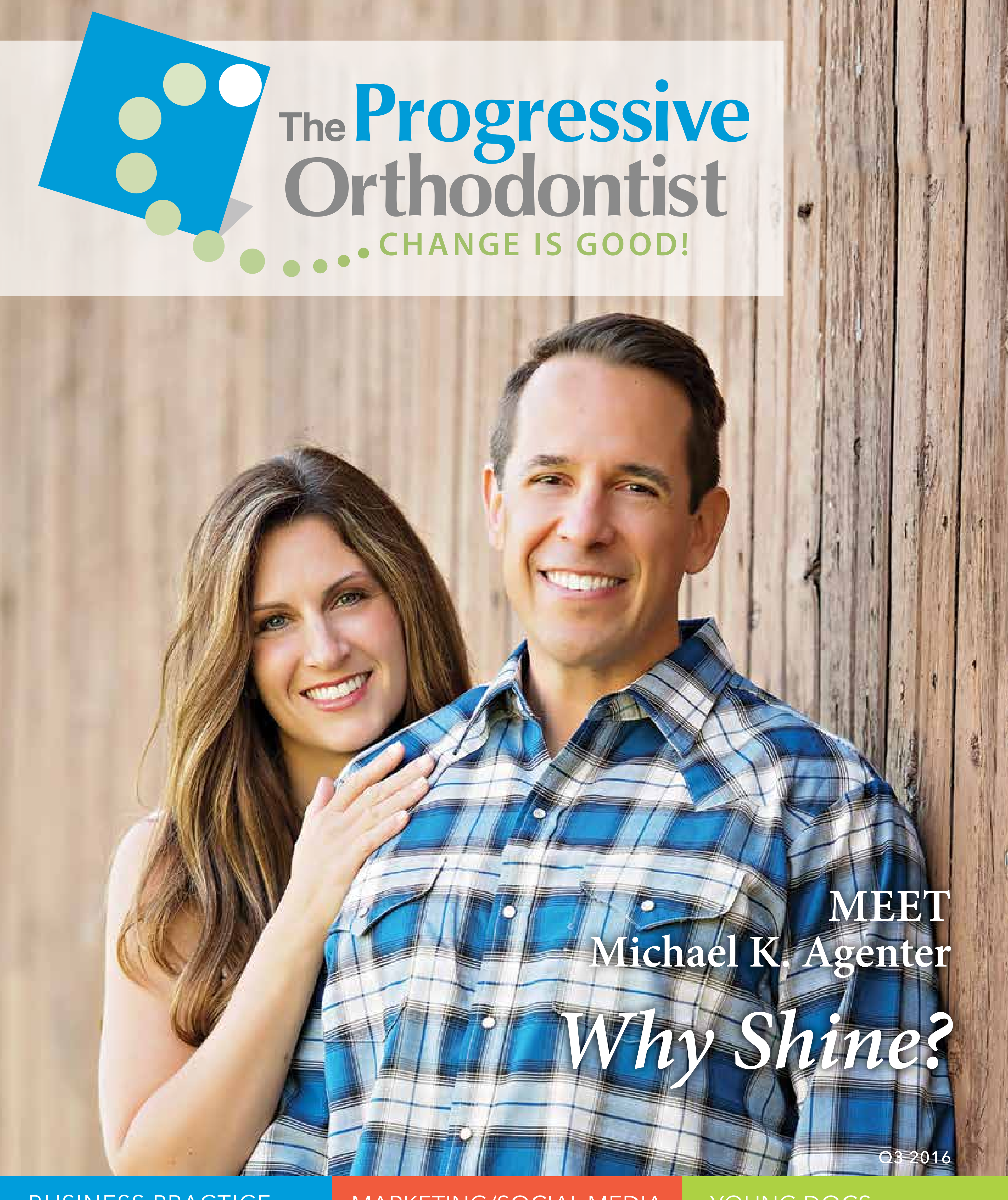

BUSINESS PRACTICE & DEVELOPMENT

From Active Wires To Passive Income

– BY DR. ALY KANANI & DR. JOHN MCMANAMAN

MARKETING/SOCIAL MEDIA

Marketing Clearly

-BY ANGELA WEBER, SARAH SHARFSTEIN & DR. BEN BURRIS

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inside this edition...

BUSINESS PRACTICE & DEVELOPMENT

21
New Sanitizing spray Enhances Practice Revenues... and Patient Health
BY DENNIS HANLON

24
Managing the pre-orthodontic patients: Is your recall/observation program working properly?
BY DR. ROBERT HAEGER

36
Meet Michael K. Agenter

68
From Active Wires To Passive Income
BY DR. ALY KANANI & DR. JOHN MCMANAMAN

MARKETING/ SOCIAL MEDIA

29
Marketing Clearly
BY ANGELA WEBER, SARAH SHARFSTEIN & DR. BEN BURRIS

32
10 Things Every Orthodontist Needs to Know About Snapchat
BY DR. KYLE FAGALA

44
Online Chat: Implementation and Results
BY SCOTT HANSEN

56
Specialist Goggles
BY JEFF BEHAN

YOUNG DOCS

17
Be an orthodontic uncle, not a parent
BY DR. TROY BACON

46
DSO Interview

72
A Few Things I Wish I Knew When I Was a Young Doc
BY DR. COURTNEY DUNN

H.R. INSIGHT

12
Attention, Doctors: Count on Your Team for Practice Success!
BY NANCY HYMAN

OFFICE LOGISTICS

50
Ortho Chairs
BY RON SHARPE

62
Infection Prevention
BY ANDREA COOK

CLINICAL CORNER

58
Expand Your Mind
BY DR. DEREK BOCK

READER QUESTIONS

67
Question from a Reader

ORTHOPUNDIT.COM

74
Those People
BY DR. BEN BURRIS

RESOURCES

78
Resources

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EDITOR'S NOTE

2016 is flying by! It's amazing that the 3rd quarter is already upon us and The MKS Forum is just around the corner. It's so interesting to watch time pass, kids grow up, patients finish treatment, our practices and families grow and change knowing that no matter what we do, the wheel keeps on turning. Change is the only thing that is assured and the older I get the more the pace of change seems to increase. Embrace it. Enjoy the ride. Life is an adventure and we can choose our attitudes. Change is good!

In that open mindset I hope you soak up and enjoy this issue of The Progressive Orthodontist Magazine. We are proud to feature the best content in the industry and we've included many of our corporate sponsors for The MKS Forum as well. Sponsors like these are what makes it possible to bring you The Progressive Orthodontist Magazine every quarter free of charge. These sponsors also make it possible to have an incredibly content rich, two day, inexpensive, easy to get to orthodontic meeting that is redefining the industry for our doctor and staff attendees. Last year we blew the doors off of the first annual MKS Forum and this year we are limiting attendance to 500 doctors and their accompanying teams. Hopefully by the time this magazine issue goes to print there are still some openings so you can attend. Check it out at TheMKSforum.com.

Remember to let us know what you think about this issue and feel free to contact me or direct your comments to the authors directly as well. Be sure to check out OrthoPundit.com in between issues of The Progressive Orthodontist Magazine for tips and tricks for the successful orthodontist. See you in Dallas in November!

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The Progressive Orthodontist magazine and study group are your educational resources for new trends, progressive insights and best practices for building a successful orthodontic practice in 2016 and beyond.

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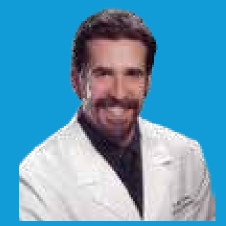

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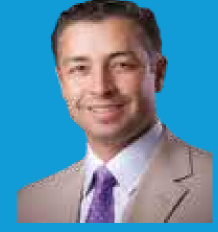

DR. COURTNEY DUNN

ANGELA WEBER

SARAH SHARFSTEIN

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DR. BEN BURRIS

Articles on page 29, 74

Contrarian, philanthropist, rabble-rouser, thought leader, business man, loud mouth, prime mover and visionary. These are but a few of the terms used to describe Ben Burris. No matter which label you choose or what personal opinions you hold, none can deny that Dr. Burris continues to change the conversation in dentistry - especially in orthodontics.

Dr. Burris graduated from The Citadel, in Charleston, SC, with a BS in biology prior to receiving his DDS from the University of Tennessee - Health Science Center's College of Dentistry in 2001 where he then completed his orthodontic residency and received his MDS in 2004.

Burris is owner of one of the largest practices in North America, creator of Smile for a Lifetime Foundation, co-owner of The Progressive Orthodontist Magazine and Study Group and key opinion leader to some of the industry's heavy hitters. Ben can be reached at bgbdds@yahoo.com.

DR. MICHAEL K. AGENTER

Article on page 36

Dr. Mike Agenter is a sole practitioner and owner of Agenter Orthodontics with three locations in Southern Ohio. He began college as a youth ministry major before realizing his desire to become an orthodontist. After graduating from the University of Michigan School of Dentistry, he served as a US Navy dental officer in San Diego and Guam. He earned his Master's degree and orthodontic certificate from the University of Tennessee, Memphis. Keeping things simple, the purpose of his life and business can be summed up in two words, JUST SHINE™. He views business ownership as an opportunity to serve his community and encourage others to do the same, providing free orthodontic treatment through the YMCA, Joshua's Place Ministry and Big Brother's Big Sister's. He leads CMDA medical/dental mission trips to El Salvador and enjoys developing lifelong friendships and mentoring relationships with teammates. Success to him means being a catalyst for positive life-change in his family and community, and inspiring others to shine as a light in their circles of influence.

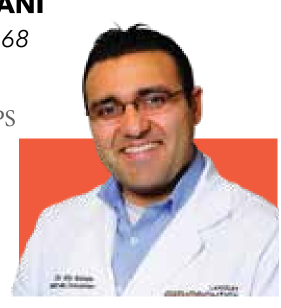
DR. DEREK BOCK

Article on page 58

Dr. Derek Bock grew up in Massachusetts, near Cape Cod. He remained on the East Coast for his undergraduate studies at Stonehill College. After receiving his Bachelor of Science as a double major in biology and chemistry from Stonehill, Dr. Derek continued his studies at the prestigious Tufts University School of Dental Medicine in Boston. He received his Doctorate of Dental Medicine from Tufts University in May 2003. Following his dental school graduation, Dr. Derek completed his post-graduate training in orthodontics at the University of Illinois at Chicago. He completed a three-year residency in orthodontics and obtained his Master of Science in oral sciences. In addition to his residency, Dr. Derek also completed a one-year fellowship in craniofacial orthodontics at the University of Illinois Craniofacial Center. It was during this fellowship that Dr. Derek received additional training in dealing with orthodontic problems as they relate to children with craniofacial syndromes, especially cleft lip/palate. Dr. Derek is an avid golfer, loves running, cycling and competes in triathlons, and is an accomplished guitar player. He and his wife, Dr. Anokhi, enjoy outdoor activities with their four children.

DR. ALY KANANI

Article on page 68



With humble beginnings as a UPS warehouse worker and part time cashier for a small pharmacy in the summers, young Aly Kanani went through the usual dental and orthodontics degrees as the status quo but with a few exceptions. Dr Aly Kanani completed his Masters degree in Economics and Management at the prestigious London School of Economics as well as a formal Masters degree in Higher Education Administration at the University of Pennsylvania. Starting as an associate in 2006 and now nine years later, Dr Kanani is the Founder and now Managing Partner of the largest orthodontics group in Western Canada with seven locations. As a trusted partner of Dental Corporation of Canada and managing the groups BC orthodontics presence, he created and manages with four other orthodontists a significant eight figure specialty orthodontics health care service for children and adults with quality care at the forefront of the groups mission.

DR. JOHN MCMANAMAN

Article on page 68

Dr. John McManaman is a board certified Orthodontist and owner of Docbraces with practice locations in New Brunswick, Nova Scotia, and Prince Edward Island. Docbraces has helped thousands of Maritimers smile with renewed confidence over the last 11 years. Docbraces practices are also recognized as having an Invisalign Elite Provider status, which ranks the practices among the top 5% of providers of Invisalign treatment in North America. Dr. McManaman received his Doctor of Dental Surgery from Dalhousie University (1999), and went on to earn his M. Sc. Orthodontics from the University of Manitoba (2003). He continues to practice Orthodontics full time while being very actively involved in many community and charitable initiatives.

NANCY HYMAN

Article on page 12

Nancy Hyman developed orthodontic training programs for Practice Builders and established marketing plans for their clients from 2003-2009 and founded Ortho Referral Systems to help orthodontic practices jumpstart patient referrals, increase case acceptance and improve implementation of practice growth systems. Nancy is a national lecturer and author, including penning Winning Marketing Strategies and is the key strategist for Hyman Orthodontics, consistently enrolling 600 plus new patients annually in a one doctor, one location practice. Nancy may be contacted at nancyors@gmail.com or 323-308-9817.

ANDREA COOK

Article on page 62

Andrea Cook's in-office, hands on training motivates and energizes orthodontic clinical teams. She bases training systems on practical knowledge gained through 20 years chairside experience. She 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.Her years of experience include working in single, double, and multi doctor practices. She has extensive experience as clinical coordinator for a multi doctor practice seeing over 120 patients per day. Andrea's experience allows her to understand and address the concerns of the clinical team.

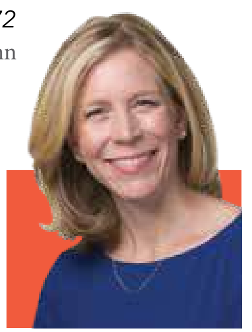
RON SHARPE

Article on page 50

Ron Sharpe has over 35 years of experience in the manufacturing, marketing and sales of Medical, Dental and office related furniture/ equipment. After 12 years as the National Sales Manager for BOYD Industries, Inc. He created The Sharpe Group, an organization dedicated to providing Medical and Dental professionals with industry leading products and services.

DR. COURTNEY DUNN

Article on page 72

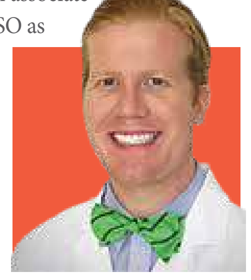


Dr. Courtney Dunn graduated from the University of Michigan Dental and Orthodontic programs in 2001 and 2004. She received the Milo Hellman award for her research and has presented at many local and national meetings. She is a diplomate of the American Board of Orthodontics, holds leadership positions in the Arizona Dental Association and is past president of the Arizona State Orthodontic Association. Dr. Dunn is in private practice with her husband, Matt, in Phoenix, AZ. She spends most of her free time being a proud swim mom.

DR. TROY BACON

Article on page 17

Dr. Troy Bacon grew up in Spokane, WA but has since lived in Los Angeles, Oklahoma City, Las Vegas, and most recently, Portland, OR. Dr. Bacon graduated with a BS in Biology from Loyola Marymount University before earning his DDS degree at the University of Southern California in 2011. After completing a general practice residency at the Oklahoma University Childrens' Physicians Dental Clinic, Dr. Bacon graduated from Roseman University with a certificate in orthodontics and dentofacial orthopedics as well as a MBA in 2015. He currently works as an associate orthodontist for a DSO as well as in his own private practice. He enjoys golf, reading, fantasy football, and 90s nostalgia.



DENNIS HANLON

Article on page 21

Dennis' career spans 40 years of senior executive experience in the specialty products arena. He has been instrumental the creation of patented concepts that have revolutionized many industrial operations on a global basis. His diverse business credentials have spanned 45 countries with executive roles that placed him among the international leaders in the fields of business and technology development.

Hanlon created Soluria, LLC, as a start-up venture when two PhD's and a senior biologist approached his business consulting firm, Cyanetix Group, with an idea for conducting research to create and patent new sanitizing spray products for removable oral devices. This concept was expanded to include removable dental appliances, and has now been commercialized with new proprietary products Guard Health™ (for athletic mouth guard users), and Smile Saver™ (for dental appliances such as retainers and aligner trays).

Hanlon holds a BS in Chemical Engineering and a Masters in Engineering Management from Missouri University of Science and Technology; and an International Marketing Management degree from Columbia University. He also served as Professor of Career Management and Entrepreneurship at Ave Maria University of Southwest Florida.

SCOTT HANSEN

Article on page 44

Scott Hansen is the owner of OrthoChats, the world's leading professionally managed chat service for orthodontists. In addition, he manages a quickly growing orthodontic practice in Kansas City. While achieving his Masters is Business Administration at the University of Missouri - Kansas City, he was awarded a certificate of achievement for his entrepreneurial work from the Regnier Institute for Entrepreneurship and Innovation. Feel free to contact Scott at Scott@ OrthoChats.com, (401) 99CHATS, or chat online at OrthoChats.com.

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DR. KYLE FAGALA

Article on page 32

Dr. Kyle Fagala is the owner and orthodontist at Saddle Creek Orthodontics in Germantown, Tennessee. Dr. Fagala graduated in May of 2013 with a certificate in orthodontics and a master's degree in Dental Science for his thesis on three-dimensional imaging of the airway. Dr. Fagala is the course director and lecturer of Development of the Occlusion, a class for 1st year dental students at the University of Tennessee Health Science Center. He also provides orthodontic treatment for children at Pediatric Dental Group in Southaven and Olive Branch, Mississippi. He loves music, specifically the drums, and spends more time than he should on social media. Dr. Fagala, his wife Anna, their son Charlie, and daughter Libby live in Germantown and attend Highland Church of Christ.

ANGELA WEBER

ORTHOSYNETICS MARKETING DIRECTOR

Article on page 29

Angela Weber is the Chief Marketing Officer for OrthoSynetics a company which specializes in business services for the orthodontic and dental industry. She leads a team of marketing professionals dedicated to developing and implementing cutting-edge strategies and solutions for their members.

Angela has over 15 years of experience in the advertising industry with a vast knowledge of current and past trends, philosophies and strategies for marketing within the healthcare industry. Angela has a proven track record of driving new patient volume through innovate marketing practices.

Angela holds a B.A. in Mass Communications from Louisiana State University and an M.B.A. from the University of New Orleans.

DR. ROBERT HAEGAR

Article on page 24

Dr. Haeger was born and raised in Saginaw, a town like many in Michigan focused on one industry, automotive manufacturing. He soon realized there was something better outside of Saginaw. Dr. Haeger attended University of Michigan undergraduate and dental school from 1980-1987. Upon graduation, he ventured west to the University of Illinois in the Windy City, where he received his Master's Degree in Orthodontics in 1989. From there he and his new wife continued their westward migration and drove their Chevrolet Chevette with 96,000 miles across the country to open a new orthodontic practice in a Seattle suburb. Forced to sink or swim, Dr. Haeger practiced as a dental hygienist and general dentist for several years while he built his orthodontic practice and established his professional reputation. Dr Haeger is still married to the same woman who puts up with him every day, has three adult children (two in college and a third starting in the fall), enjoys hunting and fishing and loves being an orthodontist. Along the way, Dr. Haeger has maintained full-time, multi-site practice, became Board Certified, worked with two PhDs to learn business analytics, ran the statistical analysis for the Schulman Study Group, is a Contributing Editor for the JCO, Adjunct Professor at UOP, published several articles on practice management, and launched a company to analyze orthodontic practices called Truenortho.

JEFF BEHAN

*Article on page 56*Jeff Behan is currently in his 29th year as a communications specialist. He is a fun and relevant speaker whose subject matter focuses on internal/external communication, connecting with existing and prospective patients, referral-building and practice branding. Over his career, he has worked with a diverse array of clients including; Major Public Utility Companies, Intel Corp. and Delta Airlines as well as numerous dental and orthodontic companies including Align Technology, Ormco, Henry Schein and OraMetrix. He is the principal member of VisionTrust Communications, providing staff training, customized communications tools and consulting with a primary emphasis on orthodontic practice development, including many of the top practices in the world. Jeff is a founding board member of VisionTrust International and serves on the board for Smile for a Lifetime.mentoring relationships with teammates. Success to him means being a catalyst for positive life-change in his family and community, and inspiring others to shine as a light in their circles of influence.

SARAH SHARFSTEIN

Article on page 29

Sarah Sharfstein is the Business Development Manager for Align Technology, Inc., the makers of Invisalign. Sarah has been with Align working in the Orthodontic field for over 9 years and has been in healthcare for almost 12. Within the field of Orthodontia, Sarah focuses on leadership, strategy, operational excellence and marketing. She brings a wealth of knowledge to each individual practice and Orthodontic Study Group she works with. Sarah is passionate about driving doctors and their teams to recognize top line revenue growth while increasing efficiency and profitability through the integration of Invisalign. When working with an individual practice, she takes a holistic approach to the business and in turn provides practice management solutions to drive its overall growth. Sarah earned her Bachelor's degree from the University of California at Davis, and has a Master of Business Administration degree from Santa Clara University, with an emphasis in Product Management and Marketing.

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ATTENTION, DOCTORS:

Count on Your Team for Practice Success!

By Nancy Hyman

WHY DEVELOP A MARKETING TEAM?

Reevaluate the current state of your practice's success and turn toward your team to build the practice you've always dreamed of: fabulous production numbers combined with low overhead. You have heard the urban legends and possibly met the doctors with the superstar statistics that seem impossible to attain. Not true! Your team is your secret weapon! In past years, a practice could be "successful" enough, depending on one's definition of success, without training or a written plan and undefined marketing roles.

Evaluate your full team to help you achieve growth initiatives directly related to your production goals. I recommend that you fully structure your team's internal and external programs. Complete participation will give team members a chance to shine and express their talents.

A HIDDEN BENEFIT TO BUILDING A MARKETING MACHINE

In addition to building camaraderie and identifying talents, your marketing machine will fully utilize non-patient hours with assigned tasks. In the past week, I received two calls from orthodontists concerned about what is accomplished during staffed non-patient time. This is a golden opportunity to accomplish practice growth tasks without compromising attention to patients.

Look for your best multitasker with an enthusiastic spirit. Organizational qualities are not enough! Who will instill a sense of loyalty to the practice as she provides encouragement and coaching?

Let's look at five key steps to organizing a marketing machine and turning free time into productive steps toward your dream practice:

KEY STEPS:

- Look for leadership qualities
- Organize leadership
- Assign responsibility
- Develop accountability and team organization
- Consider the doctor's role

LOOK FOR LEADERSHIP QUALITIES

The team leader must have non-patient time to organize subleader tasks. Look for your best multitasker with an enthusiastic spirit. Organizational qualities are not enough! Who will instill a sense of loyalty to the practice as she provides encouragement and coaching? The team leader needs scheduled time allotted to this duty to avoid shirking other responsibilities. For example, if the treatment coordinator is the team leader, allow him or her a full or half non-patient day each week to focus on adjunct patient enrollment duties and direct the subleader teams.

ORGANIZE LEADERSHIP

I recommend assigning one team leader to supervise all projects while subleaders help their teams implement individual projects. The team leader may report to the office manager or doctor depending on the level of participation desired by the doctor. With practices of six to eight employees or fewer, consider breaking each team into groups of two. Each team will be in charge of a project. Larger teams may wish to build a marketing group of five or six members and rely on the balance of the team members to participate as needed.

ASSIGN RESPONSIBILITY

Whether you utilize your full team broken into smaller duos or create a marketing team from a larger group, the

team leader will assign subleaders based on motivation and experience. Teams may explore categories of tasks such as professional relations, internal friend and family referrals, internet promotions, and community relations. I recommend placing dated annual events in a separate category due to the volume of work involved. All teams should collaborate on the most important projects.

Select the subleaders of more specialized teams from your current team or look to outside resources for staffing. Many practices hire a happy former patient or a patient's parent who desires to work while children are in school.

DEVELOP ACCOUNTABILITY AND TEAM ORGANIZATION

Split accountability tracking into four categories: daily tasks, weekly tasks, monthly tasks, and dated event projects.

Suggested activities per category are:

Daily tasks: Asking patients for referrals, offering patients to spin a rewards wheel (when applicable), and promoting an oral hygiene card signed by the dentist.

Weekly tasks: Calling potential patients to book an initial exam retrieved from DDS referral cards and professional relations visits. (Please contact me for additional information regarding the DDS referral card which includes the patient/parent name and phone number. This card allows you to proactively call the initial exam person.)

Monthly tasks: Deliver dental awards for a drawing targeting list, oral hygiene participation, and lunch drawing.

Dated events: These may be as simple as a school screening at your local high school or a biannual OSHA meeting.These tasks include: speaker contracts, venue and menu details, creating invitations and save the date reminders (email notice and hard copy) as well as mailing them out, collating responses, reminder calls (non-respondents and attendees). Day-of-event tasks may include greeting and registering attendees, assigning lunch table monitors, and distributing CEU certificates when applicable.

My primary goal is for the doctor to do what he or she does best: treat patients successfully! Plan your participation within your comfort level. Review your dental relations and consider "drop-in" visits, doctor-to-doctor lunches, and patient progress reports with a copy sent to the dentist.

Plan all events on a one-year overview calendar and break tasks into three-month segments (one month per calendar page), working backwards from the day of the event. Check the calendar daily to avoid missing tasks. If you are a list-maker like me, consider a daily task list drawn from your monthly calendar.

The team leader will check in with subleaders on a weekly basis but check in with the full marketing team or the entire staff, depending on the number of team members, on a monthly basis. The doctor's participation is optional based on his or her preference. However, the doctor should approve the annual marketing calendar and budget.

Do not be afraid to change roles when needed. At Hyman Orthodontics, we have assigned three separate practice representatives to handle dental relations within our team and one outside person during an eighteen year period.

Review statistics monthly to determine the effectiveness of your promotions. In addition to reviewing standard statistics such as family referrals, patient-to-patient referrals, direct internet referrals, and dental referrals, also review the number of oral hygiene cards returned, attendees at events, and the dollar amount of patient rewards.

What about team rewards? Kick off or reinvigorate promotions with a baseline goal with rewards above the realistic starting point. I recommend a beginning and an end point for the reward period to keep the focus on the ultimate goal of increasing participation in one area, thereby achieving a higher degree of success per project.

CONSIDER THE DOCTOR'S ROLE

My primary goal is for the doctor to do what he or she does best: treat patients successfully! Plan your participation within your comfort level. Review your dental relations and consider "drop-in" visits, doctor-to-doctor lunches, and patient progress reports with a copy sent to the dentist.

Are you comfortable asking patients for referrals and conversing about other promotions? If not, your team leader can be the practice cheerleader and keep the momentum up.

Reap the benefits of engaging your full team in promoting the practice. An organized effort and documented implementation will result in the practice success you desire. Outstanding practices know that a talented team is key to achieving goals beyond initial objectives.

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In addition...don't forget on-site coaching for practices that want to jumpstart referral systems and invigorate the new patient enrollment protocol. Ask Nancy if this option is right for you.

Nancy is a national lecturer and author, including penning Winning Marketing Strategies and dozens of published articles. She has presented lectures at national meetings for topsFest, Ortho 2, SureSmile, Opal Orthodontics and the American Association of Orthodontists. In addition, Nancy has presented AAO sponsored webinars since 2013 and is the Marketing Director of Hyman Orthodontics, consistently enrolling well over 600 new patients annually in a one doctor, one location practice.

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Be an orthodontic uncle, not a parent

By Dr. Troy Bacon

On a recent flight, an unfortunate and disconcerting customer service experience occurred. I happened to be one of the first passengers to board the plane, so while other individuals continued to store their overhead luggage and make their way to their seats, I took advantage of the last few minutes before takeoff to wrap up a text message exchange with my mother. The cabin door was closed, and the flight attendants began their usual pantomiming routine of various safety feature demonstrations - How to buckle a seat belt, how to place an oxygen mask should cabin pressure rapidly decrease, and most importantly, how to NOT use the forward lavatory unless you are sitting in first class. Despite the TSA's assurance that the mastery of each of these maneuvers would ensure safety should the worst happen, I proceeded to ignore the instructions and continued with my text conversation.

Once the theatrics had completed, one of the flight attendants passed through the aisle to ensure that seat belts were buckled, and tray tables were in their upright and locked positions. She approached, noticed me still texting, halted her stride and continued to stand next to me for a prolonged and deliberate amount of time, peering intently at my phone as my thumbs continued to punch the screen. Sensing that she meant to intimidate me into discontinuing my texting, I quickly fired off one last, "Love you mom gotta go!" before switching my phone to "airplane mode" and placing it in my pocket. I acknowledged her with the obligatory, "Sorry...I was just saying goodbye to my mom," as if the fact that I was conversing with my mother would score sympathy points and diminish the sting of her scorn. "Your phone needs to be in airplane mode" she instructed in a salty tone, as she continued her stroll toward the back of the plane, sure to vanquish the next pre-flight perpetrator. They say not all heroes wear capes.

I am not in charge of enforcing punishment should a patient not follow through on prescribed treatment. That is not my role as the doctor.

If you've ever had the misfortune of this kind of interaction, then you too know that there are better, friendlier ways of having the same message communicated that are just as effective. I'm not claiming that her position was invalid or incorrect, but I definitely would have preferred that her delivery was more refined. As much of a nuisance as this episode was for me as a passenger, I believe it must be even more of a burden for the flight attendant. I can imagine that she was thinking to herself, "Why don't these passengers just pay attention to the rules? Don't they know by now to turn off their phones before takeoff? Haven't you been on an airplane at least 100 times before? You know how this works by now!" I wonder how many times a day does she deals with the same frustration?

Once we achieved 10,000 feet of altitude and I was granted permission to use my phone, it occurred to me that we as orthodontists also create these types of lose-lose scenarios in our line of work, and we do so intentionally. How often do similar mini confrontations occur with our patients and their parents due to a lack of brushing, poor compliance, or missed appointments? How often each day do we think to ourselves, "Why doesn't this patient just do what I tell them to do? It isn't hard to brush teeth properly! Wearing rubber bands is simple! Why can't they just show up to their appointment on time?"

I'm not sure that we realize that we bring the stress of these interactions upon ourselves. Charging fees to replace broken brackets or to penalize patients for missed appointments creates tension and friction with families, which inevitably spills out into our workplace. The, "I told you so!" or, "Do this or else!" finger-wagging conversations about poor oral hygiene and elastic wear are belittling and confrontational. Why is the prevailing mindset of some doctors to dictate rather than to facilitate? And why is it instilled in us from the onset of residency that these instances of "rule-breaking" by patients shouldn't be tolerated?

I am lucky to have three nieces and one nephew, all five years old or younger. Being an uncle is amazing for many reasons, but one of the best is that I don't have to

be the parent. I have a different role than their mothers and fathers. I don't make the rules - I support the rules that mom and dad have established. Sure, I can change a diaper or clean up a mess of spilled applesauce just fine, but I am also free to let the responsible party intervene when a temper tantrum flares up or backtalk ensues. It not only makes my life easier, but it also keeps me in a favorable light with my younger kin and maintains the position of the parent as the authoritarian. In other words, I don't have to be the "bad guy" and the proper order of manners and family dynamic will still be restored. Because our time together is infrequent (I live in a different city), I focus on making it fun and engaging. I look to create opportunities that positively reinforce our relationship. There is no penalty for giving too many gifts, hugs or kind words to any of them. I want them to look forward to seeing me again as much as I look forward to seeing them.

I take a similar approach with my patients. I am not in charge of enforcing punishment should a patient not follow through on prescribed treatment. That is not my role as the doctor. I am in charge of outlining the best way to quickly, safely, and most efficiently accomplish the treatment goals of the case and communicating that plan (as well as the potential pitfalls) to the people I treat. The overall outcome of treatment is not dependent upon my heroism as an orthodontist. It's dependent upon teamwork with the patient and their parents, which involves cooperation and trust, not dictation. It is my opinion that trust is better established by a pat on the back than a kick in the butt.

If a patient is not wearing elastics, why not take an extra minute to speak with them about why it's important that they do so instead of threatening them with the alternative of a head gear, fixed appliance or even worse, extending the length of treatment? If hygiene is poor, why not administer extra toothbrushes and spend time reviewing proper brushing technique instead of reciting scare tactics about how tooth extractions may be a requirement due to decay?

I am not advocating that we wash our hands from the responsibility of ensuring that the best outcome is achieved for each patient. I am, however, advocating for a soft touch when educating our patients and their parents about the challenges each case presents and what is required of them to overcome those obstacles. Getting great results does not require being a disciplinarian or using a heavy-handed approach. We are coaches throughout the treatment process as much as we are quarterbacks and good coaches get the most out of each member of the team, recognizing that some are more or less capable than others and that failure is unavoidable. There are times when braces will need to be removed due to failing hygiene. In these instances, the message we deliver should emphasize that doing so is in the best interest of the patient's well-being and health, not that they (or their parents) failed to brush their teeth. There are times when a perfect Class I occlusion will not be achieved because of poor compliance. That does not mean that treatment was not a success and that the patient was a "bad" patient.

It is foolish and egotistical to believe that we can deliver perfect results every time or that what we instruct as doctors is gospel. Patients can only tolerate being in treatment for so long and that's OK. They are not heretics because they ignored our instruction or chose to be neglectful. Rather than striving to impress ourselves or our colleagues with post-treatment cephalometric values or plaster models, our emphasis should be on creating perfect patient experiences for those individuals while they are guests in our offices. In my experience, the compliance we seek and the respect we crave are often the rewards of this approach.

We have a tremendous advantage in the field of dentistry compared to all other specialist and non-specialist dentists. We get to be the fun doctors! We are not the scary offices, the offices with the bad noises or smells, or the offices where painful things happen. Our job is to create smiles, and we should strive to do so with our demeanor and candor as much as we do with our technique and skillset.

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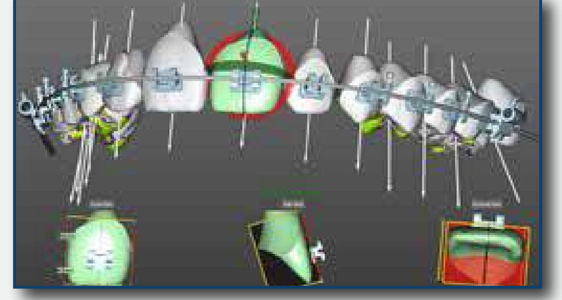

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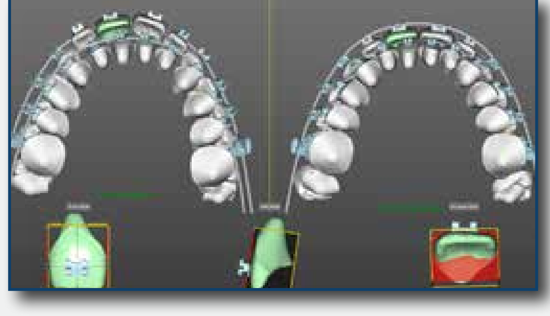

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New sanitizing spray enhances practice revenues... and patient health.

By Dennis Hanlon

It's hard to imagine practicing back when medical science was unaware of the dangers of infection, bacterial contamination, and blood-borne pathogens. (You know: those days when respected physicians thought malaria was caused by breathing bad air around swamps...and surgeons tended battlefield casualties without much thought of sterilization.)

Now we know better – or do we?

We are only now emerging from a period in the dental profession when certain bacterial contamination dangers have gone largely unchecked—dangers that many of your patients may still not recognize.

Studies by the University of Oklahoma and by private industries have confirmed that serious levels of bacteria colonize on un-sanitized dental appliances, and can have detrimental, systemic health impacts reaching far beyond the mouth.

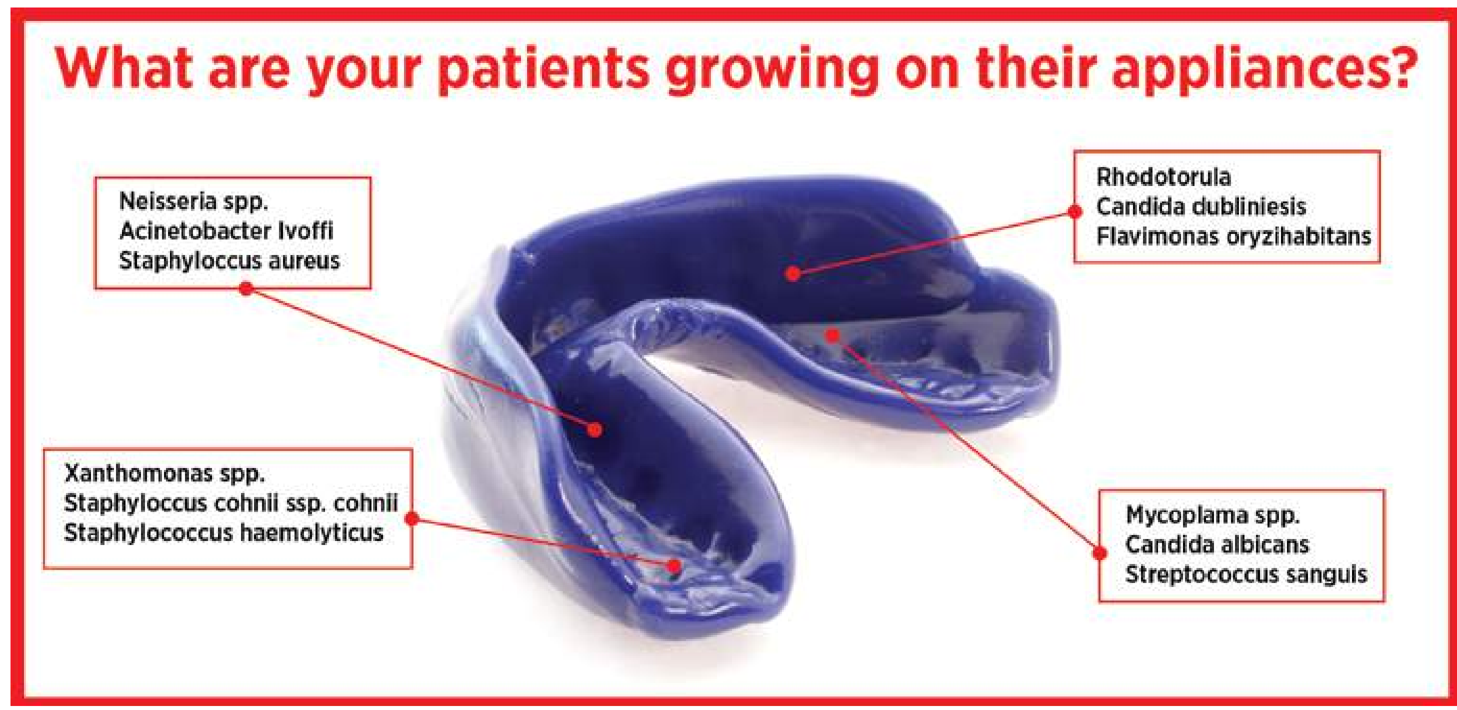
> *As one practice owner recently commented: "Knowing what crawls around on plaque-laden appliances, Soluria might be on to something."*

Those studies above have found causative links between dirty athletic mouth guards and such serious conditions as MRSA, chronic mouth ulcers, and exercise-induced asthma.

In short, the retainers, alignment trays, and custom athletic mouth guards you provide your patients can be fertile breeding grounds for a startling range of pathogens.

Fortunately, there's a new technology that enables you to safeguard your patients against these unfamiliar but significant threats...while providing a significant source of new revenue for your practice.

Soluria, a newcomer to the orthodontic field, has developed two highly effective sanitizing products that are relevant to many of your patients: "Smile Saver™" (for removable braces and retainers), and "Guard Health™" (for custom-made



athletic mouth guards).

As one practice owner recently commented, “Knowing what crawls around on plaque-laden appliances, Soluria might be on to something.”

Soluria’s are the first such products backed by lab testing that demonstrates the effectiveness of the proprietary formula in combating microorganisms on athletic mouth guards and dental appliances. They’re also the first such products that are alcohol-free, sugar-free, and derived from all-natural ingredients—all of which have made the GRAS list of FDA. (And fortunately for your younger patients, they offer several kid-friendly flavors, as well.)

INNOVATIVE PRODUCT, INNOVATIVE DISTRIBUTION

So that’s how Soluria’s technology benefits your patients—but, in addition to a standard distribution model, the company is also developing a convenient e-commerce platform designed specifically to benefit orthodontic practices, with no inventory or bookkeeping hassles.

Once you’ve equipped your patients with their new retainer, clear aligner, or athletic mouth guard, just hand them a bottle of either Smile Saver or Guard Health...and Soluria does the rest for you.

The bottle you provide to your patients will have a tag attached with a code number unique to your practice. When the bottle’s nearly empty, the patient simply logs onto an online order form and enters your practice code number. Soluria ships their product, and then issues your practice a monthly check based on the quantities shipped.

HOW MUCH BENEFIT TO YOU?

With typical usage, each bottle of Smile Saver or Guard Health lasts about a month. The transaction margins, given a practice with 200 patients on the system, and patients each ordering one bottle per month, can equate to five figures of extra cash flow per year to your practice, and perhaps even more.

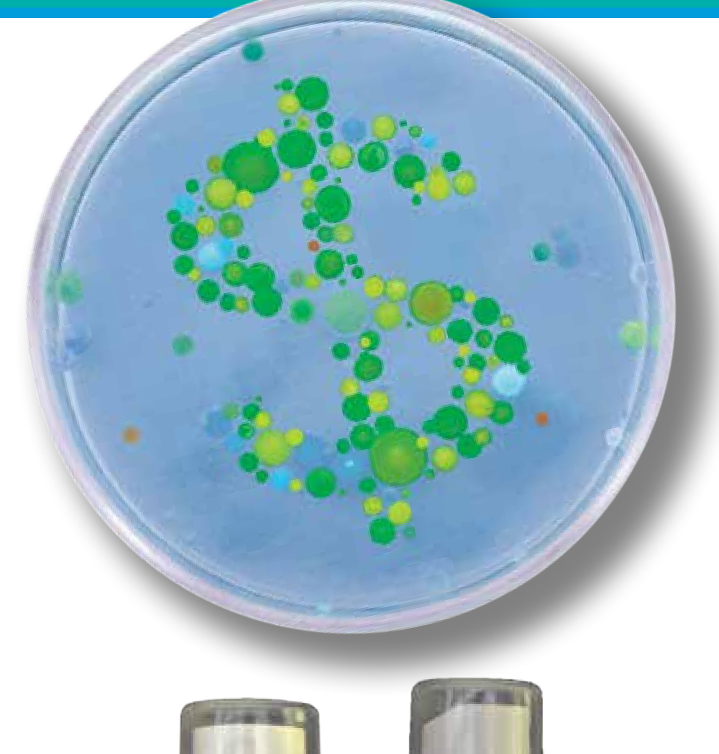
And all you’ve had to do is purchase the initial sample bottles using your practice code to prime the pump.

These products arrive precisely at a time when practices have to seek alternative revenue streams in the face of extreme pricing pressures. They also arrive at a time when Americans are becoming more attuned to sanitary concerns than ever before.

Think about it: you’ll find hand sanitizer packed into lunchboxes, book bags, and minivans from coast to coast.

Perhaps it’s time your patients had an oral appliance sanitizer packed in there, too.

SMILE SAVER™ SANITIZING SPRAY:



Bacteria's worst enemy. Your practice's best friend.

New Smile Saver sanitizing spray from Soluria protects your patients against dangerous microorganisms commonly found on removable dental appliances—including bacteria linked to MRSA and exercise-induced asthma.

Smile Saver solves these problems with just a few sprays a day. As it supports the health of your patients, Smile Saver also supports your bottom line with **a lucrative new profit stream.**

Your patients can even re-order online so you don't have to maintain inventory. Contact us to learn the details!

Smile Saver is good news for you... bad news for bacteria.

For a 200-patient practice, Smile Saver could generate additional income for your office **well into five figures!**
Bigger practices can see even larger benefits.
We can show you how.

Smile Saver is sugar- and alcohol-free, derived from all-natural ingredients, and comes in two great flavors. For your patients with athletic mouth guards, there's also Guard Health™ with even more fun flavors. Both are safe to use, and their ingredients make the GRAS list of the FDA.

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MANAGING THE PRE-ORTHODONTIC PATIENTS:

Is your recall/observation program working properly?

By Dr. Robert Haeger

We spend countless hours trying to get new patients to call our offices, and that is hugely important to the success of an orthodontic practice. But equally important is what happens after the patients come in for their initial appointments. The TC conversion rate monitors the patients that you recommend for treatment, but how you manage the patients put in your recall/observation program (these terms will be used interchangeably throughout this article) is vitally important to the profitability of your practice.

Patient starts come from only three sources: exams, the recall/observation pool and prior declines. Based on data collected from practices across the country, the top 20% of most profitable practices get 40% – 41% of their starts from their observation pools. The bottom 80% of profitable offices only get 24% – 30% of starts from their observation pool (see Figure 1). Figures 1 – 3 draw on data collected from orthodontic offices across the country and analyzed by Truenortho, a company offering benchmarking and practice management resources. (The top 20% of orthodontic offices make twice the profits of the bottom 80%, so it is worth paying attention to what they are doing.)

The percentage of starts that come from your recall pools varies dramatically based on the makeup of your practice. Practices where >18% of starts come from adults only see 27% – 28% of their starts from recall. However, high child practices see 45% – 47% of starts from observation patients (Figure 2). Based on this fact alone, you will see that a high adult practice needs to have a much higher number of exams to produce the same number of starts. With the change in patient populations over the past several years, you may notice that your number of adult exams has increased. Many offices have maintained the same level of exams and have wondered why their production has decreased. Adults have a lower conversion rate and result in your pre-treatment observation pool slowly decreasing in size. The compounding impact of putting fewer patients into observation and the lower adult start rates

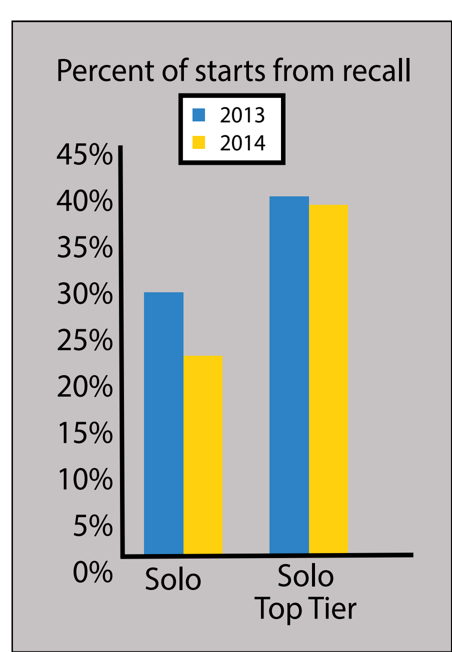


FIGURE 1: 2013 AND 2014 PERCENTAGE OF STARTS THAT COME FROM THE RECALL/OBSERVATION POOL

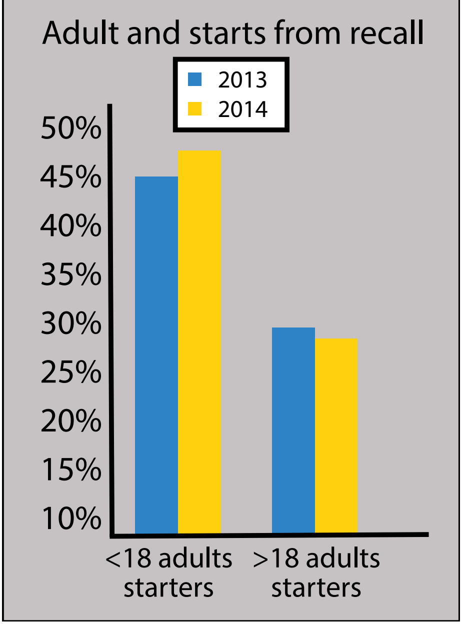


FIGURE 2: PERCENTAGE OF STARTS FROM OBSERVATION RELATED TO PERCENTAGE OF ADULT STARTS

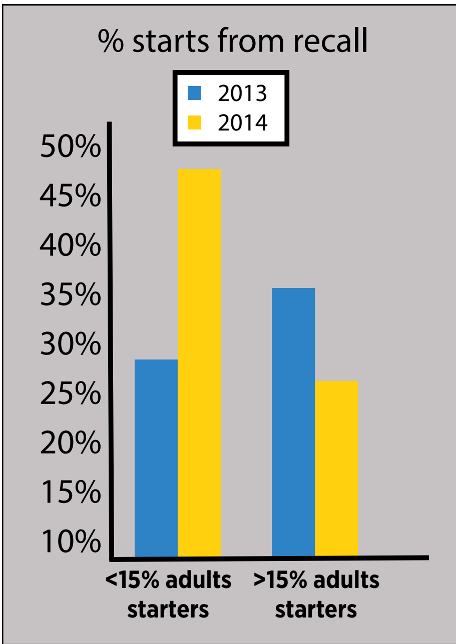


FIGURE 3: PERCENTAGE OF STARTS FROM RECALL RELATED TO PERCENTAGE OF PHASE I STARTS

explains why some practices are seeing decreased production.

Similarly, practices that recommend a high number of Phase I treatments for their patients show lower starts coming from their observations pools. Figure 3's 2014 data illustrate this trend. While 2013 data shows higher percentages of starts from recall coming from high Phase I practices, I have not been able to duplicate this finding in any other year. The better way to assess conversion of Phase I patients into Phase II is to calculate the percentage of active Phase I/Phase II patients in your practice. If 85% of your Phase I patients progress into Phase II, and your Phase I treatment is limited to less than a year, then the ratio of active Phase II patients/Phase I patients should be greater than 1. In looking at practices across the country, several have ratios of less than 1. These practices never realize the lost production from not adequately following up after Phase I.

Looking at every recall/observation appointment from my office between 2005 and 2016 shows interesting trends that will help improve your recall program. Figure 4 shows the percentage of observation patients who started treatment compared to initial exams during this same time period. As you can see, the start percentage for observation patients was approximately 10% higher than exams. The data was divided into two time periods in order to get independent samples from the same office. Because I start relatively few Phase I starts each year, the management of my observation patients is essential to my practice's success.

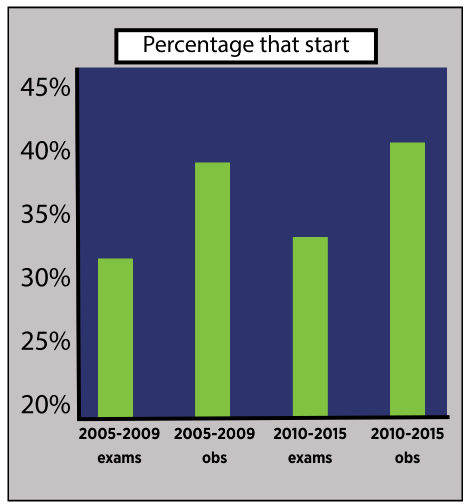


FIGURE 4: START PERCENTAGE OF EXAMS VERSUS OBSERVATION VISITS

Now that I have identified the importance of the observation patients, let's look a little deeper at the data for actionable metrics. Knowing the start percentage is nice, but understanding the decline percentage is actually more significant, because many observation patient visits end up with another recall appointment months later. How does the decline ratio change from the first through fifth subsequent recall appointments? Figure 5 shows that the decline ratio is relatively low once you get the patients to follow up in your observation program. The number of patients who actually say "no thanks" to your recommended treatment is only 0% – 3% for recall appointments 1 – 4, but it is just above 6% on the 5th recall appointment. I am not sure why the number doubles at the 5th observation appointment.

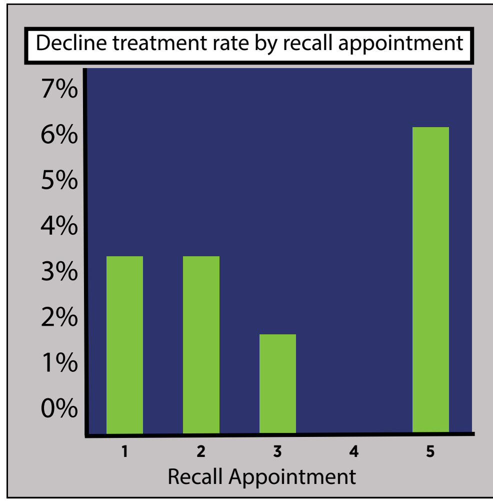


FIGURE 5: DECLINE PERCENTAGE FOR RECALL APPOINTMENTS 1 – 5

We now know that observation patients are a great source of starts, and at really high percentages. The next logical question is, how to make sure these patients show up for their follow-up appointments? The best way to find out is to study no show percentages for patients (this includes no response to our follow-up attempts).

Let's first look at no show percentages for recall appointments 1 – 5. Figure 6 depicts the no show percentages dropping with subsequent follow-up appointments. In other words, the first recall appointment is the most significant, because once the patients make it to their first observation visit, their no show rates continue to drop. In fact, the no show rate for the fourth observation is less than 4%. Couple that with the fact that only 0% – 3% decline treatment during this same time period, and you will see that observation patients are very important to a successful practice.

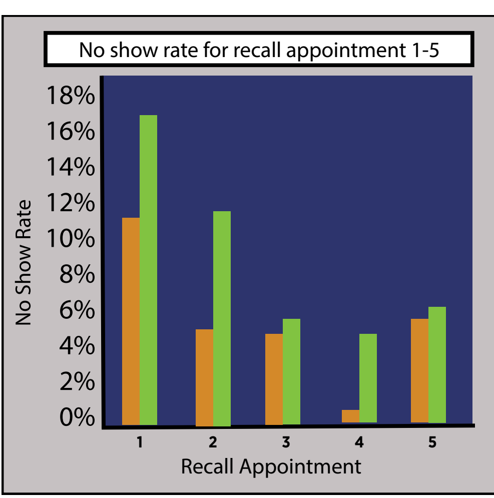


FIGURE 6: NO SHOW PERCENTAGE BASED ON OBSERVATION APPOINTMENTS 1 – 5

There are many ways to manage your observation pool, from running a "Kid's Club" to scheduling appointments when patients leave the office. This article will not examine the success or failure of specific observation programs, but will rather speak to high-level tactics that should be incorporated into all recall programs. Ask yourself some questions about the logistics of your observation program. Are there any months that have lower no show rates? And is there an ideal interval for observation visits?

Because no show rates deminish after the first successful follow-up appointment, the most effective way to study the optimal months is to look only at no show rates

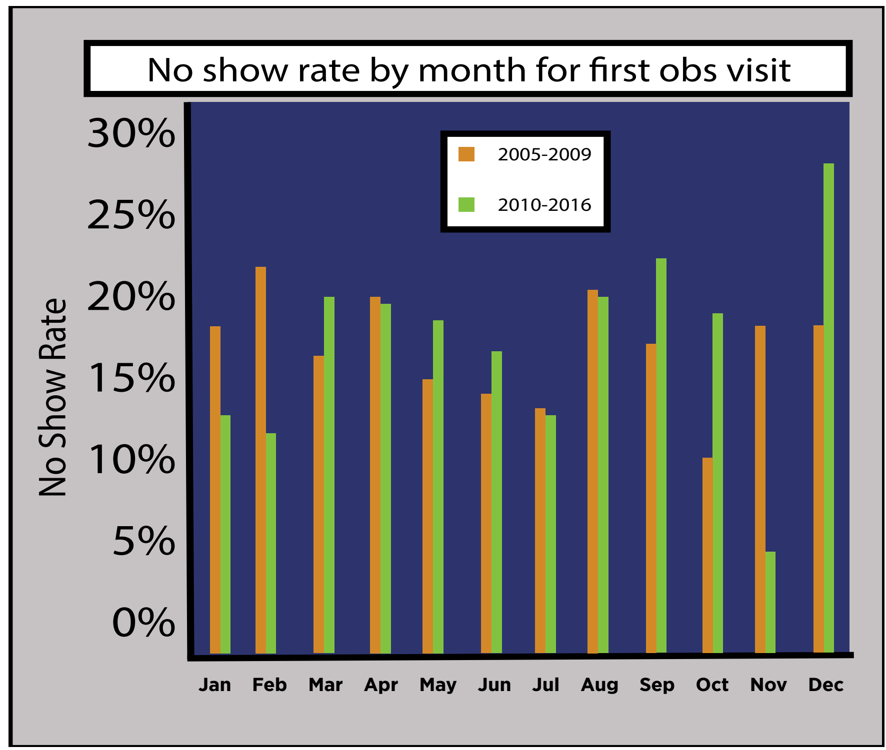


FIGURE 7: NO SHOW RATES BASED ON THE MONTH OF THE PROPOSED FOLLOW-UP

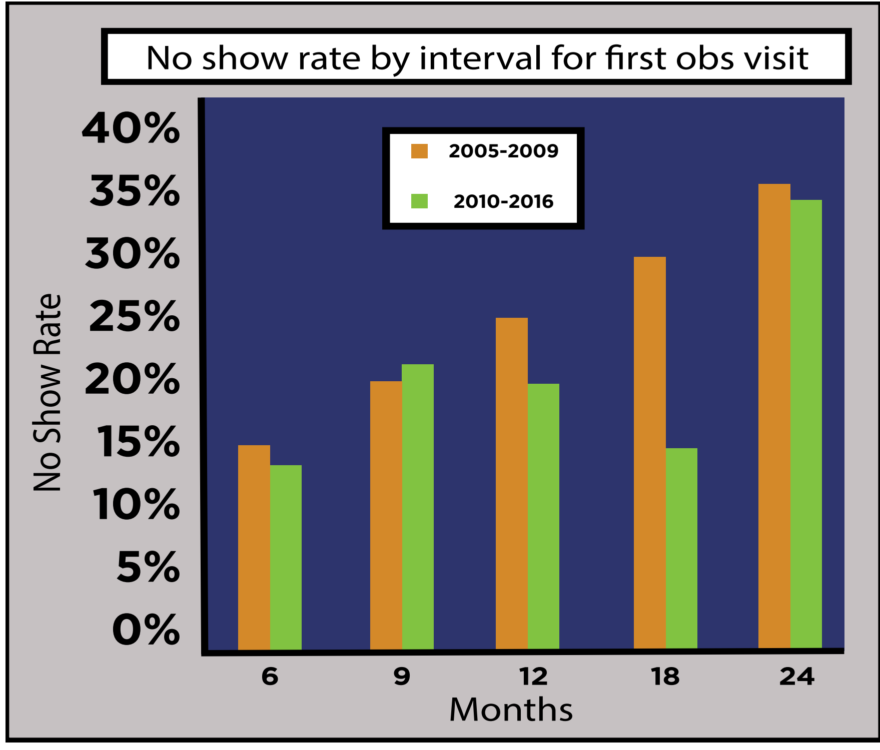


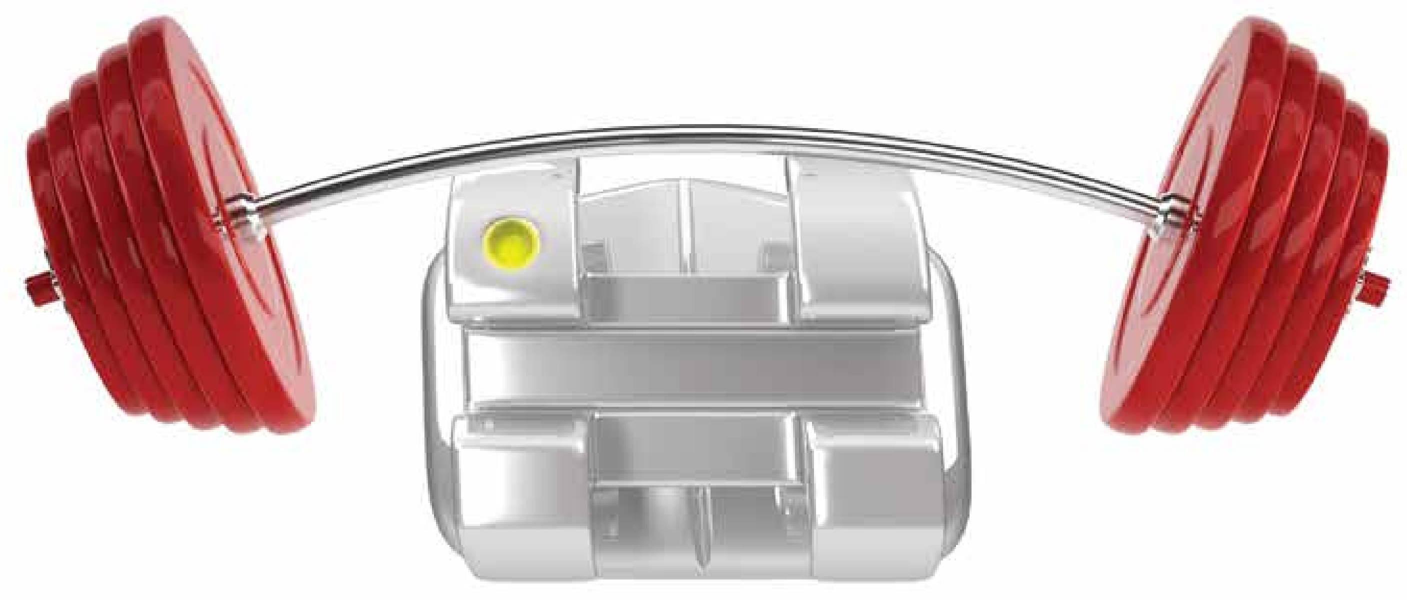
FIGURE 8: NO SHOW RATE BASED ON THE INTERVAL FOR THE FIRST OBSERVATION APPOINTMENT

for the first recall appointment (Figure 7). Again, in an effort to divide my practice data into two data sets, Figure 7 includes all patients from 2005 – 2009 and 2010 – 2016. Based on the data from Figure 7, I would try to schedule as many first observation appointments as possible in June, July, October or November. My second choice would be January or February. Once the patients show up for their first observation appointment, then I would not be concerned about what month to schedule the visits. (This makes sense when you think about how busy families with children are in August, September and December.)

The final area of investigation is the interval for the first recall appointment. Figure 8 shows the no show rate for first recall appointments increasing as the interval increases from 6 months up to 24 months. I would disregard the 18 month no show rate for years 2010 – 2016 due to a small sample size.

CONCLUSIONS

1. The most profitable orthodontic practices get 40% – 41% of their starts from their observation pool.
2. Practices with higher percentages of adults or Phase I starts are more dependent on initial exams for starts.
3. The first recall appointment is by far the most significant.
4. Start your follow-up interval with new observation patients at 6 – 9 months and progress to longer intervals for subsequent visits.
5. If the patient is due for their first follow-up in August or September, try to make the visit in June, July, October or November.



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MARKETING CLEARLY

By Angela Weber, Sarah Sharfstein, and Dr. Ben Burris

Getting braces isn't what it used to be. This is not to say that less people are getting orthodontic treatment. To the contrary, more people than ever and especially more adults are taking the plunge to get the smile of their dreams. The difference is that clear aligners are now the people's choice when it comes to orthodontic treatment.

What changed? Simple, Invisalign has educated patients about their options. By spending big bucks to go direct to consumer in a pharmaceutical-style campaign, Invisalign has created demand that is forcing doctors to offer their product. The Invisalign Doctor Locator has become a lead generating powerhouse to be coveted and feared. Invisalign controls a new patient base and lead creation stream that can literally make or break an office. In addition to its marketing power it also delivers the best clinical results hand down. This is the reason I've chosen to reengage Invisalign.

I'm now fully committed to being THE practice to see for Invisalign in my area and this requires a significant change in mindset as well as practice. In only three weeks since the Arkansas Dentistry & Braces staff and doctors completed orientation/training and became Invisalign friendly, we are already pushing 100 Invisalign case submissions.

How did we do this? The Doctor Locator doesn't work that fast!? You are correct. Our long-term success will be dependent on the Doctor Locator but the initial spike in Invisalign cases had to do with harnessing our existing systems, engaging our patient base and marketing to our advantage.

Let's have a look at what caused our Invisalign surge:

INTERNET MARKETING: Angela Weber's team does this incredibly well for us and even better since I got out of her way and let her do it the way she wanted to without my amateur input. We get over 30,000 hits on our practice website every month and most of those hits are the result of effective social media marketing. That's powerful and having this in place allowed us to tweak the message and instantly get Invisalign patients.

WEBSITE ENGAGEMENT: Again I rely on Angela Weber and her team for a great website. A great website is not only attractive and informative, it is effective. Effective meaning that people don't just look at it, they engage and appoint through the portal. We receive hundreds of consultation requests directly through our website portal. That's the whole point of a practice website. If you aren't getting appointments from your website then you're missing out. Take steps to harness your leads or you are just wasting your advertising dollars.

RECALL OF NO-SHOWS AND NONSTARTERS: We have plenty of patients who do not start the first time they come to visit us. We went on a mission to contact every single one of the potential patients who either didn't show for their new patient visit or declined treatment in the last two years. Any excuse to contact this pool of potential patients should be taken advantage of and when the hook is as good as Invisalign at a steep discount, people are happy you called.

SPECIAL OFFERS: Along those lines, we wanted to make a strong entry into the clear aligner market. We are a high fee practice when it comes to orthodontics but we wanted to be very competitive while ramping up Invisalign. We offered a $2000.00 limited time discount and it has been wildly popular. A deal with a timeline creates a call to action that moves potential patients to become new patients. How can we do such a thing? Aren't we losing money? No. By entering the market this way, we jump up our new patient flow, increase overall starts, increase the amount of restorative patients and increase overall revenue. Yes the short-term effects of discounting and a lab fee can lead to a cash crunch but it is a temporary state. This is just another good example of why we dentists should live on less than we make – so we have the cash flow to make a necessary change when change is necessary. Change is expensive but not changing can be catastrophic!

Embracing clear aligners is not difficult. I fought it for so many years for so many reasons that embracing Invisalign feels like turning around and swimming downstream after years of battling the current. Invisalign sells itself if you'll let it.

CHECKLISTS FOR HYGIENISTS: We love checklists. We have checklists for everything we do and by following our lists we insure that every aspect of every patient's oral health is addressed at every visit. Also, a checklist takes the pressure off of our team. They are not being pushy or assertive; they are just following the checklist for a given appointment. By making sure we don't miss anything our patients and our practice benefit.

ASK FORS: This is exactly what it sounds like. When I'm in a new patient appointment for kids needing orthodontics I have the ability to offer them both Invisalign and braces, at the same time, I ask mom if she has considered Invisalign for herself. We know mom cares about straight teeth, they are sitting in your office with little Johnny so why not ask? Also, when someone calls our office asking for an appointment we ask, "Is there anyone else in the family who would like to be seen?" This is amazingly effective scripting and doubles our new patient flow at minimum.

SCRIPTING THAT CREATES AWARENESS: with Align Tech has been instrumental to changing our mindset and practice. Sarah also taught us a very clever and effective bit of scripting. When patients call for any reason at all we say, "Thank you for calling Arkansas Dentistry & Braces, are you calling about our Invisalign special?" It's amazingly simple and effective and leads to Invisalign starts.

Embracing clear aligners is not difficult. I fought it for so many years for so many reasons that embracing Invisalign feels like turning around and swimming downstream after years of battling the current. Invisalign sells itself if you'll let it. Patients want it and converting cases is the easy part once you get your head right. Use these tips to get patients in the door. Give them what they want. Climb the Invisalign Doctor Locator and reap the stability and benefits that come with that accomplishment! Then all you have to do is to get good at moving teeth with plastic! Luckily there are tons of resources out there to help you do this.

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10 Things Every Orthodontist Needs to Know About Snapchat

By Dr. Kyle Fagala

Are you on Snapchat? If you're like most orthodontists I know, then the answer is most likely "no." To be honest, this answer is completely understandable. Snapchat users are mostly teens. The app originally found its popularity, at least in part, as a sort of sexting platform (not a good combination if you ask me!). However, Snapchat has evolved beyond its early negative reputation to become one of most engaging and entertaining social platforms out there. You need to be on Snapchat, and let me explain why.

1. WHAT IS SNAPCHAT?

Launched in September 2011, Snapchat has rapidly grown to a total of 200 million monthly active users. Impressive when you consider that Facebook launched in 2004, Twitter in 2006, and Instagram in 2010. At just 4.5 years of age, Snapchat is faring better than its competition did at the same point in their respective histories. If that doesn't impress you, then consider that Snapchat's 400 million snaps (a.k.a. posts) a day represents more volume than Facebook (13 million statuses a day), Instagram (70 million photos and videos a day), and Twitter (50 million tweets a day) combined. Snapchat is also, without a doubt, the hottest social media platform among teens, with around 45% of teens regularly using the platform. It is also popular among young adults and will only continue to "age up"' in the market. As an example, think of how Facebook went from being a site exclusively for college students to now including people of all ages. The "age up" is inevitable with premiere social media sites.

The best and easiest strategy to get more followers on Snapchat (or any social media platform) is to join early.

In my opinion, it's also inevitable that Snapchat will eventually add tools that will allow small businesses to promote themselves on the platform. Like any other social media site, early adopters will be rewarded with larger friend lists from which to promote. Said another way; the early bird gets the worm, in this case, the worm being access to a highly-engaged audience once promotional tools are launched. Even if small business promotional tools are never introduced (which I seriously doubt, since Snapchat eventually needs to turn a profit), then being on Snapchat allows you to understand better and engage with your teenage and young adult patients. Not a bad thing.

2. HOW DO YOU USE SNAPCHAT?

Unlike every other social media app, Snapchat opens with the camera up and ready to snap. It almost begs you to show people what you are doing at that exact moment. You can take a photo by tapping the shutter button or a video by holding down the shutter button for a maximum of ten seconds. Videos can then be slowed down or sped up for comic effect. You can also add filters, as well as draw or type on the photos. You then share your photos privately or publicly for 1 to 10 seconds. Recipients can allow the time to run out on your media, or advance through your updates by tapping their finger on the screen.

3. WHAT MAKES SNAPCHAT DIFFERENT?

Snapchat is a sort of amalgam of text messaging, Vine, and Draw with Friends. Ultimately, people use it to share in one of two ways:

Privately: You can send photos, texts, or video clips to one or several friends that, much like a tape in Mission: Impossible, will "self-destruct" in 1 to 10 seconds.

Publicly: Alternatively, photos or videos can be posted to "My Story," where the media remains visible to friends for 24 hours.

Unlike an app like Instagram, photos and videos are rarely filtered, touched-up, or planned out. Snapchat is all about "living in the now" with posts that feel more authentic, more real. Unlike Facebook, parents and grandparents aren't there, and unlike practically every other social media site, neither are brands. In fairness, some brands are there (MTV, ESPN, Food Network, People Magazine,

Comedy Central, etc.), but most brands, especially small businesses, aren't. Major brands also don't get in the way of your friends' posts, but are instead organized in sections called "Discover" and "Live."

4. WHAT ARE THE CURRENT LIMITATIONS OF SNAPCHAT?

For better or worse, posts are short-lived. 24 hours is the longest your posts can live on Snapchat. After that, they're gone forever.

There's no way for people to see your posts without being your friend.

There's also no way to search for or discover other people. There's much less chance to network beyond your pre-existing friend group.

No hashtags, hyperlinks, sharing, or public comments are possible. Comments can be made, but only the original poster will see the comments. Fortunately, this eliminates most political arguments (your move Facebook and Twitter).

5. IF I CAN'T PROMOTE MY PRACTICE ON SNAPCHAT, WHAT'S THE POINT?

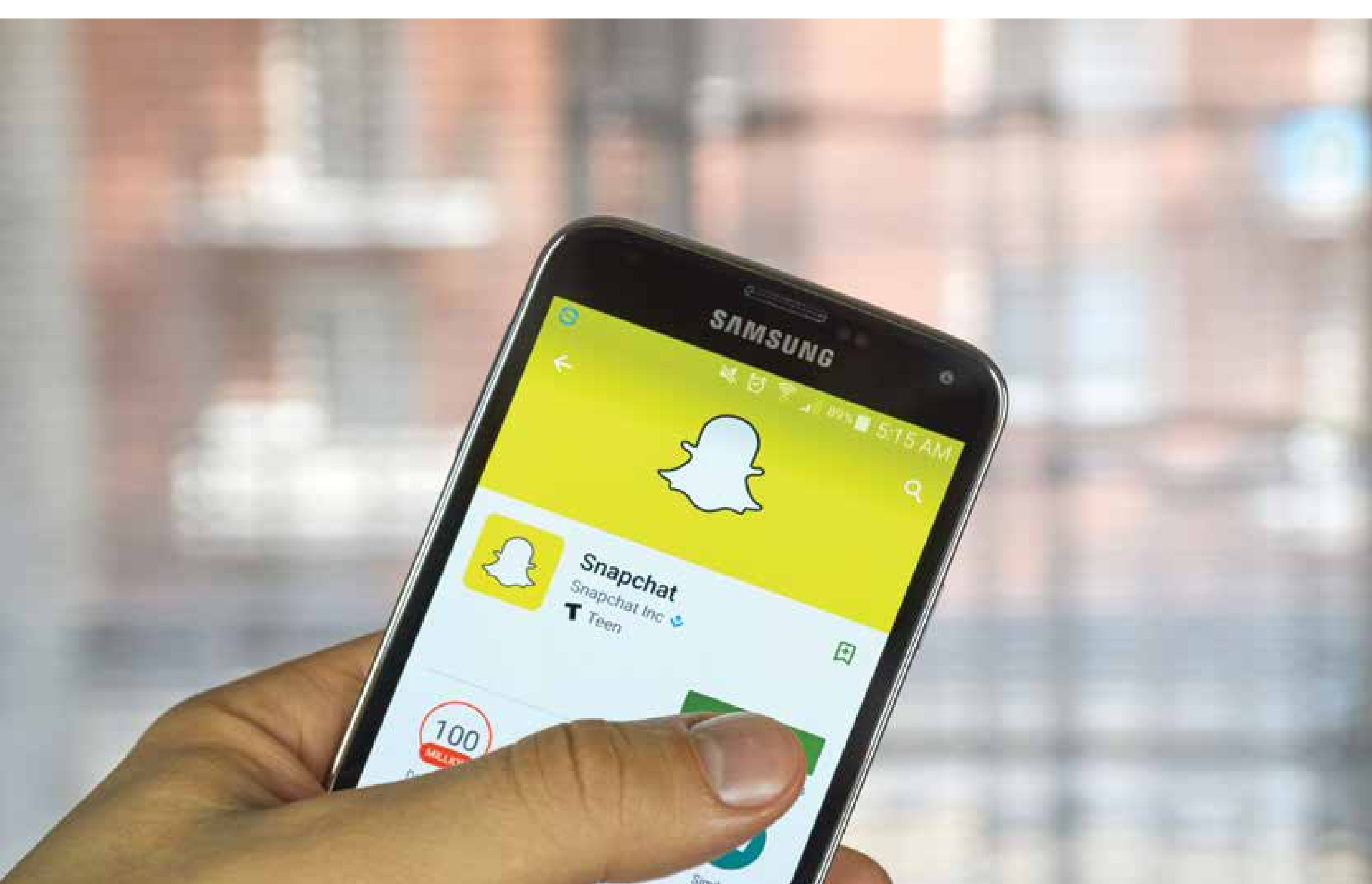
To quote Master Po from the 1970's classic Kung Fu "Patience, young Grasshopper." The opportunity is coming; I promise - you just have to wait. Currently, you can promote your practice in a similar way to Twitter or Instagram. You just can't promote with ads or be noticed by users who haven't already friended you. Essentially, your potential audience is much smaller than on other social media sites. However, as mentioned earlier, broader promotional tools are coming, and there are so few orthodontists on Snapchat currently, that great opportunity abounds.

6. HOW DO YOU RECOMMEND AN ORTHODONTIC OFFICE USE SNAPCHAT?

There are two basic options. You can tell your practice story or your personal story. I have always argued that people are more interested in following people on social media instead of businesses, and so I believe that a Snapchat account focused around your life as a doctor, father, friend, sports fan, and so on is more interesting than an account focused purely on one's orthodontic practice. However, neither option is wrong, and I could see an orthodontic office with two iPod Touches creating some great content.

7. HOW CAN I MARKET MY PRACTICE ON SNAPCHAT?

In large part, social media is about slowly building your brand and maintaining TOMA (top-of-mind awareness). However, if we're talking marketing ideas that could immediately produce new patients, then a few ideas that come to mind. One would be a 24-hour, Snapchat-exclusive sale on braces. Make the deal substantial enough and it could spread virally. You could also do



giveaways for people who screenshot your snap and post to Instagram or Twitter. Helping to promote your Snapchat account on sites where you already have a good following. Lastly, you could reward patients for friending your office on Snapchat, or run unique giveaways or contests on the platform.

8. HOW DO I GET FOLLOWERS ON SNAPCHAT?

The best and easiest strategy to get more followers on Snapchat (or any social media platform) is to join early. Someone has to choose to follow you, but I would recommend adding everyone you can. You can add friends by username (MemphisBraces, for example), from your address book, by Snapcode, or even by using a feature called "Add Nearby" that finds nearby Snapchat users who are using the "Add Nearby" function at the same time. Additionally, you can promote your Snapchat username on your other social media channels.

9. WHAT DO YOU DO IF A 13-YEAR-OLD PATIENT ADDS YOU ON SNAPCHAT? WON'T THEIR PARENTS BE MAD IF THEY FIND OUT?

If you're going to be friends with young patients, your content needs to be wholesome. My life is an open book, and I have nothing to hide. I want patients, both young and old, to follow me on social media. I love building relationships and telling my story. However, it is never wise to share inappropriate photos or videos, and it's wrong to have private conversations with anyone under 18. Don't go there, and if you don't trust yourself to represent your practice well, then do NOT download Snapchat.

10. WHAT ARE SNAPCHAT GEOFILTERS?

To quote Snapchat: "Geofilters are special overlays for Snaps that can only be accessed in certain locations. Simply choose the geographic area you want your filter to be available in and upload an image asset. All images must be original artwork and have to be approved by the Snapchat team. Businesses and individuals alike can purchase On-Demand Geofilters for their event, business, or a particular location."

This feature launched recently to small businesses, but it allows orthodontic offices to have a unique geofilter for snaps taken inside your office. The geofilters aren't cheap at roughly $5 to $10 a day (depending on your competitive area and office size) plus the associated design costs, and they can only remain active for 30 days at a time. However, I can think of multiple fun applications for an orthodontic office. You could overlay sunglasses and a big brace face for new patients or a Cheshire Cat smile for debond days. The most cost-effective option would be a geofilter for special events like patient appreciation parties, holidays, or CE events. Check out https://www.snapchat.com/on-demand if you're interested in learning more.

Mark Zuckerberg tried to buy Snapchat for $3 Billion in 2013. Zuckerberg saw the potential of Snapchat earlier than most, and now more are starting to follow suit. Heck, even The White House joined Snapchat in January. Now is your chance to cash in on Snapchat before everyone else!

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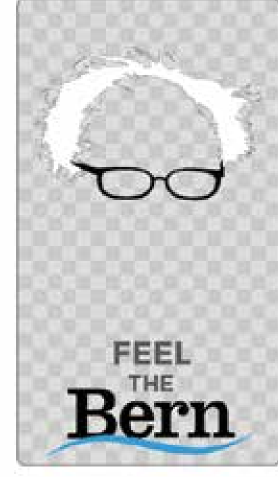

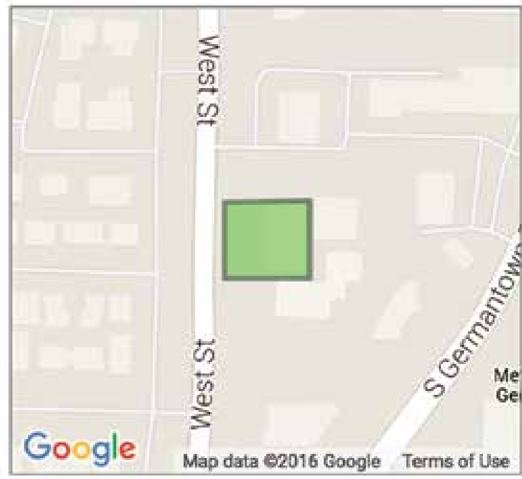

HERE'S AN EXAMPLE OF ON-DEMAND GEOFILTER PRICING. SNAPCHAT REQUIRES A MINIMUM AREA OF 20,000 SQUARE FEET. FYI, I DON'T FEEL THE BERN, BUT I KNEW KLIFF KAPUS WOULD APPRECIATE THE SHOUT-OUT. ;)

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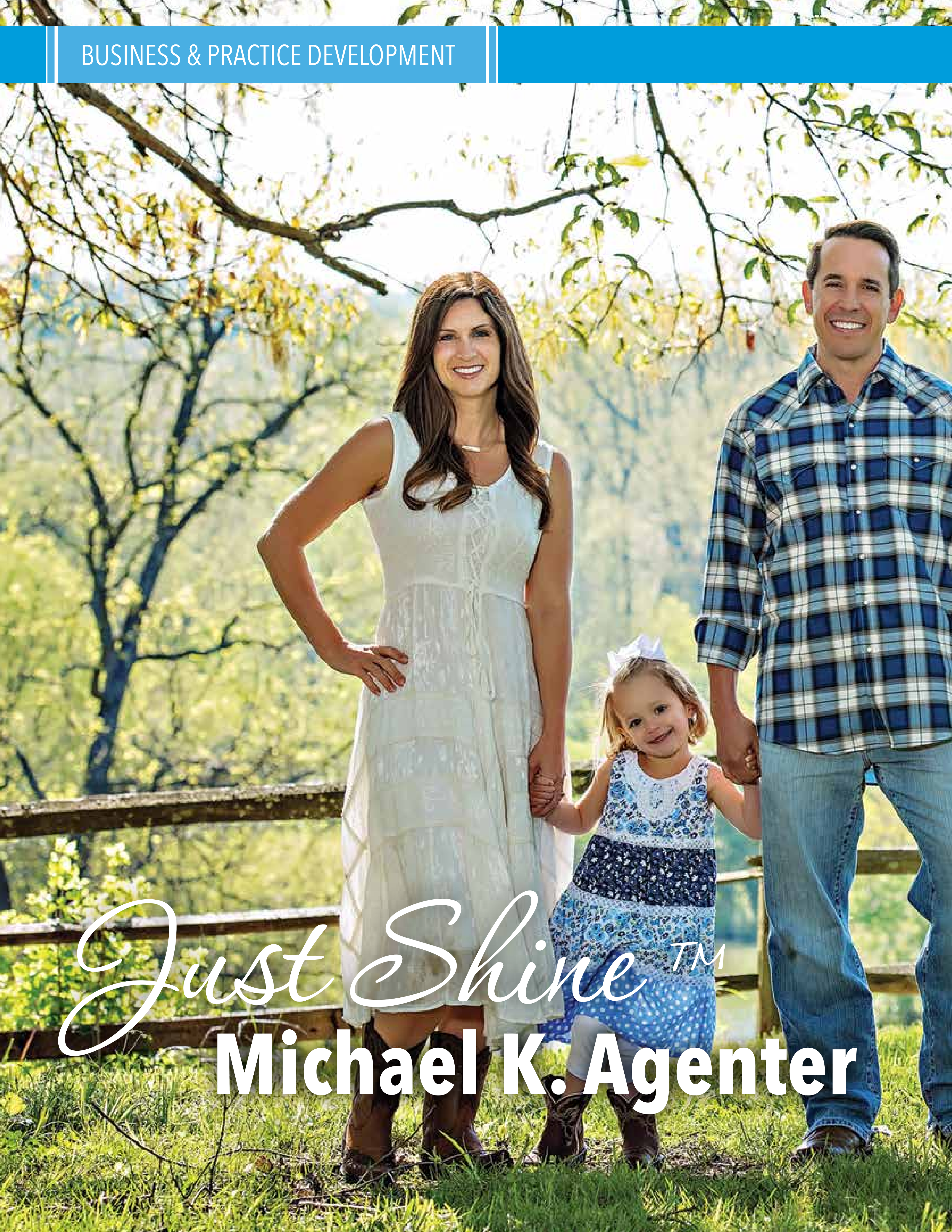


Just Shine™

Michael K. Agenter

We recently sat down with Dr. Mike Agenter to talk about his practice, his family and his thoughts on life in general. Enjoy!

Why JUST SHINE™?

Growing up, I was that tiresome kid posing the endless why questions. Perhaps you remember me. Over forty now and presumably navigating the second half of life, I continue to excogitate why. Why do I exist, why was I born in an affluent nation, why am I an orthodontist and business owner, why am I accountable to so many, why me? Perhaps ineluctable, my approach to leadership reflects my inquisitive nature. Whether pouring into my office team, teaching my kids, coaching youth sports or mentoring students, I always begin with a foundation for why we do what we do. It's just the way I'm wired.

When founding Agenter Orthodontics, I partnered with organizations focused on the development of confidence and character in the next generation. Our initial tagline, "Better Smiles, Better Community," was born out of our affiliation with a local food pantry that provided backpacks loaded with food to underprivileged kids for the weekends. A portion of the proceeds from each orthodontic treatment we render continues to support backpack programs. Distilling our mission and vision to the essence of what drives us, we shortened the tagline to JUST SHINE™. Shine is an action verb meaning "to glow or be bright by reflecting light" and it explains why my business exists. While my team is highly motivated to deliver outstanding orthodontic care, what drives us on a daily basis is our passion to be a catalyst for positive life change and to inspire others to shine within their own circles of influence.

When all is said and done, orthodontics is something I do, it's not who I am. As mentioned previously, creating amazing confident smiles is the currency we deal in as orthodontists. In truth, our businesses afford a tremendous platform for enriching our communities, a platform that will likely be amplified as our industry becomes more and more direct-to-consumer.

SO TELL US ABOUT YOUR FAMILY GROWING UP.

The greatest values I derived from my parents were gratitude, joy, contentment and determination. My father grew up on a cattle farm and dropped out of college for a sales job, ultimately ascending the ranks of a Fortune 500 company. My mother waited tables before establishing her career with the Department of Natural Resources. Neither were college graduates. They divorced when I was six and mom raised my sister and I as latch-key kids outside a small town in Northern Minnesota. Understanding the sacrifices made by single parents, I am humbled by her determination to rise above circumstances and show us the joy in life. Growing up without Dad in the home was tough, and before high school I made an onerous decision that would indelibly mar my relationship with Mom. I chose to live with Dad. This is not to say I would choose differently given the benefit of hindsight, just that in my experience divorce sucks and nobody wins.

Dad remarried and my little brother was born with transposition of the greater vessels of his heart. Given the relative

novelty of transposition surgery, we are thankful he is alive and healthy. Observing firsthand what the medical community was able to do for my brother sparked my interest in health care. Living with Dad, I admired his overwhelming sense of optimism and kind demeanor. Dad had an unswerving confidence that things would work out and he genuinely liked people. He was a human magnet and the gel that kept our family together through difficult times. In 2009 (the year I started my business), his optimism and good nature were ultimately tested with a diagnosis of fourth-stage lung cancer. Given a prognosis of months, his oncologists were awed as the cancer went into remission and our family enjoyed five more years with Dad. Lamentably, my father-in-law was concurrently engaged in his own battle with advanced prostate cancer. They passed five weeks apart, both from metastases to the brain. Those fortunate to spend time with Dad in his final years recall him frequently saying, "I'm doing the best with what I've got." Naturally Dad hated cancer and envisioned it gone, yet he experienced inexplicable peace and joy in the middle of his fight, continually sharing his bold confidence and hope with others battling cancer.

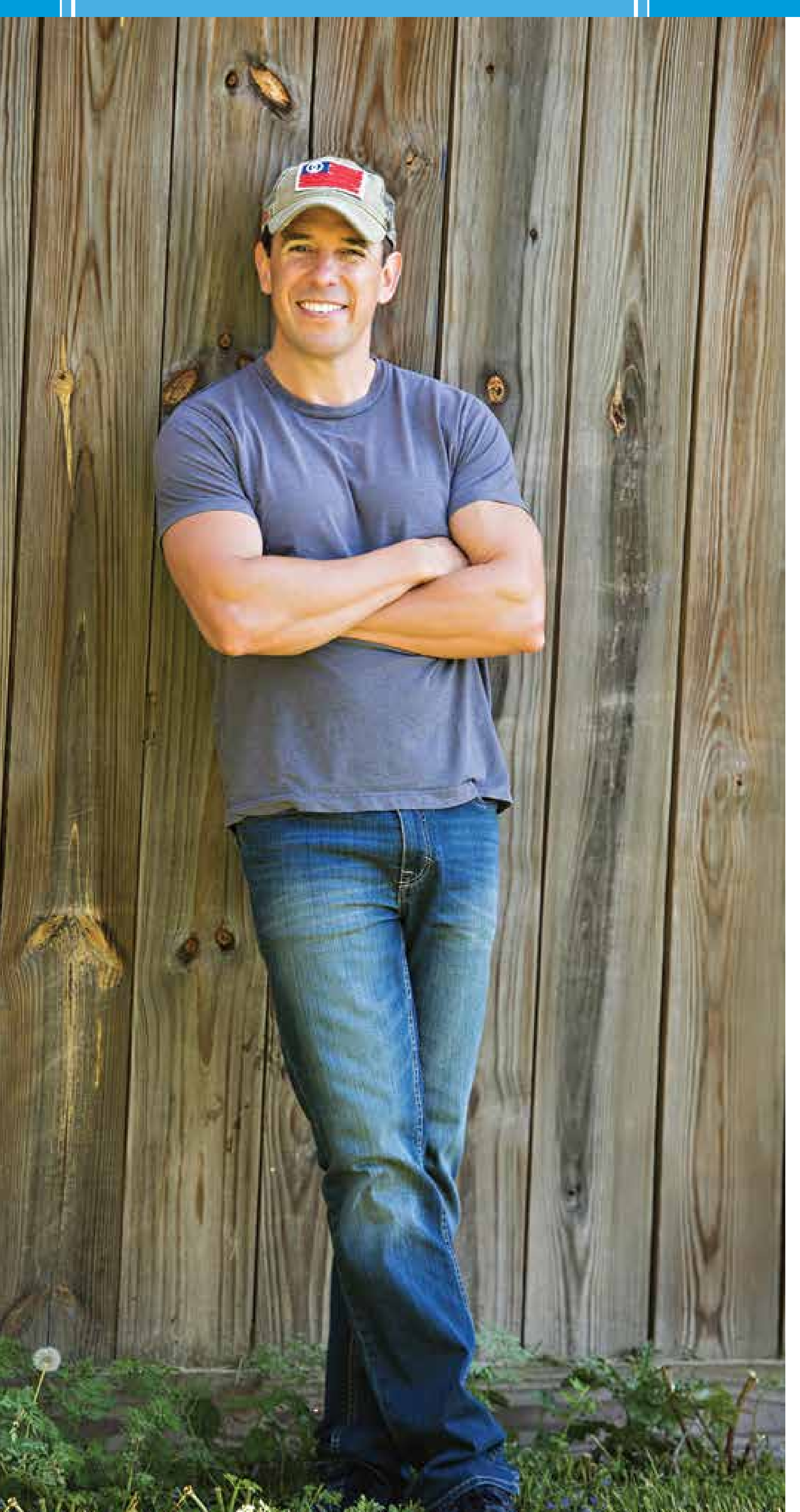
Nothing I possess is permanent; therefore, stuff does not own me. I play the game of life with house money. As a result, I take more chances, have a broader perspective and fear less.

FOR THE PRAGMATISTS, HERE ARE SOME PEARLS I GLEANED FROM A DIFFICULT SEASON:

1. Human perspective and reasoning wholly transform with an understanding that our days are numbered.
2. Peace and joy exist in the midst of suffering for those willing to look for it.
3. We can choose to focus on remorse for our situation or gratitude for another day of life. But don't be fooled, what we focus on increases.
4. Gratitude is a daily choice, but the long-term benefits make it worthwhile.
5. Nothing I possess is permanent; therefore, stuff does not own me. I play the game of life with house money. As a result, I take more chances, have a broader perspective and fear less.

TELL US ABOUT MARRIED LIFE AND CHILDREN. I KNOW FAMILY IS A BIG PART OF YOUR LIFE.

Given my parents' divorce, I didn't really consider marriage until I met my wife on spring break. Kelly was a nursing student in Atlanta and I was finishing dental school at Michigan. We talked for hours on a lifeguard tower in South Beach, Miami the night we met. Returning to Ann Arbor, I could not help but tell my friends about my future bride. Indeed, we were engaged six



months later on the same lifeguard tower. Although it's hard to believe that was fifteen years ago, watching our children ages 7, 5 and 3 grow up is a constant reminder that life moves rapidly in a singular direction. What I admire most about Kelly is her kindness and generosity. Aside from being the most beautiful woman I have ever met, her kindness was what attracted me. Having self-funded my way through school, I mastered the discipline of frugality out of necessity. It has taken years, but she has mostly broken me of my tight-wad nature and helped me to esteem people and time above financial security.

Raising kids has been my hardest endeavor to date but also one of the most rewarding. I do not recall losing this much sleep in dental school, the Navy and orthodontic residency combined—and I have no teenagers yet.

Raising kids has been my hardest endeavor to date but also one of the most rewarding. I do not recall losing this much sleep in dental school, the Navy and orthodontic residency combined—and I have no teenagers yet. A beautiful illustration in retrospect, the sacrifices made by my parents and their love for me were incomprehensible until I became a daddy. Waiting so long to have kids, I view the first half of my life as primarily about me and my development. I hope to say one day with confidence that the second half

was characterized by serving and building into others, beginning with my wife and children.

Perhaps the most selfless gift my wife has given me is her commitment to homeschool our children. Being a mom is a full-time, unpaid, back-breaking and typically under-appreciated job. Adding sole responsibility for our children's education to her job description drives the degree of difficulty and time demands to crazy high levels, yet this remains one of her greatest passions. For my part, I count myself fortunate to have the flexibility to participate in their home school co-op and coach many of their sports. Being entirely transparent, at times I have placed our marriage on cruise control while expecting it to thrive. Considering my efforts to scale a business and deliver top-notch patient care, I am often genuinely perplexed by my cluelessness when it comes to women and marriage. Fortunately, Kelly and I have benefited from older mentor couples who have been honest and direct about what needed to change for our marriage to survive and eventually mature. My wife has become my best friend and, although our marriage is far from perfect, we have learned to erect and defend healthy boundaries that in turn promote romance in our relationship.

THE FOLLOWING ARE PRACTICAL THINGS I DO THAT HELP FOSTER INTIMACY IN MY MARRIAGE, MOST RELATE TO TIME MANAGEMENT:

1. Schedule regular date nights.
2. Schedule personal time for my wife away from the kids and me.
3. Read books on marriage and take marriage retreats or weekend staycations.
4. Say "no" to good things to reserve time for great things.
5. Set boundaries on screens. Our dinner table, bedrooms and car are screen-free zones. Kids are known to talk more openly when facing the same direction, and some of our best conversations with our kids take place in the car.
6. Fully engage whoever I'm with, wherever I am. As a natural multi-tasker, this is challenging but liberating. I have repeatedly attempted to mix work with just about everything and failed miserably. I realize many are able to manage this juggling act more gracefully, but I cannot seem to pull it off. I leave my phone in the car when I go to the gym and restaurants. I allocate administrative time every week and I arrive at the office a little earlier in the mornings as needed. I have become more productive at work and in the gym and am able to fully engage my family and others. Although young, my kids are remarkably aware when Daddy is physically present but either mentally unavailable or not to be bothered. The irony is that I took work home to have more time with family, but for me it created more problems than solutions. Okay, so that was more of a discourse than a pearl.

Time and again I am humbled by the contentment and gratitude exhibited by those living in utterly impoverished nations. They may own virtually nothing yet will freely give of anything they have.

WHY DENTAL MISSIONS?

A better question may be, "why not dental missions?" After returning from the mission field, I am fully mindful of the many things I take for granted. Time and again I am humbled by the contentment and gratitude exhibited by those living in utterly impoverished nations. They may own virtually nothing yet will freely give of anything they have. In my own life, I instinctively pursue comfort and financial security, fully aware such things are neither fulfilling nor sustainable. Comfort connotes favorable circumstances that are typically fleeting, whereas contentment requires merely a choice. So why dental missions? If for no other reason, because I have a useful skill and there is a need. More than three billion people or over half the world's population survive on less than three bucks (USD) a day. More than eighty percent of the world's population survive on less than ten bucks a day. By comparison, the average American spends seven bucks a day on entertainment and twice that on transportation. By any measure, Americans are incredibly rich by the majority standard and the disparity is growing. While I do not pretend to have a solution, I can do something. I point this out this not to shame any of us but to provide a suitable context for the stresses and struggles we all experience—whether in business, marriage, parenting or life in general. First World problems, though legitimate, are generally transitory and resolvable with a bit humility and sacrifice.

My first dental mission trip entailed a short drive from San Diego across the border into Mexico with the non-profit organization Thousand Smiles. Taking leave from a GPR in the Navy, my wife and I accompanied a team of primary care dentists, oral surgeons and an orthodontist to treat children and adults suffering from the complex untreated needs associated with cleft palate. It was incredible to see that even orthodontic treatment could be rendered in the mission field! I served on my first Global Health Outreach medical/ dental mission trip to El Salvador in 2012 and began leading GHO teams in 2013. The teams are not set up to provide

orthodontic care, however outside the state of Ohio my dental license allows me to perform general dentistry, so I get to be an exodontist for the week. The team travelling to El Salvador in June is typically made up of fifty or so individuals from across the United States including physicians, dentists, pharmacists, nurses, physical therapists, students and logistics—basically anyone without a health care background who wants to serve. What I enjoy most about missions is building relationships with team members. Whether students, doctors or individuals from the local host team, everyone has something unique to contribute out of their life experience. Away from the security and familiarity of home, enduring friendships are forged while serving patients as well as one another. Although the majority of the team is composed of new members each year, there are a few steadfast individuals I am grateful to serve with every year who have become part of my extended family. If you have experienced dental missions, you can identify with returning home knowing you have gained exceedingly more than you could possibly give. For better or worse, dental missions will indelibly alter your life. Akin to discovering anything truly wonderful, it becomes part of you.

If you have interest in serving on a mission team or questions about my personal story, feel free to reach out to me at mikeagenter@hotmail.com. As Dicky Fox said in Jerry Maguire, "Hey, I don't have all the answers. In life, to be honest, I failed as much as I have succeeded. But I love my wife. I love my life. And I wish you my kind of success."

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Online Chat: *Implementation and Results*

By Scott Hansen

For e-commerce websites, the results are clear, online chat works. Research shows that buyers who use chat are 7.5 times more likely to complete a purchase than visitors who do not chat. Innovative, service-focused companies around the world including Zappos, Apple, and REI have successfully implemented online chat to improve their service experience and drive revenue.

However, very little research exists about the implementation and effectiveness of chat for professionals. Unlike e-commerce sales and support, which include many black and white questions and answers, professionals must rely on nuanced delivery of service that is often custom-tailored for each patient. There is a stark contrast between specific orthodontic questions from potential patients and simple product questions about features and specifications. How much are braces? Do you accept my insurance? Would Invisalign work for me? The answers to these questions are complex and often require a visit to the office.

So, given the challenges of individually answering common patient questions over chat, you might wonder, Is it worth implementing in my practice? What results should I expect? What are the drawbacks? Should I have my staff answer the chats? What's the cheapest way to get started?

After more than three months of extensive testing across six practices and 11 doctors, we answered these questions and more. In addition to our test-doctor data, we have collected and analyzed data from our current 22 OrthoChats orthodontists internationally. These clients range from small rural one-doctor one-location practices to five-doctor practices in the urban core. As you will see in the following data, we have found that chat is a useful engine for practice growth. However, implementation of chat, as we have learned from experience in our practice, must be done carefully and deliberately to reap significant benefits.

Chat is the next frontier for patient interaction. If done well, chat is not only an incredibly compelling lead-capture tool but also an innovative service delivery medium for existing patient.

ADVANTAGES OF ONLINE CHAT

►Low communication barriers help engage your web visitors more frequently

25% of web users prefer using chat to the telephone. The statistics show that 5-6% of web visitors are likely to engage in online chat. Of those chatters, nearly 40% will be new patients. Naturally, you will begin to increase the number of new patient consultations in your practice.

►Increased user session duration boosts organic search ranking

Because the average chat length is 7 min 36 sec., chatters are staying on your site longer. Average session duration is a statistic Google uses to rank your website. From the available data, we saw the average session length for our clients rose nearly 10% compared to the same period the previous year.

►Chat availability means fewer time-consuming calls during busy periods

Client data shows that 61% of chats occur from 10:00 a.m. to 4:00 p.m. CST., 19% happen before 10:00 a.m., and 20% after 4:00 p.m. By using a chat service during the day, your staff can focus their efforts on outstanding in-office patient service.

►Easier accessibility means more convenience for existing patients

Before your office opens and after your office closes, if your chat is live, your patients can get simple questions answered without getting the answering machine at your practice.

COSTS OF ONLINE CHAT

►Professionally managed chat is a financial investment

There are multiple sources for managed chat for your practice. Expect to spend at least $700-$900 per month for an adequate solution.

►Increased bounce rate detracts from organic search ranking

We noticed a slightly higher bounce

rate after installing chat on practice websites. However, the evidence suggests that the benefit of session duration outweighs the adverse effect of the slight increase in bounce rate. We did not hear any reports of falling organic rankings. On the contrary, several of our clients reported organic search improvement after adding chat.

Adding chat can be a very profitable decision for many orthodontic practices. After weighing the benefits and costs, the next phase is implementation. The theory behind chat is relatively easy to understand; lower the barriers to people interacting with your practice, interact with a higher percentage of your potential patients, schedule more consultations. However, the practice of chatting professionally is difficult to execute. You need a well-trained team of chatters working for you to make chat effective.

Remember, though there are tremendous opportunities in interacting with your potential patients via chat, the communication is very delicate. A potential patient can exit out of the conversation at any time without consequence or a feeling of guilt (unlike hanging up the telephone). If not done well, online chat can be a turn-off to your patients. Use the following implementation help to avoid making costly mistakes with chat.

IMPLEMENTATION OPTIONS

►Install and manage the chat on your own.

There are many options for chat software including Comm100, BoldChat, LiveChat, and LivePerson. You can expect to spend $20-$100 per month depending on features.

Danger: Depending on your chat volume, it can be difficult to answer all chats reliably. Chat can quickly turn into an inconvenience to your patients if they do not receive timely replies. Most will wait only about 20 seconds before leaving.

►Outsource the management of chat to non-industry-wise professionals

There are many, many options to outsource your practice's chat. However, most companies will only offer a message-taking service and will not be able to answer most new patient questions nor will they be able to adequately build value for your practice and your specific treatment offerings.

Remember, though there are tremendous opportunities in interacting with your potential patients via chat, the communication is very delicate.

For a quality service, expect to pay a $700 minimum monthly fee and $.50 per chat minute of overages after the monthly maximum has been met.

Outsource the management of chat to industry-wise professionals

If you do not have a large practice with an already established call center, this will be the highest ROI option for you.

Expect to invest between $900 and $ 3,000 per month for an orthodontic-experienced professionally managed service.

Once you have chosen an implementation path, there are several points to consider when making your decision. Following, are a list of important questions to ask when selecting a professional chat provider.

►Are your chat agents employed in-house, or are they outsourced/contracted?

►Do I have to sign a contract?

►Do you have any service guarantees?

►What are your average client results?

Because this is a high-touch service, it is crucial that you demo the service. Ask the chat firm to provide you with a list of clients. Once you have the list, get on each site and act like a new patient. Ask hard questions. Remember, the chat firm will be operating as an extension of your brand.

QUESTIONS TO ASK YOURSELF DURING THE CHAT DEMO

►Is the aesthetic appealing? Will it make my site look trashy or spammy?

►Do I feel like I am talking to a real person or a robot?

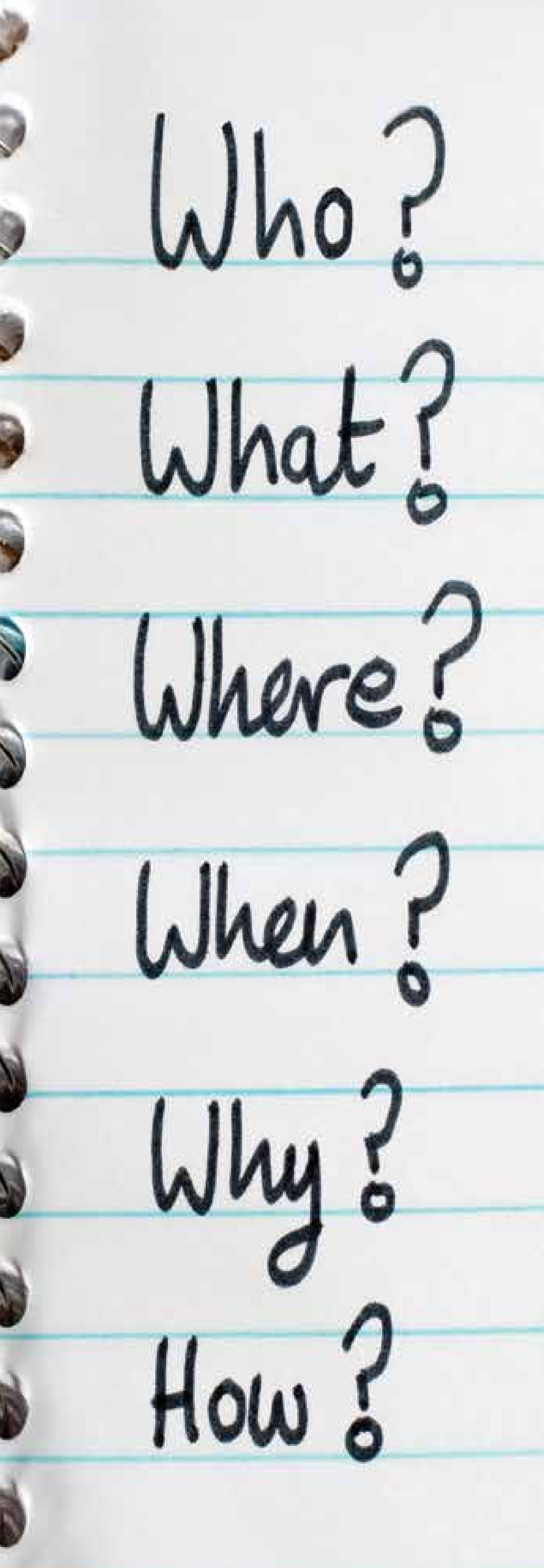
►Does the grammar and spelling of the agent represent the quality of my practice and my patient care?

►How does this make me feel?

►Does the agent know enough about building value about orthodontic treatment to represent my services and treatments well?

►If I were a new patient, would I be compelled to give the agent my contact information?

Chat is the next frontier for patient interaction. If done well, chat is not only an incredibly compelling lead-capture tool but also an innovative service delivery medium for existing patient. Hopefully, this article has helped provide clarity to this relatively new concept of professionally managed chat. Remember that these are statistics from the available chat data from our test doctors and clients over a three-month period. As these statistics change with time, I will be happy to update readers with more relevant data. Happy chatting!



DSO INTERVIEW

We sat down with a young doctor who works for a DSO supported practice to explore the issues, attitudes, prejudices, and worries surrounding this career choice. DSO supported practices comprise 20% of the dental market, and some say that will rise to 50% in the next five years, so it is vital to understand what is going on.

ProOrtho: How long have you been out of school?

Doc: 1 year

ProOrtho: Why did you choose to work with a DSO?

Doc: It was a good opportunity to fill several days at once which can be difficult as a new graduate. Working for multiple employers, especially in ortho, can be complicated regarding schedule coordination, different sources of income, varying practice styles, etc. Additionally, the DSO paid very well and being able to start seeing a full schedule of patients right away was a big plus.

ProOrtho: Was that your first choice?

Doc: Towards the end of residency, I had accepted an associate position with another doctor. I was looking to add extra days, and the DSO fit my schedule well. Initially, I assumed the traditional practice would be my long-term focus, and the DSO would supplement until I was ready to buy the other practice or start my own. However, I soon realized that I much preferred the DSO environment. When things didn't work out with the other practice, I decided to commit to the DSO full-time.

ProOrtho: Why did you avoid working with a DSO initially?

Doc: Fortunately, I didn't avoid it. However, I was aware of some concerns about corporate-type practices that definitely made me pause and think about it first.

ProOrtho: Tell me what you were told by your peers and professors about DSOs?

Doc: The dentistry is shady. The patients are a nightmare. You will be pressured to meet unrealistic production goals. You won't make any money doing Medicaid. You won't be able to take good care of the patients like you would in your own practice. You won't be able to make your own decisions. Working for a DSO is not as prestigious, and you won't be regarded as highly by your peers. The ultimate goal is to own your own practice anyway.

ProOrtho: What surprised you about working with a DSO?

Doc: How scary and exciting it was to start as the doctor in charge with a packed schedule from day one. Even though the high-volume can be stressful at times, I started learning very quickly from my successes and failures.

How much I actually like treating the patient population that often tends to end up at a DSO due to Medicaid/insurance and financial needs. There are certainly challenges, but it has been extremely rewarding professionally and financially, both aspects which I've heard others doubt.

ProOrtho: What do you like about working with a DSO?

Doc: Obviously it is important to find out who you are really working for, how certain situations will be handled, and where you can provide input. I'm sure each DSO is different. In my case, I am allowed to make my own decisions including when to accept/not accept a patient, the treatment plan, early dismissal, etc. Guidance is available if I need help or haven't dealt with a particular issue before. My suggestions for improving patient care and processes are considered by the administration and often implemented.

I enjoy being able to focus on the ortho and the patients without the stresses of owning a business, especially so soon out of residency. There is no obligation to network with local practitioners or solicit referrals, although I do maintain my outside professional relationships and continue learning from my peers. It's great to have general dentists and specialists under the same umbrella to make communication between providers easier.

ProOrtho: What do you not like about working with a DSO?

Doc: Because it's not my practice and the supplies are standardized for many offices, there is less ability to experiment. Sometimes I read or hear about what others are using and wonder if I'm missing out. However, it does help me learn what I am capable of and to be creative with the products available. In many cases, I've realized that keeping things simple is a good thing.

The staff often work with several different doctors, so it's difficult for them to keep track of individual preferences which can reduce efficiency at times. They are not my employees which is nice in the sense that I'm not in charge of the human resources challenges, but I also then have less control over with whom I work.

In a large organization, there is the high potential for seeing patients of other doctors although we are working on minimizing crossover. This can be particularly difficult in ortho because of the longer treatment plans and doctor-specific methods of case progression. When patients bounce between several providers, it's easier for things to get off track or be overlooked.

I also occasionally worry that by not learning as much about the business aspect now that I will be at a disadvantage if I want to open own a practice in the future. At this point, however, I am not sure if I ever want that, so I am focusing on improving as a provider for now.

ProOrtho: How does your experience working with a DSO compare to what you've heard from peers in a more traditional setting regarding pay, work environment, quality of life, after-hours obligations, or any other differences?

Doc: The pay is far better with the DSO as compared to the traditional rates I've seen. On the order of 2-3 times the average per diem in our area.

I think our work environment is very good compared to some traditional practices to which I've been exposed. There are occasional hiccups, but one benefit of a large organization is having dedicated resources to continually refine policies and procedures. There are, of course, those amazing traditional practices that everyone admires, but there are also plenty that are a total logistical mess. So I am grateful that I can fit in and function well in my current situation.

I am busier than many of my peers just starting out. I realize that successful traditional practices are also very busy, but it can take a while to get there. I am fortunate that my daily hours are compact, and the patients accept it without much complaint. When I get started, I barely stop moving until I'm finished. But I like it that way.

I do spend a fair amount of time after hours reviewing my cases and making sure I stay organized. I'm sure those in traditional practice do as well. But I don't have to spend additional time running a business or networking.

I am more directly in charge of my treatment approach than some new grads. This can be both good and bad as I may not be getting as much benefit from direct mentorship as someone in an associate position would. However, it has been a positive experience to own my decisions and learn from my mistakes.

ProOrtho: What advice would you give to young doctors, students or residents when considering their employment options?

Doc: Get out there and visit as many practices as you can, talk to former residents and colleagues, reply to classified ads. At least contact and interview (in person) with as many different employment sources as possible. Even if one doesn't seem right for you at first glance or you already have a doctor promising you an associateship. Things pop up and also fall through at the last minute, trust me. More exposure will help you identify what you like and don't like about particular environments, schedules, doctors, staff, etc. It's so frustrating to start somewhere and know within days that it's not for you, especially when patients, contracts, etc., are involved. The trial and error approach many new doctors experience can be uncomfortable. So do your best to be open to all options and don't be afraid to ask questions and observe before you commit.

ProOrtho: Anything else?

Doc: DSOs can be a great opportunity to practice without having to own a business. They may not be for everyone, but I'm glad that I gave it a chance, and I may never want to leave!

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ORTHO CHAIRS

By Ron Sharpe

When I was growing up in Florida, there was a TV commercial with a tall, gangly man in an oversized suit, a heavy southern drawl, and hair constantly out of place. He used the pitch line “Tires don’t have to be sexy” and several times a night, on the local channel, we would hear why Tires don’t have to be Sexy to work properly, and the most expensive are not always the best product for your needs. It was an interesting way to get a message to their potential customers, and yet it held a great deal of truth in its simplicity. Just because it is expensive does not always make it the best product for your needs.

So, with that said, let’s talk Orthodontic Treatment Chairs. Like tires, not necessarily always sexy, but something that all orthodontist need every day in your practice. Also, like tires, orthodontic treatment chairs need to be put in place and just work, day after day, year after years, without you having to pay them a great deal of attention. And lastly, because most orthodontic chairs are purchased directly from the manufacturer, they can be less expensive than the standard dental chairs that you can buy through your local general dental dealer.

At the most recent AAO I walked the exhibit floor and counted more different types of treatment chairs then I have ever seen at an orthodontic meeting. It

looked a lot more like a general dental meeting than a specialty meeting. Indeed, competition can bring out the best of us, but are you as specialist being presented with the right products for your practice.

HOW MANY CHAIRS DO I NEED?

The easiest answer to this is as many as you can comfortable place in your space without compromising staff and patient flow. I worked with an office in New York City were the doctor only had two chairs because the cost of real estate was so high. Along that same line, I worked with a doctor in New Orleans that had a nice size office (plumbed for five chairs) but chose to work his entire career with two chairs in the orthodontic bay, and a single records/private room. His staff consisted of himself an assistant, and a front desk person. If you think about it, this is not a bad model. On the other end of this spectrum, I have worked with single doctor practices that have multiple offices with 8-12 chairs per office.

The reality is that most of the offices that I work with have 1 or 2 TC (Treatment Coordinator) rooms, and 5-6 chairs in an open/semi-open orthodontic bay. (I classify a semi-open as an orthodontic bay that has a divider wall/ panel between each chair.) This seems to be the most typical layout for a single doctor practice. When I work with two doctor practice, 8-10 chairs in the bay look like the magic number, with TC rooms increasing to 3.

WHAT IS AN ORTHODONTIC TREATMENT CHAIR?

Most chairs that are designed specifically for orthodontics will have a winged back that supports the majority of patients by capturing their elbows/upper arms keeping them close to the body and out of the way of both the doctor and the staff. They will also have a back that is shorter than a standard dental chair, allowing for greater access to patients of different sizes. They will have simple back up and down with some chairs adding a vertical up and down feature, and they will be constructed to endure the high volume of patients seen every day in an orthodontic office. Orthodontic chairs are a hybrid of the dental chair. The companies that specialize in building chairs specifically for orthodontics have spent a great deal of time designing these chairs to fit the needs of your specialty.

Patient comfort is always important and means the chair supplies comfort and support to not only the preteens but to larger teens and adults. This is tough in that if the back of the chair is too large, the smaller patients get lost and you constantly have the patient scoot up in the chair, or you are pulling them up to get their head into position on the headrest. And on the other side of the spectrum, if the chair is too small, your larger teen and adult patients feel like they are falling or hanging off the chair. Another thing to look at here is how the back and the seat sections of the chair align with each other while the chair is reclined. I have seen chairs that as the back reclines a gap is created between the back and seat sections creating the ultimate "Butt Crack." This pulls the patients into this crack and in many cases keeps them from proper positioning on the headrest. Your chairs should be designed to keep this crack to a minimum and allow for the patients head to comfortably fall back onto the headrest as the chair is reclined. Does this work with all patients, no, but with the right chair design the amount of scoot/pull should be minimized.

Patient comfort is always important and means the chair supplies comfort and support to not only the preteens but to larger teens and adults.

ORTHODONTIC CHAIR DESIGN

From the doctor/staff point of view, orthodontic chairs need to be designed to allow easy access to the patient. A nice thin back is a must, along with foot

controls that are out of the way when the doctor/staff slides under, but still allows for easy access when an adjustment of the chair is required. The chair needs some ability to adjust the height either manually or with a lifting mechanism. Also, realize that most chairs that are designed for orthodontics will have a shorter back and longer headrest adjustment than a regular dental chair. This allows for easier access to smaller patients but still allows for the larger teen or adult.

WHAT MAKES THEM MOVE?

Here is a big difference between General Dental and Orthodontics. Many modern day dental chairs are constructed with a combination of hydraulic pumps and springs. These have certainly proven themselves and for the most part are adequate. Orthodontic chairs, on the other hand, have maintained the use of electric motors. Electric motors have proven themselves over decades of use to be durable and long lasting. While most use a standard 110 Volt AC actuator motor, some of the more progressive manufactures have moved to the Low-voltage DC motors. The DC motors have been proven to provide higher lifting capacity and much quieter operation over their 110 Volt AC counterparts. My Recommendation here is to make sure and operate any chair you are looking at in a quiet location so you can hear the noise level. One of my favorite things to do was to sit on the back of the chair and see if the back motor would lift an adult.

FIXED BASE CHAIRS

Let's look at the different styles or looks of an orthodontic chair. The first being the standard Fixed Base (FB) Orthodontic Chair. This style chair offers a static height that in most cases can be adjusted to meet the requirements of the user. The back will move up and down, and the headrest will move in and out to adjust for shorter and taller patients. This is a great basic chair, and I have sold thousands of this style. They use a single motor, few moving parts, and can last for decades. The trick with this style chair is to make sure the height at which it is set is comfortable for you to do most everything you need to do. Failure to set your chair at the proper height will result in years of sore backs and frustration in not being able to see what you need easily. Don't be afraid to ask the chair manufacturer for either some way to lower the chair or raise it with some kind of spacer. Most manufacturers allow for this in their fixed base design. One more thing to consider when looking at FB style chair is the foot controls. Are they easy to access? You should not have to be lifting your foot up and turn it at an obtuse angle to move the back up and down. Most manufacturers offer a "Return to Home" feature even at this level of chair.

One of my favorite things to do was to sit on the back of the chair and see if the back motor would lift an adult.

LIFT BASE CHAIRS

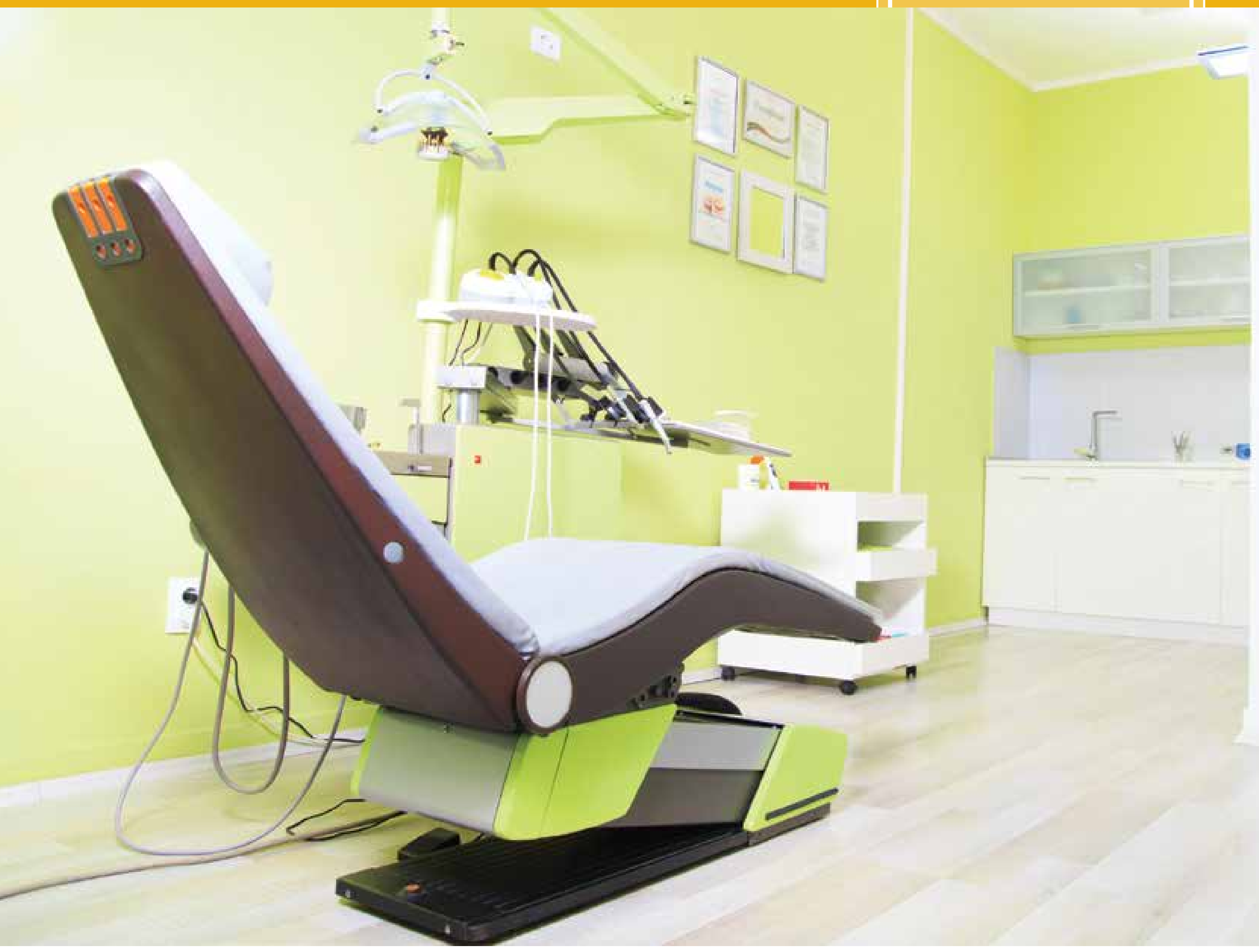
Your next option will be a Lift base chair. This style will have all of the features of the FB chair along with vertical movement of the entire chair top. This allows for greater flexibility of patient positioning. It also is awesome if you have a big variance in the size of staff. A tall doctor and shorter staff will need the flexibility of a lift base chair for proper positioning. These chairs are more expensive, but in the long run, may prove to be not only more comfortable for doctor and staff, but more efficient as well. As I look at trends, one of the bigger ones is a move to more offices going to the lift base chairs. Once again, look at the foot controls. Make sure they are easy to access and use.

DROP TOE CHAIR

While not really different in function, several manufacturers offer a Drop Toe or Knee Break version of the orthodontic chair. These are available in both the Fixed Base and Lift Base versions but offer additional benefits to the office. These are used a great deal in both the TC rooms and in Records. The advantages they offer are with the toe down; it is a much more comfortable "seated" position with their legs down, rather than the patient having their legs extended out in front of them as in a standard chair. Also, this style chair offers greater access from directly in front of the patient for taking pictures. You don't have to move the patient to a different straight back chair, or lean in from the side to get the pictures you may want for records. For the TC Room, this Drop Toe Option uses a smaller foot print when it is in the home position thereby giving the perception of a bit larger room without compromising function. With the Drop Toe Chair, the back of the chair and the toe section are linked together. Therefore as the back is reclined, the toe section comes up and you basically end up with the same positioning and comfort as you would have with a standard chair.

RECORDS ROOM

While the Drop Toe Chair just described is very useful for records, the Records room may call for a very particular and upright chair. There are a couple manufacturers that offer a true upright "Barber Style" chair for the Records room. This chair will also have the drop toe, but is designed to use the majority of the time in the upright position. Reclining this style is done manually. The advantages are this style chair offers a very small foot print and comes with 360 of rotation.



CHAIR OPTIONS AND ACCESSORIES

PROGRAMING

Several companies offer as an option the ability to set programed positions. This allows for the use of a single button to have the chair to a preset position. Programing is great in really busy offices so that when the doctor is coming to a chair, the assistant can touch a button and the chair will go to a preset the doctor is comfortable with. With multiple presets, the you can save positions for multiple doctors, upper and lower arch, for the doctor and the assistant, whatever may work best in your office.

HEADREST

Here is where your preference really is tested. Most manufacturers will give you a varied selection of standard headrest options. The one I asked about the most is the Ponytail slot or hole style headrest. Yes, it allows for the patients head to lay flatter but there is the downside that this hair has to go somewhere and it may end up in your lap. I recommend the "V" style headrest that allows for room for hair but keeps it off you or your staff. Take a look at all of the options. Sit in a chair and have them put each headrest on the chair so you can feel how comfortable they are for the patient, and then switch to see the access each headrest provides for you.

While it is the total package that makes an orthodontic chair good, it is the headrest that can make a chair great. The entire reason for having a chair is to comfortably position the patients head/mouth for easy viewing and access.

ARTICULATING HEADREST

The articulating headrest can really expand your access. Articulate the headrest back and you can open your field of view in a hurry, and because of this increased access, some doctors and staff find this to be a more affordable option to adding the lift base option to a chair. The articulation needs to easy to access and allow a great range of positioning.

UPHOLSTERY

Dental manufacturers as a whole use commercial grade fabrics for their chairs. While there are several different grades, finishes, colors, and patterns, they should all last easily 5-7 years with no excessive wear problems. I like to recommend that the upholstery be changed every 7-10 years. Most manufacturers will have an option for you to recover or replace the upholstery. There are also companies around the country that specialize in the re-upholstery of medical and dental equipment. You can usually find these by a quick search of the web.

UPGRADED FOAM AND UPHOLSTERY

There are companies that offer an upgrade to the foam and fabric of their chairs. This can add a real upgrade to the level of comfort of the chair, but at a price. I recommend this upgrade in the TC room as that is the first impression a potential client is going to have. Any advantage you can garner by offer an extremely comfortable chair as a first impression is well earned.

ORTHODONTIC CHAIR CONSTRUCTION

The construction of your chairs is vitally important. While many Dental Chairs will use a light frame with and overlay to support the upholstered sections, orthodontic chairs are built to handle the high work load and years of use they will see. Steel is of course extremely strong and will last for decades. Steel frame chairs usually have upholstery that either clips on or bolts onto the steel skeleton like frame. This can allow for a thinner look and greater access to the patient. A steel frame chair will give you decades of use, and even as the upholstery and actuators wear out and are replaces over the years, the frame will live on.

There are a couple manufacturers that use a Tumble molded plastic structure for the support of the upholstery. This molded plastic is usually mounted on a steel base and ends up with a thicker look. To compensate for the thicker look, the upholstery on this style chair is usually a thin pad that has the option of being flipped over for extended use.

Aluminum is also making a presence in the construction of treatment chairs and in a couple of different ways. Incredibly I have seen chairs that use aluminum frames that are not much more substantial than a folding beach chair. While this may keep the cost down, you should not expect these to last. I have also seen aluminum used in a casting that create a solid frame and clean look that will certainly give you years of wear and tear.

And, as important as anything else, is the company you are purchasing the chairs from a company that you feel comfortable working with.

You will also see chairs constructed of sheet metal. While a very cost effective way to manufacture chairs, it is probably the most difficult to determine the quality of the product just by looking. As you can imagine, sheet metal can come in different thicknesses, and how the edges are folded or bent can actually add to the strength of the final product. Really take a good look at this style of construction to insure you are getting a product that will last for several years.

Let's not forget or past, historically, chairs were constructed using both a wood frame and base. These had lots of foam and looked really bulky. But, the truth is I was in an office last week that was still using this style chair and the doctor loved them. One of the advantages of this style was they came with motors that just could not be beat. These older style motors (they just don't make things like they use to) just ran, and if they did go down, in many cases they could be repaired rather than replaced.

When it comes to the finish of the frame of the chair and the base of the chair, most manufactures have moved to Powder Coating their metal surfaces. This is a process of spraying the metal with a powder and then baking it onto the metal forming a bond that is much stronger the paint can provide. This process should give you years of wear and tear without ever rubbing the finish off the frame or base. I highly recommend that you verify that all surfaces are treated with this process, and you don't end up with an untreated metal surface sitting on your flooring surface.

THE BOTTOM LINE

Talk to your contemporaries, ask them what they are using and what they like and dislike about the product. Think about how you want to work and how you want to position the patients you are working with. How much adjustment do you need in your chair, and how different is your body style versus that of your staff. And, as important as anything else, is the company you are purchasing the chairs from a company that you feel comfortable working with. You will have a relationship with this company for years to come, and you need to feel they are going to do what is realistic and reasonable to help you take care of your product.

So while orthodontic chairs don't have to be sexy, they do have to work, and work, and work. Take your time and really look at the quality of the construction of the chairs and the level of service provided by the company you are considering.

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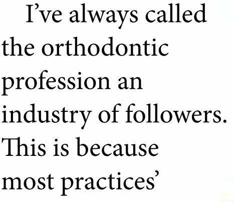
SPECIALIST GOGGLES

By Jeff Behan

Something I've noticed in my work with orthodontists over the years is that they all tend to view the world through something I like to call "specialist goggles." These little ocular wonders are a lot like loups. They do allow the wearer to see a small area clearly, but everything else gets blurred beyond recognition. While it's appropriate to put loups on to perform specific tasks, they're not helpful in seeing the big picture, understanding what's going on around you and moving around without stumbling and falling.

Many doctors, perhaps even you, approach their marketing and practice development through the lens of their specialist goggles. They spend all their time and energy selecting, paying for and implementing various programs without considering how things at the programmatic level relate to their mission and vision (if they even have one), their strengths and weaknesses (and everyone has both of those), and their particular competitive landscape.



I've always called the orthodontic profession an industry of followers. This is because most practices' marketing programs consist of monitoring what other orthodontists are doing (including their closest competitors) and then copying that. Maybe it's not intentional. Maybe it's not even a conscious activity. But it's very common. Today, most practices are fixated on their search rankings. Search is incredibly important because it represents people who are ready to buy. However, too many practices throw all their attention (and budget) at showing up in search without understanding that only targeting people who are ready to buy means a last minute fight to win the consumer on a battlefield of look-alike providers. Does your plan include strategies to win their hearts and minds before they search? Strategies, you say? "We don't need no stinkin' strategies!" Uh, yeah, you do.

Things like growing the practice by 20%, being known as the practice that cares for your community and delivering an amazing customer experience every day are all great strategic initiatives, but they're theoretical, descriptive and broad. If you're going to realize them, you need tactics that support these goals. You won't achieve these goals by fixating on your search rankings. But you will improve everything, including your search rankings, by implementing tactics designed to support these strategies. Then, when your target consumer is ready to buy and enters the fray we call "search," you'll stand out from the orgy of choice they'll find there. Heck, they'll even search for you by name.

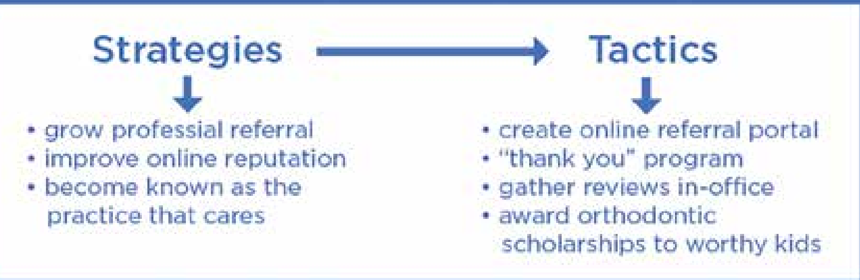
Tactics are operational, specific and detailed. These are the "how" for the strategic goals you've embraced. The main tactical areas in Orthodontics are:

- ►Direct, relationship marketing
  - ►professional and patient referral
- ►Online media marketing
  - ►The website, social media, search, reviews/listings
- ►Advertising
  - ►print, venue, mail, web, radio, television
- ►Community/Event Marketing

Most of the practices I engage with are implementing tactical programs without awareness of how those programs fit into the bigger picture. They've garnered a sense of what is working for other doctors and, based solely on that, decided they should do the same thing. If they're lucky, it will work for them too, but very often those programs have a doctor with a big personality and a spectacular, engaged team involved in the implementation - and those are the key elements to success. So a different team, implementing the same program, can fail miserably. That's what often happens when you start without tying tactics to strategies and understanding every person's role in delivery.

Here is a very simple look at some useful strategies and some of the tactics they suggest.

Every one of the tactics in the list above was thought up by a leader; someone who stands out in a sea of followers. Today, hundreds of practices try to implement them with team members who don't understand how they (the tactics) or they (the team member) fit into the bigger picture. Even worse, they invest in programs designed to help them improve in an area where they're already performing well. Just yesterday, a client informed me that they had signed up for a program designed to improve their search rankings by getting them lots of reviews. The practice is already at the top of the 3-pack, and organic search already has plenty of reviews and a 5-star ranking. Unfortunately, all they're focused on is search and the fear of someone else moving up in the rankings. I'd rather see them focus their dollars on other strategies, but through their specialist goggles, they couldn't see the bigger picture, and there are always vendors ready to take advantage of that.



Let's take one strategy, improving online reputation, and see how the strategic approach moves you from broad concept to specific implementation:

It is important to note that you can do all of the above and still have a mediocre online reputation. If that's the case, you'll need to consider the role of your team (and yourself) in the patient experience. If you don't run on time, you're at risk of people talking about that online. If you have a team member who suffers from permanent bitch face (that's a real thing!), you're at risk. You get the picture. My point is that simply buying into a program because it works for someone else won't necessarily make it work for you. Plus, doing anything without your delivery channel (your team) understanding both the "how" and the "why" never yields the best results. You may be tempted to implement a program that helps you "filter" negative reviews before they get posted online. I wouldn't blame you for doing that, and have even recommended it to some clients, but don't think it gives you a pass on actually delivering a great patient experience.

Hopefully, most of you know what the "Take a NAP Initiative" in the chart above is. It's just what I call getting your online listings claimed, cleaned up and optimized. Your NAP is your Name, Address, and Phone number. A critically important initiative because as search engines give more weight to the location of the searcher in determining which results to load, those listings (and there are over 60 that are worth including) are the basis for being found. They are also the platform for patient reviews.

Before embracing any tactical level practice development initiative, ask yourself the following questions:

- ►What am I trying to accomplish (strategy)?
- ►What does my target need/want?
- ►What is an appropriate budget?
- ►What is the competition doing?
- ►What is the call to action?
- ►When is the best time to do this?

I think it's always a good idea to get help from an informed, outside source to help you remove your specialist goggles and build a big-picture marketing program. But even if you don't, if I've encouraged you to approach your practice development and marketing decisions in a more strategic way that's a good start.

One final note is to make sure you measure everything you're doing. Otherwise, you won't be able to refine your program; dropping some initiatives and tweaking others to maximize your return. The alternative may leave you quoting the last seven words of every failed business, "That's the way we've always done it.

EXPAND YOUR *mind*

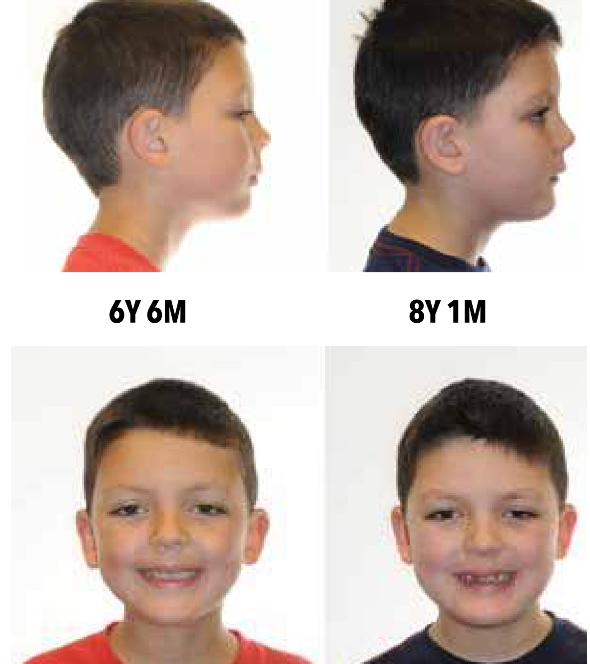
By Dr Derek Bock

Having a symbiotic relationship with a pediatric dentist has many benefits; both in business and patient care. Most orthodontists have been classically trained, where we kick the can down the road for comprehensive treatment and avoid 2-Phase treatment like the plague!! This is due in part to limited research on the benefits of early treatment modalities, and partly due to the antiquated mindset and clinical dogma that is so pervasive amongst those who teach us. I'd like to present a case that should challenge your established mindset on early treatment, and hopefully, peak enough interest for you to explore this space in our profession where the most potential life impact exists!

SUMMARY AND DIAGNOSIS:

- 6y6m Caucasian male on initial presentation
- 8y1m when we initiated treatment
- Diagnosed Sleep Apnea via two sleep studies
  - o Tonsil and adenoid removal at five yrs of age
  - o Still apnic per the 2nd sleep study
- Class II Skeletal Relationship
  - o Mandibular retrognathic with strong pogonion camouflage
- Maxillary constriction with high palatal vault
  - o Maxillary intermolar distance 31.3 mm
  - o Obligate mouth breather
  - o Low posterior tongue posture

PHOTO SERIES TIMEPOINTS:	DATE	AGE
1. New Patient Exam:	6-21-2012	6y 6m
2. Initial:	1-28-2014	8y 1m
3. Expander Delivery:	2-12-2014	8y 2m
4. Expander removal/bonding:	10-28-2014	8y 10m
5. Progress:	2-16-2015	9y 2m
6. Progress:	5-6-2015	9y 5m
7. Final:	7-27-2015	9y 7m
8. Retention Observation:	3-22-2016	10y 3m



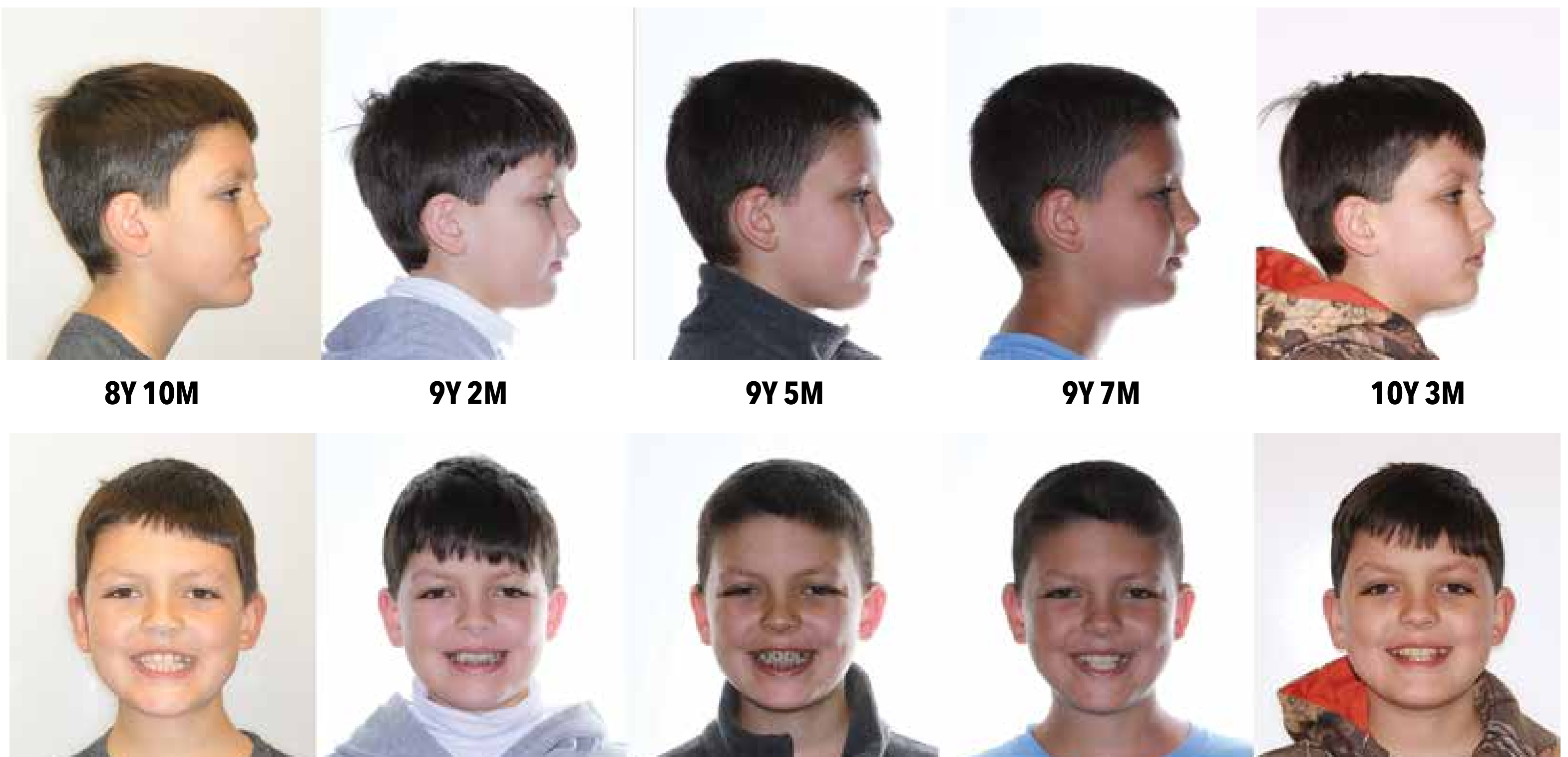
OBJECTIVES:

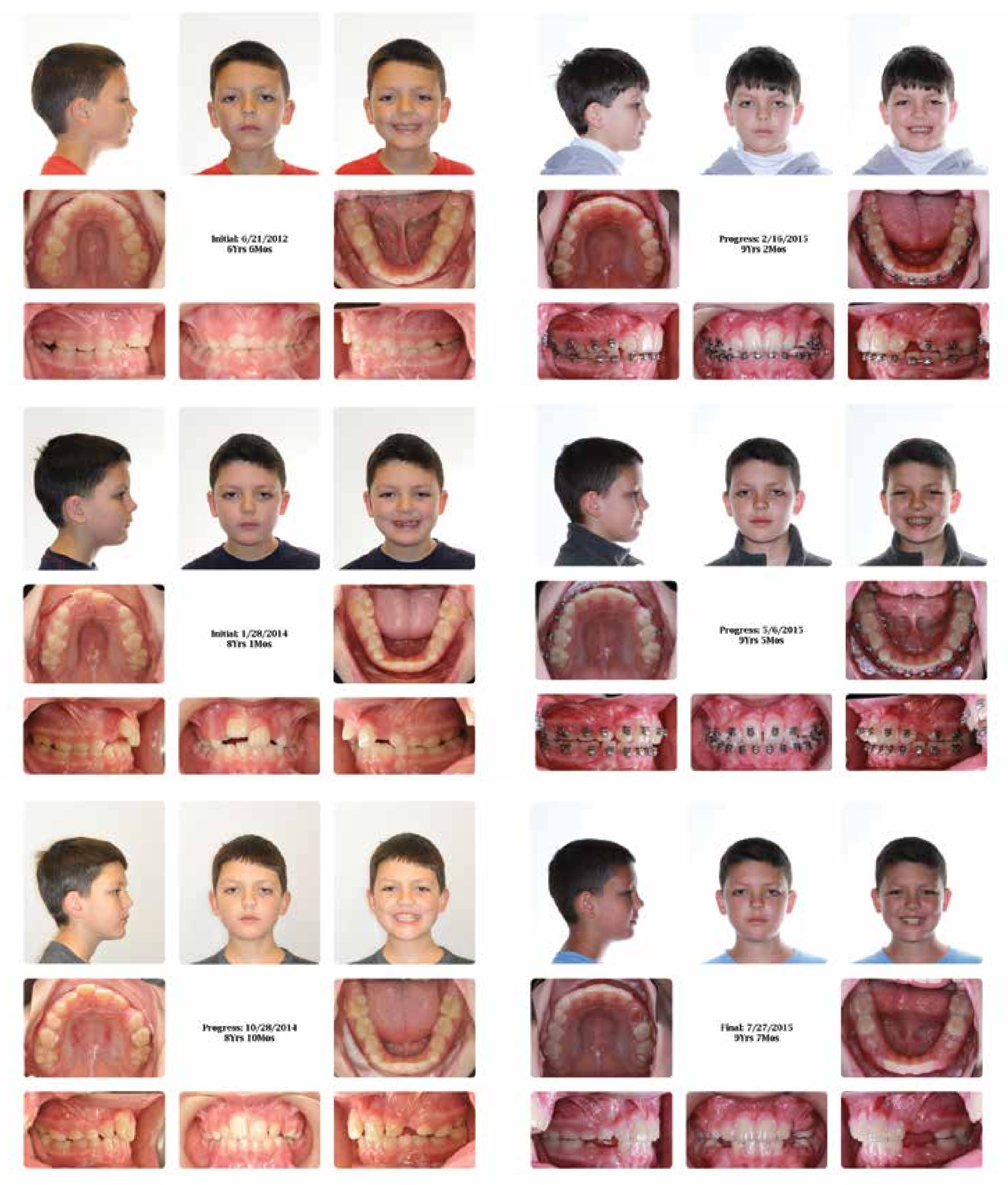
- Significant maxillary expansion for:
  - o Airway demand
  - o To help create arch-length
  - o To allow full mandibular curve of Wilson decompensation
- Arch development to aid in future maxillary and mandibular dentition eruption
- Idealize incisor torque during arch development to reduce Phase II needs/complexity

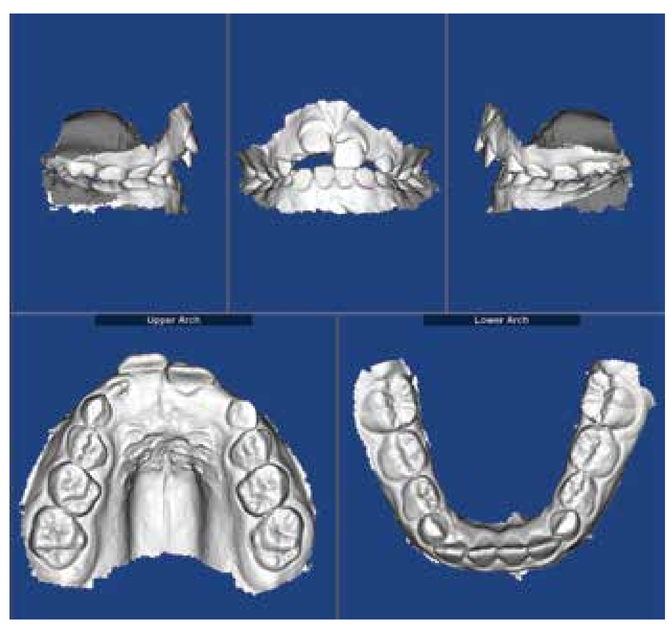
GENERAL MECHANICS:

The patient was 6-years old when he initially presented to the office for an orthodontic consult. He was placed in our observation system to wait for the development of maxillary and mandibular incisors. Treatment was initiated with a Haas RPE that contained a 12mm screw. Initial turning instructions were 1x/day for 4wks. There was a 12-week consolidation phase, during which the normal force of occlusion began to flatten the curve of Wilson. Turns were restarted at this point for 1x/day for 3wks to max out the screw. The patient was reappointed for expander removal and full extended bonding with open coil PSL mechanics. Standard torque maxillary and low torque mandibular Damon Q PSL brackets were utilized. The patient had a normal arch wire sequence for my practice; .014CuNiti, .018CuNiti, 14x25Cuniti, 18x25CuNiti. Final arch wires were 19x25ss in the maxillary arch and 17x25ss in the mandibular arch. Prescribed retention was removable maxillary and mandibular Hawley retainers with 2-2 labial bows and adams clasps on the 6's.

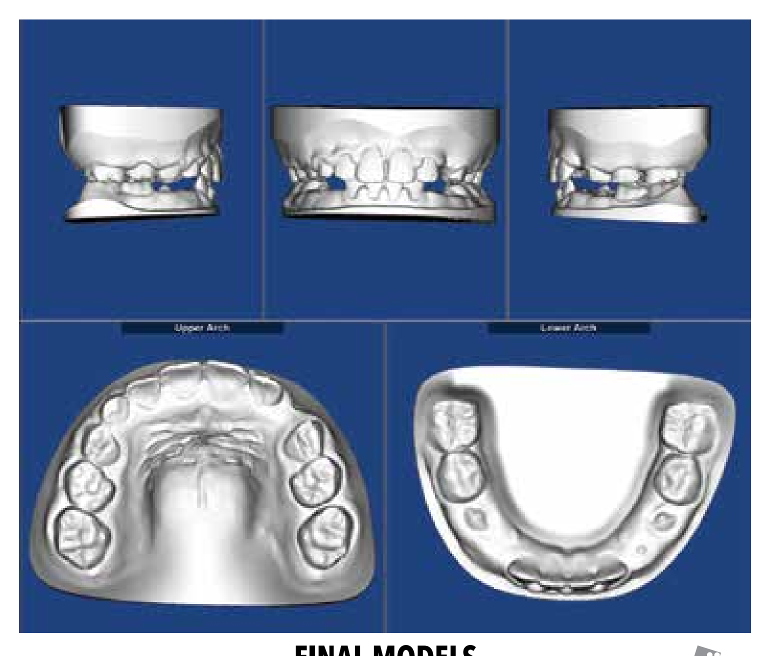
Compare the serial records and measurements and look at the positive impact that we achieved for this young man in a relatively short amount of time with minimal clinical effort. There's an entire segment of the patient population that could benefit from relatively straight forward Phase I treatment with skeletal expansion and arch development. This treatment shouldn't be taboo just because it's not well documented in poor study design. For more Radical Phase I treatment modalities, come over to my group; www.facebook.com/groups/PragmaticOrthodontics. We can explore this case in detail, along with all the other cases that are posted on a daily basis.




Initial: 6/21/2012
6Yrs 6Mos
Progress: 2/16/2015
9Yrs 2Mos
Initial: 1/28/2014
8Yrs 1Mos
Progress: 5/6/2015
9Yrs 5Mos
Progress: 10/28/2014
8Yrs 10Mos
Final: 7/27/2015
9Yrs 7Mos



INITIAL MODELS



FINAL MODELS

INFECTION PREVENTION

By Andrea Cook

Sterilization is a complex process requiring specialized equipment, adequate space, qualified dental health care professionals trained continually with regular monitoring for quality assurance.

Guidelines for Infection Control in Dental Health-Care Settings --- 2003

This quote from the current CDC guidelines leaves many of our offices struggling with understanding and gaining compliance. Infection prevention and instrument reprocessing are certainly not as fun and exciting as a new cone beam machine, but it is one of the most critical areas of the office. An increase in unannounced inspections has led many offices into implementing changes and protocols to gain compliance.

Clinical team members are often not trained in the systems, processes, and protocols with which they must comply. Many times I see team members following sterilization protocols that are not based on regulations but based on what the last team member did. Even if they are knowledgeable on the current regulations, the busy pace of our offices can make achieving compliance a challenge for the best team. Most often non-compliance is due to staff turnover and new team members not being fully trained ~ employees are simply not aware.

Here are recommendations based on the most frequently asked questions by the clinical team as I travel to orthodontic offices across the county:

ALL STERILIZERS MUST BE TESTED ON A WEEKLY BASIS

Correct functioning of sterilization cycles should be verified for each sterilizer by the periodic use (at least weekly) of Biological indicators (BIs) (i.e., spore tests). Test strip should be placed inside the package.

CDC guidelines, 2003

> *When sterile items are open to the air, they will eventually become contaminated. Storage, even temporary, of unwrapped semicritical instruments, is discouraged because it permits exposure to dust, airborne organisms, and other unnecessary contamination before use on a patient.*

RESULTS MUST BE RECORDED AND KEPT IN THE OFFICE

Results of biological monitoring should be recorded and sterilization monitoring records (i.e., mechanical, chemical, and biological) retained long enough to comply with state and local regulations.

CDC guidelines, 2003

POUCHES

Pouches must be folded along the perforation when sealing to ensure proper seal forms. Do not fold the pouch further down and seal.

INSTRUMENT RINSING

After cleaning instruments, use water to rinse chemical or detergent residue.

CDC guidelines, 2003

TRANSPORTING CONTAMINATED CRITICAL AND SEMICRITICAL PATIENT-CARE ITEMS

Contaminated instruments should be handled carefully to prevent exposure to sharp instruments that can cause a percutaneous injury. Instruments should be placed in an appropriate container at the point of use to avoid percutaneous injuries during transport to the instrument processing area.

CDC guidelines, 2003

STORAGE OF UNWRAPPED STERILIZED INSTRUMENTS

Semicritical instruments that are sterilized unwrapped on a tray or in a container system should be

used immediately or within a short time. When sterile items are open to the air, they will eventually become contaminated. Storage, even temporary, of unwrapped semicritical instruments, is discouraged because it permits exposure to dust, airborne organisms, and other unnecessary contamination before use on a patient.

CDC guidelines, 2003

HANDPIECES

For processing any dental device that can be removed from the dental unit air or waterlines, neither surface disinfection nor immersion in chemical germicides is an acceptable method. Dental handpieces and other intraoral devices attached to the air lines and/or waterlines must be sterilized using heat.

CDC guidelines, 2003

DENTAL HANDPIECES AND OTHER DEVICES ATTACHED TO AIR AND WATERLINES

Dental devices connected to the dental water system and that enter the patient's mouth (e.g., handpieces, ultrasonic scalers, or air/water syringes) should be operated to discharge water and air for a minimum of 20--30 seconds after each patient

CDC guidelines, 2003

DENTAL UNIT WATER LINES

Only using source water containing <500 CFU/mL of bacteria (e.g., tap, distilled, or sterile water) in a self-contained water system will not eliminate bacterial contamination in treatment water if biofilms in the water system are not controlled. Removal or inactivation of dental waterline biofilms requires the use of chemical germicides.

CDC guidelines, 2003

SINGLE USE/DISPOSABLE ITEMS

A single-use device also called a disposable device, is designed to be used on one patient and then discarded, not reprocessed for use on another patient

CDC guidelines, 2003

Your state may have additional regulations with which you must comply.

Offices can access resources designed to help them follow infection prevention guidelines thanks to new materials released March 29, 2016, from the Centers for Disease Control and Prevention. The CDC released a document entitled Summary of Infection Prevention Practices in Dental Settings Basic Expectations for Safe Care and Companion Checklist.

• http://www.cdc.gov/oralhealth/infectioncontrol/guidelines

This report summarizes existing recommendations to make them much easier to understand and use in all dental settings including our orthodontic practices. The Summary focuses on standard precautions and the foundation for preventing transmission of infectious agents during patient care. The Summary is intended to supplement the existing CDC recommendations, not replace them.

WHAT THEY ARE:

Basic infection control expectations for providing safe dental care

Based on the principles of Standard Precautions and CDC's Guidelines for Infection Control in Dental Health-Care Settings–2003

Companion to CDC's Guidelines for Infection Control in Dental Health-Care Settings–2003

WHAT THEY ARE NOT:

Replacement for the current CDC Guidelines contained in Guidelines for Infection Control in Dental Health-Care Settings–2003

This resource includes tools to help our team members follow infection prevention guidelines. These include:

►a summary of basic infection prevention principles and recommendations for dental settings

►a checklist to evaluate dental staff compliance with administrative and clinical practice infection prevention recommendations

The emphasis is the importance of having one individual in every dental practice assigned to be the infection prevention coordinator. That person would be responsible for developing written infection prevention policies for the practice based on the current standards. The infection prevention coordinator would also ensure that the practice has the needed equipment and supplies required for adherence to standard precaution practices and communicate with all team members to address infection prevention issues.

If the answer to any of the applicable questions is no, efforts should be made to determine why the correct practice was not performed, remedy the practice, educate the team member, and reassess the practice to ensure compliance.

INFECTION PREVENTION COORDINATOR ROLE IN YOUR PRACTICE

►Review existing policies and standard operating procedures

►Identify gaps and outdated information

►Develop written infection prevention policies and procedures

►Act as a resource for the rest of the team or organization

►Maintain related permits, licenses, and other documents

►Provide training and education related to infection prevention

►Monitor compliance through observations, checklists, and other methods

►Evaluate current systems

►Immunization of the team

►Occupational exposure to infectious materials

►Post-exposure management

►Hand hygiene procedures

►Use of PPE

►Monitoring the sterilization process

►Evaluation of safety devices

►Dental unit water quality

The infection prevention checklist is a companion to the Summary. It can be very helpful to make sure your office has appropriate infection prevention policies and practices in place. This should include adequate training and education of your team on infection prevention practices and proper supplies to allow them to provide safe patient care and a safe working environment.

Filling out the checklist will help your team assess your current compliance. Also, this will identify procedures and protocols that If the answer to any of the applicable questions is no, efforts should be made to determine why the correct practice was not performed, remedy the practice, educate the team member, and reassess the practice to ensure compliance.

Although the principles of infection control remain unchanged, new technologies, materials, equipment and data require continuous evaluation of current infection control practices. The unique nature of many orthodontic procedures, instruments, and patient care settings also may need specific protocols to aid in preventing disease transmission among doctors, team members, and their patients.

To help offices gain compliance, I have developed a written job description for the infection prevention coordinator as well as written infection prevention policies for today's orthodontic practices. Please contact me to help you and your team implement the new CDC Safe Patient Care Guidelines into your busy practice.

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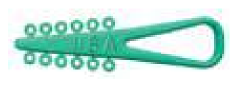

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QUESTION FROM A READER

I had a fantastic FB messenger conversation the other day. Inspired, intelligent questions make for the best insight so I thought I would share, with Haidee's permission. Enjoy!

Haidee Henderson Cline: Ben, I saw you wrote for SmileDirectClub. Matt reviews cases for them and, despite my being open to industry innovation, I find this service in particular is doing harm. They are going with "the customer is always right" allowing them to request and dictate treatment. Their form has a checkbox for "do you want IPR". Of course no one wants it!
I really love reading all of your work, but I sometimes wonder if you are of the mindset that the Ortho specialty has lost its value? I am not being combative, I'm genuinely curious if that is your leaning now?
He what do you think about botched work that orthos frequently fix? At least that is Matt's experience. I feel like the Ortho is becoming like Botox in nail salons. You can get it done, and it might work, but you might also get a jacked up eyebrow. Hope you are well. Nice to meet you and your family in Vail.

Ben: Well, I dropped my specialty license and am a general dentist in Arkansas so I think I'm being very consistent in my position. SDC patients do not overlap with traditional Ortho patients. We know this because zero type c cases end up at an Ortho office. I am pushing SDC to say, "if you can afford an orthodontist then go see one". SDC is for people who cannot get any care otherwise and better is better. I'm a hard core access to care guy. I'm very consistent on this point. Orthodontists are not willing to do what it takes to educate the public about what we do as a group or individually. Therefore we are doomed as a specialty. I'm just an early adopter of the coming reality. Read The Innovator's Dilemma and you'll understand SDC. Thanks for reaching out. I appreciate the interaction and love when people question what I'm doing and why.

Haidee Henderson Cline: I've read it! My background is business strategy helps me see what's coming, or at least what I think is coming. I tell Matt to watch out about Invisalign. With SDC doing what they are doing, and branching out to brick and mortar, if they start infringing on Invisalign, align tech will go the same route. Nothing to stop them. That is one big reason our strategy for our Ortho practice is kids...the market that probably won't be fragmented to the other services. Unless of course GDs convincingly and successfully start doing Ortho. Oh wait....

Ben: I'm betting align and SDC will be on the same team before its all over with.

Haidee Henderson Cline: And if they can sign up virtual clinchecks they won't need practices for distribution. You'll be able to get aligners at a kiosk in the mall or maybe even your hair salon!

Ben: I've been saying that for years.

Haidee Henderson Cline: I keep saying that unless botched work becomes common place, nothing will change. And if botched work doesn't become commonplace, then what's the problem?

Ben: We are chickens http://orthopundit.com/r-i-p/

Haidee Henderson Cline: Thanks for the link. But are u suggesting or predicting that GDs can quickly get the training necessary to treat kids and adults who need advanced work?

Ben: I'm suggesting that if plastic surgeons didn't do a good job of educating people about why they should see a plastic surgeon that PCPs would be doing cosmetic surgery

Haidee Henderson Cline: Last question... genuine curiosity...you went to Ortho residency for how many years? 2 or 3? Was it full time? Do you believe the knowledge and expertise you gained there could be gained through CE? Or do you believe the 2-3 years of training aren't necessary for quality Ortho treatment? I got an MBA and went full time for 2 years. If someone asked me if I thought it was worthwhile I would say yes, but apparently an Executive MBA done on weekends for a year accomplish the same goal. However, I wasn't learning to move teeth inside a jawbone. My specialty can be learned in weekends. Can quality Ortho?

Ben: I went for three years and started a ton of cases – more than anyone who graduated in the years before or after that I know of – and finished a bunch of those plus took on every transfer case I could get my hands on. Still didn't know crap coming out of school. Learned how to practice from Dwight Damon, David Sarver, Terry Dischinger and doing. I don't think CE would be easy but you probably could. I know you could work for a busy orthodontist for a year or two and be better than someone out of residency.

FROM ACTIVE WIRES TO PASSIVE INCOME

By Dr. Aly Kanani & Dr. John McManaman

The financial burden on a newly qualified health care professional is tremendous; having spent the first 30 years of their lives in training to become a professional. Spending money on university education and professional school, individuals will say lot of money must be spent by health care professionals before they are allowed to earn any back and the first dollar earned is already spent on debt repayment. Educational debt for professionals in dental fields in particular can run into the hundreds of thousands of dollars. Next, the dental professional has to take on more debt to establish their business through opening a dental or orthodontics practice as it is most common for doctors to work for themselves.

Since self-employed dental professionals only get paid when they are working they take loss in wages whenever they take time off for any reason including being sick, maternity leave, or disability. The idea and purpose of being a dental professional may be attractive to some who have qualified as dentists but the lifestyle of long hours and little time off rarely offers the same appeal.

With this in mind it is clear that the financial stability of many dentists and

Looking for financial security is something which is as important during the lifetime of the practitioner as it is to them to leave behind for loved ones.

orthodontists in particular could be described as precarious at best. There are many factors that could result in less than favorable income for the dentists and dental specialists in particular who spent years and hundreds of thousands to gain qualification. The best advice that can be given to dentists and dental specialists who are in this situation is to diversify their income. This advice in fact is valuable to any person but has proven to be especially helpful for professionals who have debt at stake and are being challenged in an ever changing dental marketplace. Passive income streams can be gained through proper mentorship by investing in real estate or even in other businesses outside of health.

Creating passive income streams will allow any dental practitioner to know that they and their families are financially covered in case of illness or disability. Perhaps most importantly, diversifying into passive income streams such as real estate for dentists and dental specialists allows the individual to determine the quality of life they want and not be forced to work all hours to pay for the loans taken out, stress over increased competition and changing market pressures that could drastically impact their income.

Looking for financial security is something which is as important during the lifetime of the practitioner as it is to them to leave behind for loved ones. In this sense it is not advisable to concentrate on topping up pension funds with the above average money earned in a private practice. As many investors know, property is a sound investment as it is something which will always be there and cannot be lost by an economic upturn or a physical disability.

Being able to profit from alternative and dependable income streams will allow options in the future and the freedom to follow an alternative path should the person determine that they would prefer not to continue in their clinical practice and retire early. There are many uncertainties in life and the best way to defend against financial loss is to create alternative streams that are not dependent on one another.
If it was always in the plan for the dental professional to sell their clinic at retirement age, it is worth knowing that the value of the business would be exponentially increased through owning the office building outright.

The largest assets most health care professionals have are their homes and their businesses. While it is likely that a family home is passed down through inheritance to a person's children or beneficiaries it would be unlikely that a dental practice would be unless the successor was also a dentist or dental specialist. One primary investment that is advantageous to dental professionals who have started their own practice is to purchase the building in which the practice is located and as such become the anchor tenant. A steady income stream can be derived from renting out the rest of the building and when death does occur there is an asset retained from the business to pass along, allowing the family beneficiary to continue to profit from the rental stream or sell the building entirely. Considering that rent on the office would have to be paid to someone it is better for the long term beneficiary of these payments to be the health care professionals themselves.

Getting started in diversifying income streams away from active income into several passive income streams must start by taking the time away from the dental office to weigh up options and put actions into place. We suggest to begin by taking a half day to one or two full days off from actively working in the practice to concentrate on working on the practice. By breaking the pattern of working all the time in the clinic you will be diversifying your interests and have time to implement step by step changes.

Other real estate focused passive income streams that could be of interest to any health care professional operating their own clinic is investing in a business that is outside of the health care industry. This can be facilitated when the practitioner owns the property their unit is contained within and another, or a few, units are still available for rent in the building. Of course, investment in any business is possible but if it was contained within the building the clinic was in which the practitioner owned it would be easier to monitor the ongoing progress of the business.

Any of the above circumstances would not be good considering that most people accrue debt in relation to their projected future income streams, so if the practitioner's sole income stream decreases there has to be another way of thriving while comfortably covering the debt.

The idea of decreasing reimbursement is a very valid threat as competition has already and will continue to put significant downward pressure on fees and for the fact that many dentists and dental specialists rely on payments set by insurance carriers relating to any specific service and when decreases happen it can greatly change the income stream. The possibility of a mental or physical disability becoming an issue in a dentists career would also play havoc to their active income stream.

Any of the above circumstances would not be good considering that most people accrue debt in relation to their projected future income streams, so if the practitioner's sole income stream decreases there has to be another way of thriving while comfortably covering the debt. We would always recommend speaking to tax attorney, there may be the additional benefit of lower taxes and different tax strategies in earning passive income streams versus active streams. By creating more streams of income to ensure that a legacy is left for beneficiaries in the event of a death it is possible to decrease the spending on insurance since there won't be the same need for life insurance coverage to ensure the stability of the health care professional's family after their passing.

Important to any person is quality of life and the opportunity cost in having time to pursue interests while working in a profession that was chosen but which is hectic with high volume and long hours cannot be understated. Beyond that, uncertainty in the future stability of the clinic or the practitioner's ability to continue practicing means that there are several reasons why it is important for a health care professional to diversify their income and seek to reduce the reliance on their active income streams through creating strong passive income streams such as through purchasing real estate.

It is never too early to be concerned about the path to financial independence, especially for health care professionals who, by nature of the profession, start their career with huge debt. Take the first step, get good mentorship, speak to people whom have done it already, surround yourself with like-minded professionals and teams of like-minded advisors, and make time to consider your options today.

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A FEW THINGS I WISH I KNEW WHEN I WAS A YOUNG DOC

By Dr. Courtney Dunn

1.) PRACTICE WHERE YOU ARE NEEDED

I was in dental and orthodontic school at a time where students were mesmerized with tales of young dentists moving to wonderful places and making more money than we even thought was possible. We heard of successful young doctors paying off practice loans years ahead of schedule and orthodontists with months long waiting lists of new patients. The predominant message to us was all you have to do is practice where you want to live, treat people well and you will become a huge success. The docs telling us these stories were trying to give us good advice, and for a while, it was probably true. But, when the economy tanked, those of us who picked a location based on awesome weather, family proximity or general lifestyle experienced a jolt of reality. Those outliers who ignored conventional wisdom and found a location that actually needed an orthodontist had a much easier time.

I can't imagine the message to current orthodontic residents is the same as it was when I was a student, but I still consistently run into people who are looking to practice in the most saturated areas in the country. I actually know orthodontists whose practices are growing at such a high rate that they desperately need associates, but can't convince residents to come to their area. They complain about "wining and dining" future prospects and speak of new grads actually turning down very high salaries because of location. Why do people insist to work harder to make significantly less money? You will have a much easier time in business and life if you can find a place that needs you. And if you end up in a less than ideal location – travel often. You will have the money to go wherever you want - and probably in the first class cabin.

2.) THE REAL WORLD IS REALLY, REALLY DIFFERENT

As orthodontic residents, we live in the bubble of academia. Orthodontic residents are astute enough to realize that the real world is different, but they aren't quite aware of how different. Residents feel that we get a glimpse of the world with the part time faculty sharing their experiences. This will vary greatly depending on who the part time faculty actually are. As I was educated in the Midwest and shadowed some part time faculty in their Midwestern practices, I had a feel for how I was going to run my practice. When I selected a large urban area in the Southwest to practice, I quickly realized those Midwestern rules didn't apply and I needed to adapt to a different professional culture.

> *Keep your ears open and learn as much as possible. You may think you know it all, but you don't know what you don't know.*

Secondly, in the real world patients have budgets – and many options for orthodontists. In residency, we have the luxury of offering TADS, orthognathic surgery and expensive appliances at significantly reduced or no cost to the patients. Because of this, we get to try a lot and it is awesome! We come out of school so eager to incorporate this new, exciting technology. Patients are sometimes much less enthusiastic. TADS are great, but often scare mothers. Surgery is expensive and often not covered by health insurance plans. People may not be that excited about having holes drilled into their children's jaws to speed up treatment by a few months. And there is that 500-pound gorilla sitting in the room – overhead. You may want to use these great adjuncts and the patient may agree, but mom may be visiting 4-5 other offices and will ask you to match the cheapest price. Do you really need to use those expensive products?

3.) FIND A GOOD ATTORNEY AS SOON AS POSSIBLE

Good representation is notoriously expensive. Because of this, many new graduates shy away from consulting an attorney when they should. Fresh out of school, I considered myself competent enough not to get sued. So, securing a relationship with a good attorney was very low on my priority list. What I didn't know

was that the need for an attorney has very little to do with malpractice. Your attorney is there to help you with a variety of business related items, and when you need them they are worth every dime. I never anticipated how many situations I needed to talk to or use an attorney. Never sign a lease agreement, employment contract or practice purchase agreement without someone representing your interests (ask me how I know).

4.) YOU DON'T KNOW WHAT YOU DON'T KNOW

Every day I learn something new. Every. Single. Day. I thought I knew it all when I graduated from residency, but there was so much I didn't understand. There was also a great deal I was not ready to understand. This applies to all aspects of running a business and the clinical practice of orthodontics. Keep your ears open and learn as much as possible. You may think you know it all, but you don't know what you don't know.

5.) THE ONLY THING THAT IS CONSTANT IS CHANGE, SO EMBRACE IT

It is important to have a vision for what you want and to never compromise your personal ethics. But, it is also important to adjust that vision as you see newer and better ways to do things. Change may also be required out of necessity to keep your practice open and profitable. That large, one doctor practice you always wanted may require a partner to run it smoothly. You may need to add satellite locations. You may need to take additional PPO insurances or drop some plans where reimbursement is low. You may not be able to use those expensive brackets you fell in love with in residency. As we are graduating more and more orthodontists, staying on top of the changing market and adapting to said changes may be the differentiator between someone who makes it and someone who doesn't.

6.) SURROUND YOURSELF WITH SUCCESSFUL PEOPLE THAT ARE BETTER THAN YOU

It easy and comfortable to associate with people who are similar to yourself. But, limiting your circle to these people will only inhibit your personal and professional growth. Spending time with people who are significantly "better" or smarter than you will broaden your horizons in unimaginable ways. I was recently at a roundtable discussion with a group of high achieving orthodontists and was overwhelmed with the amount of information and inspiration I was experiencing after a few short hours. Your life will dramatically change when you can see things through a fresh perspective. Make sure to choose that perspective from someone who is wildly successful. I'll paraphrase Dave Ramsey, "You can't get rich doing what broke people do." Spend time with people who are rich, and I'm not just talking about money. Find people who are rich with love, gratitude, intelligence, wisdom, generosity, creativity - everything you hope to achieve. Your life will be better because of it.

BEN THERE **DR. BEN BURRIS** DONE THAT

THOSE PEOPLE

By Dr. Ben Burris

I did a talk last week for a very nice group of orthodontists who reminded me of how far we have to go in our profession. As I always do, we spent a good bit of time talking about access to care because I am a huge advocate of increasing access to care AND I've built my practices by finding and serving the underserved. It's good for society and it's good for business to be inclusive, but we orthodontists are far from inclusive by and large. I don't know why I was shocked by the amount of resistance I received when the topic of accepting Medicaid and offering flexible financing came up. I guess I feel that I speak and write about this stuff so much that everyone should know better by now. Obviously I'm not as widely known as I'd like to be because I haven't come close to overcoming the generalized brain damage and prejudice we orthodontists are taught in residency about those who differ from us in gender, race, economics, language, religion or geography. We orthodontists are judgmental and tend to decide who is worthy of braces and our time and who is not – even before we meet them – because that's the behavior our professors modeled. Pre-judging people and patients is not right and being taught to be this way is not an excuse but I know that the majority of orthodontists still think this way so I guess I should expect it. I have no problem raging against the machine and I expect pushback from the established norm, but I have to admit that when a minority, female orthodontist said, "I don't want those people in my waiting room running off my regular patients," I was taken aback. The irony was so thick that even Guy de Maupassant would have been thrown for a loop!

But don't you dare think this is an isolated event or feel superior where you sit and read because "you would never" do or say such a thing. It's a rare orthodontist who doesn't fall into the "those people" trap. It's a mindset and "those people" go by many names but it's the same sickness: "quality new patients", "ranking patients, A, B or C", and "the right kind of patient" are but a few examples of the "those people" mindset with updated terminology.

Shame on us.

Pre-judging patients is being prejudiced. Period. It doesn't matter the trait you choose to discriminate against. when you judge individuals based on characteristics you've assigned to any group, you're wrong!

Don't you dare judge people or their motivations to get braces for themselves or their children. Don't you dare deny access to those who would have a better life for their kids. Who are you to judge whether or not someone else can pay or will show up or will brush or will comply? Who are you to say who will and who won't have access to care? Don't "those people" love their kids every bit as much as you? Doesn't everyone deserve a great smile?

Pre-judging patients is being prejudiced. Period. It doesn't matter the trait you choose to discriminate against, when you judge individuals based on characteristics you've assigned to any group, you're wrong! What do I mean? Let me give you a few more examples of the "those people" mindset in action.

"The people that Dr Smith refers never show up"

"Medicaid patients don't comply and have bad hygiene"

"Those people who come from advertising are low quality new patients"

"People from that part of town are not the kind of people we want in our practice"

"We spend less time with a type C patient than with a type A new patient. We rate our new patients when they call and appoint accordingly"

All of these activities are STUPID, prejudiced, inhumane and bad for business!! Are you at capacity? What else do you have to do? Consider every new patient a blessing and thank them for calling you! New patients are the lifeblood of an orthodontic practice and you cannot afford to discount a single one of them.

I'm sure you still know better and think this is a load of malarkey because I've had this conversation many times and watched the arms of the audience cross as they lean back and snarl.

Let's think about this logically and with an open mind for 30 seconds. When one of "those people" calls your office and you and your team already KNOW they are terrible and won't show up, how do you think that new patient is treated on the phone? Do you think the "type C new patient" or the patient from Dr. Smith gets a warm fuzzy feeling during that encounter with your team member who is already unhappy this "low quality patient" is bothering them? When "those people" try to make an appointment to come to your office and give you money, you and yours treat them poorly based solely on who referred them, where they live or how much money they make and then cannot understand why they don't show up. Looking at it from this perspective, do you think it's possible that "those people" being treated badly by your people on the new patient call may have something to do with them not showing up at your office and, instead, choosing another orthodontist? I do. Because it's my office they come to when you run them off.

Do the right thing. Be inclusive. Stomp out prejudice in your office. Your patients, your community and your bank account will thank you.

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In our ever changing world, those of us who want to run a dental business as opposed to owning a traditional practice (ie; owning a job) must think differently. Dental school and residency programs taught us how to be dentists but actually gave us a paradigm that makes it difficult for us to think properly about dentistry as a business. Where and how does one learn how to move from a practice to a business?

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Half day programs:

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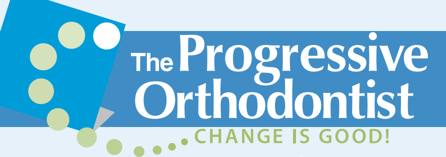

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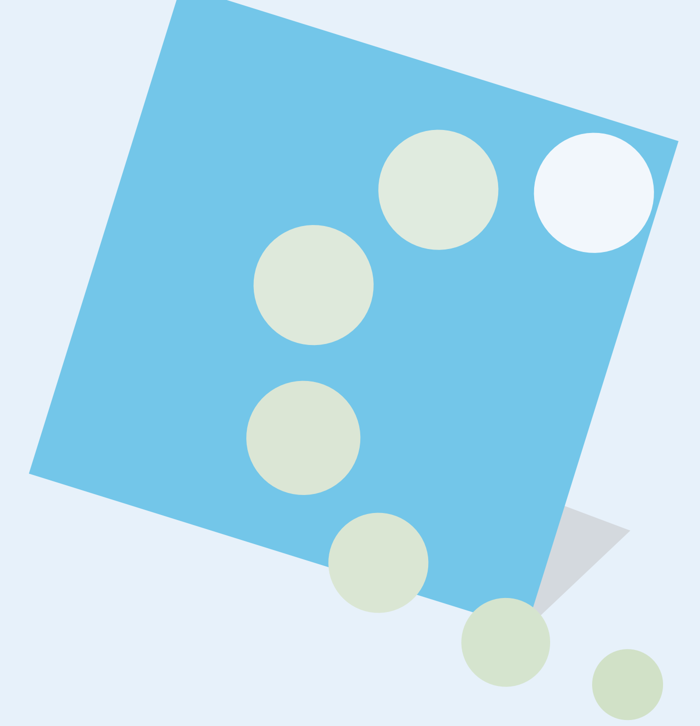

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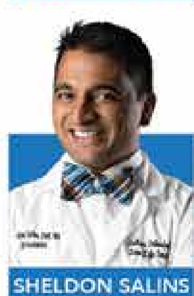
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