the message. The staff understands they can and do make a difference in the success of our practice. Living in Alaska makes staff training a challenge but I take the entire staff to the PCSO or AAO meeting biannually. Not only is it a great venue for learning, but it is also a great time for sharing ideas and bonding with other staff. During the year we get together for staff meetings/training and for outings with no other purpose than to have a good time. One of our favorite events is the annual “shop, drop and drink” during the Christmas holidays. We travel to a local mall and each staff member is given $75 to shop for another staff member (not knowing who). At the end of one hour we meet in a local restaurant, drop our shopping bags and enjoy our favorite beverage. Gifts are then exchanged with much merriment and goodwill.

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

Koropp: Currently the economic climate is hurting the orthodontic community considerably. Especially in light of the fact that many/most people consider orthodontic treatment an elective procedure that can be put off until some later date. In Alaska it seems that we are also seeing fewer companies and institutions that are providing orthodontic insurance benefits. This ultimately reduces the number of people who can afford quality orthodontic treatment.

The patient pool is then reduced further when you include non-specialists who are providing orthodontic services, mainly through non-traditional treatments such as Invisalign. It is extremely important that the orthodontic profession maintains the highest quality of care and, in turn, educates and informs the general public as to the advantages of seeking an orthodontic specialist. It seems clear that if the orthodontic profession does not look out for its own, nobody else will. Orthodontists need to educate their patients, as well as get involved with community leaders and organizations so that people understand they should seek a specialist for their orthodontic needs.

Koropp Orthodontics features five semi private patient care areas in the operatory. The outside photo is a picture of the exterior of the practice’s Dimond location. Dr. Koropp has been at the same two locations for 26 years. He purchased his Wasilla office with his partner in 2002.
Facebook now has 800 million users, including more than 60 percent of active online U.S. consumers spending an average of seven hours a month on the site. These figures emphasize the power of social media to create interactive dialogue.

Running an orthodontic office and actively engaging with patients on Facebook can be challenging without support. To lend a helpful hand, we’re offering 52 weeks of Facebook orthodontic posts for your practice. You can use these posts to start or enhance the conversation with your patients online. Remember to personalize each Facebook post and include a link, photo or video to support the topic!

1. January 24 is Parent’s Day. Dr. [name] would like to thank his/her parents for all they have done. Tell us why you are thankful for your parents.

2. Want to see your smile morph through your Invisalign treatment? As you change your trays each week, you can see the progression – all the way to the last tray. Just log in to our Web site at [Provide direct link to patient login] to view your own personal Invisalign ClinCheck movie. Plus, you can share it with your friends and family on Facebook or via e-mail.

3. Join us today for our fourth annual [practice name] blood drive. We donate because we believe it’s the right thing to do. Why do you give blood?

4. It’s Valentine’s Day. The average woman smiles approximately 62 times a day compared to men who only smile eight times a day. Guys, will you remember to smile at your lady today?

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5. Dr. [name] just got a haircut. What do you think of the new style?

6. Congratulations to our patients [names] on opening their new shop in town at [location/address]. Can't wait to stop by and check things out!

7. Celebrate National Children’s Dental Health Month in February. We are giving away a $100 gift card to Toys “R” Us. Tell us how your children take care of their dental health and you could win.

8. [Practice name] tip of the day: Leave a toothbrush at work in your desk so you can brush your teeth after lunch. What's your favorite way to keep your mouth feeling fresh during the day?

9. Check out our page on RealSelf.com at [insert direct practice profile link] to see what the discussion is all about as it relates to cosmetic treatments.

10. “A laugh is a smile that bursts.” – Mary H. Waldrip

11. February 28 is National Tooth Fairy Day. Losing baby teeth can be traumatic. There isn’t much that can make it better than the smiling, caring Tooth Fairy! What do you think the Tooth Fairy looks like?

12. Guess whose [practice name] team member smile this is. [Include a picture of a team member's smile.]

13. Did you know we have a mobile-enabled Web site? Check it out at [Web site address] on your mobile phone to quickly get our doctor and team bios, map to our office, important links or click to call our office.

14. Have you flossed your teeth today?

15. Today we are featuring our Team Member of the Month, [name], our [title]. [Name] has worked in orthodontics for more than 25 years and he/she ensures we always provide top-quality care and customer service to our patients. How have you interacted with [name]?

16. Don't forget! If you “Check In” at our office on Facebook, you could receive a $20 Starbucks gift card. Try it!

17. We have QR codes up in our office. Check them out next time you are here and be sure to scan them all. If you find the right one, you’ll be entered to win a $100 shopping spree.

18. Our [title], [name] just had a baby. Congrats to [name] on her/his new bundle of joy, [baby’s name].

19. For your convenience, our practice Web site now offers secure online payment options. Just click the “patient login” button on our Web site at [include direct link to patient login].

20. Would you rather have perfect: teeth, eyesight or hair? According to Glamour Beauty, 44 percent say teeth.5 [http://xr.com/5liq]

21. It’s Take Your Child to Work Day. Today Dr. [name]’s son/daughter is shadowing his/her dad/mom in our office. He/she wants to be an orthodontist one day. What are you doing on Take Your Child to Work Day?

22. Would you rather have perfect: teeth, eyesight or hair? According to Glamour Beauty, 44 percent say teeth.5 [http://xr.com/5liq]

23. What’s the best joke you know? One that makes everyone smile. Post clean jokes only!

24. What are you smiling about this weekend? According to a recent study, folks with big smiles might actually live longer than those who don’t.6 [http://xr.com/ywpw]

25. Moms help with our homework. They cheer us on and fix our boo-boos. Moms can also be our chauffeurs, our cooks, the one who picks up after our messes and so much more! We want to recognize one mom with a $100 gift certificate to [name of spa]. Tell us why your mom deserves this day of pampering by August 3 to win (for your mom that is).

26. We recommend that a toothbrush be kept at least six feet away from a toilet to avoid airborne particles resulting from the flush.7 Where do you keep your toothbrush?

27. Did you know Dr. [name] is a member of the American Association of Orthodontics and a board certified orthodontist? AAO member professionals stay one step ahead of their peers by keeping informed of market trends. They

28. Running an orthodontic office and actively engaging with patients on Facebook can be challenging without support.

5. Would You Rather: Have Perfect Teeth, Perfect Eyesight or Perfect Hair?” Glamour Beauty.
6. “Life span may be as wide as your smile,” Los Angeles Times
learn how the latest products and technologies benefit the patient. By selecting a board certified orthodontist, you know you’re receiving the most up-to-date and best orthodontic care available.

29. We are putting together care packages for overseas military. We’ll be including toothbrushes, floss, toothpaste and more. If you’d like to include anything in our care packages, please let us know.

30. Today Dr. [name] and his/her spouse, [name], are celebrating [X] years of marriage. Congratulations! Anyone else celebrating a birthday or anniversary this month?

31. “If you see a friend without a smile, give him one of yours.” – Proverb

32. Our office now offers a massaging chair, aromatherapy and warm towels during your appointment. What do you think of that?

33. Floss picks or traditional floss?

34. Today is National Junk Food Day! Don’t forget to brush and floss your teeth and don’t forget to wash away the junk food stuck between your teeth.

35. Click “Like” if you brush your teeth after lunch!

36. In France, the Tooth Fairy is a mouse!

37. We’re having a Web site scavenger hunt. Go to our Web site at [Web site address] and find the answers to these four questions: [1) Question One 2) Question Two 3) Question Three 4) Question Four.] Send your answers to us at [e-mail address] and you could win a $25 gift card.

38. We are excited to announce that we were awarded the Invisalign Premier Provider status for 2012, making us one of the top Invisalign providers in the country!

39. We use environmentally friendly methods and materials wherever possible, while minimizing waste and energy. Our toothbrushes are even made of recycled yogurt containers! What do you do to stay environmentally friendly?

40. It’s Halloween. We want to buy your candy! Our goal is to collect 300 pounds. We’ll be accepting candy all week long. One dollar per pound of unopened candy. We’ll be sending all candy to service people overseas.

41. This month, we are pleased to present [patient name] as our Smile of the Month. Visit our blog to learn how his/her smile was transformed with Invisalign, the clear way to straighten your teeth. [Link to on-site blog.]

42. 2012 is quickly coming to a close and so is your chance to use your remaining dental insurance benefits! As a valued patient, we want you to get the most from your dental care, but there are only a few months left before your current insurance benefits expire. For any treatment you need that is not fully covered by your insurance, we offer several payment plans through [insert specific third-party financing options]. This option offers you flexible monthly payments plans to fit your budget. Call us now to book your appointment before 2013 arrives!

43. Today is our 10th annual food drive. We are in need of pasta, cereal, peanut butter, baby food, toilet paper, canned tomatoes and vegetables or anything you have that is not perishable. Thank you for helping us feed our hungry neighbors.

44. According to a study at DePauw University in Indiana, people who smile often are more likely to have healthy marriages! Do you agree or disagree? [http://xt.com/oj3b]

45. We’re celebrating Silly Hat Day. Wear your silliest hat to the office today and you could win a $25 Starbucks gift card!

46. The Go-To Mom, Kimberly Blaine, educates us on how the Invisalign treatment helps you achieve that perfect smile. Get the facts in less than four minutes. [http://xt.com/ap4d]

47. Believe it or not, smiling boosts your immune system! See more interesting facts about smiling at www.pickthebrain.com.

48. We’d love to wish you happy birthday on your special day with an e-mail greeting. Be sure to send us your e-mail address so we can remember your special day.

49. Has your experience with our office been great? Leave a review for us on Google! It only takes a minute and we greatly appreciate your feedback. [Link to Google Places listing.]

50. We just hit [number] fans here on Facebook. Yay!

51. See what Wikipedia has to say about “orthodontists.” [http://xt.com/6rv9]

52. You are never too old to have a beautiful smile and we can help. Make it a New Year’s resolution by calling our office at [phone number].

To download 365 Days of Facebook Posts, visit http://goo.gl/cWMWp or scan the code to the right.

Author’s Bio

Rachel Mele is the director of business development at Sesame Communications. As a member of the Sesame Speakers Bureau, she speaks and writes regularly on Internet technologies including search optimization, social media and effective Web marketing. Rachel’s data-rich presentations make the complexities of dentistry in the digital age easier to understand and manage. Rachel is an accomplished Toastmaster and the VP of public relations for her local club in Wallingford, Connecticut. Rachel can be reached at rachel@sesamecommunications.com.
Sesame Communications Appointed to UOBG Preferred Partner Program

In partnering with Sesame Communications, the United Orthodontic Buying Group (UOBG) will help orthodontists meet patients where they are most likely to be found today – online. UOBG members will receive special discounts as well as the option to use UOBG coupons on select Sesame online services designed to accelerate practice growth. UOBG Preferred Partners offer exclusive opportunities for orthodontists, often creating unique programs or services available to UOBG members. Learn more about UOBG Preferred Partner Program at www.uobg.org/pub/Partner-Selection, or visit www.sesamecommunications.com for more information on Sesame.

CareCredit Introduces New Mobile Web site and Mobile App

CareCredit has launched an optimized version of its Web site www.carecredit.com and a Web-based app, giving patients another way to learn about and apply for financing at the practice or practically anywhere via their smartphone, iPad or other tablet device. Similar to fax, phone and online application methods, with the smartphone-optimized Web site or Web-based app, patients receive credit decisions almost instantly and are given their account number and available credit so they can immediately schedule care. For more information on CareCredit, call 800-300-3046 ext. 4519 or visit www.carecredit.com.

3M Supports Healthy Smiles for Kids in Need

For the fourth year in a row, 3M has renewed its support of Smiles Change Lives (SCL) as an official sponsor of this national nonprofit organization. SCL is a national orthodontic charity committed to providing essential orthodontic treatment to children from low-income families.

3M’s past support was key in expanding SCL’s network of orthodontic providers, which now totals close to 600 orthodontists nationwide. The company is a proponent of a number of SCL program initiatives and provides product support to SCL’s partner orthodontists. With the support of the program’s corporate sponsors, including 3M, SCL hopes to put 900 children on the path to healthy, happy smiles in 2012. For more information, visit www.smileschangelives.org/learnmore.
Azúr Safety Glasses

Azúr Safety Glasses weigh only 0.8oz. to provide lightweight protection and all-day comfort. The integrated side-spring frame flexes open to reduce temple pressure and gently hug every face. Azús also feature interchangeable, one-piece polycarbonate lenses that extend 150 degrees around the face for an unobstructed view. Each pair of glasses includes a padded case and three replaceable lenses: a clear, fog-resistant safety lens, an orange curing light safety lens and a tinted lens. Visit www.indigreen.com for more information.

VALO Cordless

With the same powerfully efficient broadband technology offered by the VALO, Ultradent adds a battery-operated, cordless wand for mobility. VALO Cordless features custom, multi-wavelength LEDs to produce high-intensity light at 395-480nm, capable of polymerizing all light-cured dental materials. The new handpiece is designed to rest in a standard dental unit bracket, or can be custom mounted. It offers consistent curing intensity and output in a durable, aerospace aluminum body with a Teflon coating and a sleek, ergonomic design. For more information, please contact Ultradent’s customer service at 800-552-5212 or visit www.valo-led.com.

ClearVision Digital Sensor System

The ClearVision digital sensor system features rounded corners, contoured surfaces and a flexible cable that allows the sensor to be positioned as needed for accurate image acquisition. ClearVision uses high-speed USB 2.0 technology and comes with a quick calibration flash drive to prepare your sensor for a no-hassle installation. In addition, ClearVision uses advanced CMOS technology to optimize resolution while reducing noise to produce sharp, detailed images that can be manipulated without sacrificing the integrity of the images and is compatible with leading practice management systems. For more information, visit www.progenydental.com.

FlossBow Ortho Flossers

FlossBow Ortho Flossers from Practicon are specially designed to help patients quickly and easily floss behind braces without a threader. FlossBow improves ortho flossing compliance and patient care. With other ortho flossers, the floss can pop loose from the thin extension. FlossBow features strong floss and secure end points to solve this problem. Plus, its double-ended design is like having two flossers in one. FlossBow is individually wrapped and features a refreshing mint flavor. Visit www.practicon.com for more information.

Invisalign G4

Invisalign G4 is engineered to help you deliver the clinical results that are expected from Invisalign. Optimized root control attachments provide greater mesio-distal root tip control for canines and central incisors. This feature is applicable for space closure (including diastema), mesio-distal root uprighting, bodily movement and midline shift. Multi-plane movement features improve predictability for upper laterals and a new multi-tooth approach provides better clinical outcomes for anterior open bites. For more information, visit www.aligntechinstitute.com/G4.

New Products

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.
A common topic the media discusses from time to time is the amount of radiation exposure that occurs in a dental or orthodontic office. On November 22, 2010, The New York Times published an article titled, “Radiation Worries for Children in Dentists’ Chairs.” In the article they discussed the usage of cone beam CT scanners on children, and quoted Boston periodontist, Dr. Nicholas Dello Russo saying “The parents of these children have no idea about the amount of radiation used in these CT scans, and even more frightening, neither do the dentists.” These types of articles are typically catered to the lay public, where a quote from an expert will convey the message that there is no such thing as safe radiation. While this might be true to an extent, dental radiography is safe, minimal and has an important role in a person’s overall health when used judiciously.

To address the concerns and allay the fears of patients and their parents who object or question the use of X-rays in dentistry and orthodontics, the Arizona School of Dentistry & Oral Health Postgraduate Orthodontics Program Class of 2013 created an educational visual aid under the direction of their instructor, Clifford Running, DDS. The goal of the graph is to be simple and informative, comparing the radiation we encounter in our daily lives and common medical tests to dental radiography. Through visual aids such as this one, skeptical parents and patients can be clearly informed of the amount of radiation exposure for all the types of X-rays used in the orthodontic office, even cone beam CT. As one can see, the amount of exposure in an orthodontic office is quite low when compared to other common sources of radiation.

The information in the graph was gathered from a variety of sources, the majority from the organizations Radiologyinfo.org and Health Physician Services. The graph assumes the use of digital dental radiography. The members of the orthodontic residency program who created the graph are the following: Brad Milde, Blake Hillstead, Ryan Bullen, Shruti Oruganti, Tien Srisurapol and Trent Cox.

References

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VERSATILITY
• Adjustable KV and MA - allows you to keep radiation levels low
• High resolution, low dose limits excess radiation
• Pediatric Mode
• Works natively in MAC OS environment
• Provides volume sizes for every clinical application
• Open architecture allows for 3D upgradeability

EASE OF USE
• User-friendly Graphic User Interface
• Open face architecture for easy positioning
• Comes with user friendly Romexis software for ease of use
• Fully integratable with 3rd party software
• Comes with a complete software system for diagnosis

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