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# Dentaltown

APRIL 2025

REAL DENTISTRY FOR REAL DENTISTS

Dentaltown®
APRIL 2025 VOL. 26, ISSUE 4
REAL DENTISTRY FOR REAL DENTISTS

**Dr. Jared R. Robbins** explains dentist and oncologist communication

**Dr. Alan Pressman** treats a perio-endo lesion

**Jaclyn Nona** advocates for an in-house marketer

**Dr. Jeffrey E. Greenberg** shares seven onboarding strategies

# Dr. Anna Berik

Owner of Bubble, a pediatric dental office designed specifically to reshape how children and families experience dental care

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COVER PHOTOGRAPHY: GEORGE ANNAN JR.

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# Built to Win

Everywhere you look, people are talking about an economic slowdown. Inflation, interest rates, layoffs—you name it. But let's be clear: we're not in a full-blown recession yet. And even if we were, guess what? Dentistry isn't just built to survive—it's primed to thrive.

## Why is dentistry recession-proof?

Because dental care isn't optional. It's not like skipping a vacation or eating out less. People can put off checkups, sure, but eventually, tooth pain wins. A small cavity ignored today becomes a root canal and crown tomorrow. And when the economy rebounds? That backlog of deferred care turns into packed schedules and record production numbers.

Even better, dentistry has an edge over other health care fields. People don't "shop around" for ER visits, but they do for dentists. They choose providers based on trust, convenience and affordability. Practices that offer flexible financing, in-house membership plans or patient-friendly payment options will keep patients walking through the door—no matter what the stock market does.

## The boom in aesthetic and ortho cases

Here's another shift that's making dentistry even stronger: the line between "essential" and "elective" procedures is disappearing. Orthodontics, veneers, whitening—these aren't just cosmetic anymore. Today's patients see them as investments in their confidence, careers and social lives. Whether it's young professionals straightening their teeth for Zoom meetings or parents finally getting the smile they've always wanted, demand is growing. The best part? These are cash-heavy services that aren't tied to insurance headaches.

Smart practices are capitalizing on this by making treatments easier to say yes to. Clear aligners, same-day crowns, smile makeovers—when you pair these with easy financing, you're setting up your practice for major growth, no matter what the economy throws at you.

## Tech and AI: Your secret weapons in tough times

If you want to keep your practice recession-proof, you need to run it like a business. That means cutting waste, maximizing efficiency, and embracing technology. AI-driven diagnostics, automated scheduling, digital workflows—these aren't just "nice to have" anymore. They slash overhead, speed up procedures, and make it easier to manage your patient base.

Think about it: AI can analyze X-rays in seconds, catching early signs of disease that a human eye might miss. Automated patient communication keeps your schedule full. Digital workflows make same-day dentistry possible. The dentists who embrace these tools will stay ahead. The ones who don't? Well, they'll be left wondering why their competitors are growing while they're stuck in neutral.

## U.S. economic trends

Right here in Phoenix, we've already seen signs of economic recovery. Housing prices are climbing, construction is picking up, and while some sectors are slowing down, others are heating up. This pattern is playing out across the country.

In dentistry, we're seeing a major surge in patient demand. During the pandemic, people put off treatments. Now, they're coming back—only now they need more than just a cleaning. That small cavity they ignored? It's a cracked tooth now. That mild gum disease? It's advanced periodontitis. Practices that are ready to handle this influx are going to see massive growth.

## The future is bright—are you ready?

Here's the deal: dentistry is not slowing down. The pent-up demand from the past few years is turning into packed schedules, bigger treatment plans and higher profitability. The best dentists—the ones who invest in their teams, embrace technology and make treatment accessible—are about to see their best years yet.

Don't buy into the doom and gloom. Be aggressive, be strategic and get ready—because the next big boom in dentistry isn't coming. It's already here. **DT**

# Embrace the Startup Hustle

## Applying entrepreneurial thinking to transform your practice

BY BRIAN WEATHERLY, CEO OF HENRY SCHEIN ONE

Thirty-five years ago, I found myself in the trenches of a software startup, working around the clock. My brother and I weren't just building software; we were problem-solving, pushing the boundaries of technology and constantly asking, "How can we forge the new frontier?" That mindset of continuous improvement and customer-driven, patient-centric innovation has stayed with me throughout my career. Now, as CEO of Henry Schein One, I see that same spirit as the key to the next generation of dental technology.

The dental industry is at an inflection point. Just like in the startup world, those who embrace innovation and think differently will drive their practices ahead.

### Think like a builder

Entrepreneurs disrupt the way things are to create better solutions. As a practice owner, think about whether you are spending too much time on manual tasks like scheduling, patient communications, and insurance verification, and how technology can improve those processes. Better means finding ways to streamline workflow, reduce inefficiencies, and create more time for patients. Just as my team and I once built software to help dentists manage their businesses more effectively, today's dental technology is evolving to reduce administrative burdens.

### Optimize for efficiency and scalability

One of the biggest lessons from the startup world is that growth only happens when you create a scalable workflow. Many practices rely on a patchwork of loosely coupled tools, which leads to inefficiencies, missed revenue opportunities and a frustrated team. Instead of forcing a one-size-fits-all approach, practices should focus on building a safe, customized workflow that meets their unique needs. The right solutions should not only streamline operations but also provide transparency, security and flexibility, allowing your practice to grow without compromise.

### Leverage data to make smarter decisions

Successful startups use data to make smarter decisions, tracking user behavior, measuring outcomes and refining their approach based on insights. Dental practices can benefit from the same strategy. The right dental technology should provide a clear view of patient retention, case acceptance rates and financial performance. But not all technology is equally insightful or seamlessly integrated into your workflow. Choosing a highly connected platform ensures easy access to the data that matters, helping you make informed decisions, allocate resources efficiently and grow your practice.

### Prioritize the patient experience

In the startup world, the best products thrive not just because they exist, but because they solve real problems and seamlessly integrate into users' daily lives. The same is true for dental practices. Patients today expect convenience, transparency and a seamless experience. I bet you do too. How convenient is it to check in for a flight from your phone instead of waiting in line at the airport? Or deposit a check through your banking app without visiting a branch?

These small technological shifts make a significant impact on your life. Practices that use automation to simplify scheduling, reminders, payments and follow-ups will not only improve patient satisfaction but also increase retention and referrals.

### Be willing to evolve

Adaptation is key to survival. What worked yesterday won't necessarily work tomorrow. The most successful practice owners will be those who embrace change, whether that means adopting new technology, shifting business models or rethinking the patient journey.

I believe the power of technology can revolutionize dental practices. But more importantly, I believe in the power of practice owners to reimagine what's possible and lead their teams to success.

The question is: Are you ready to build the future of your practice? **DT**

NAREG APELIAN, DMD
Director of Continuing Education

# APRIL ONLINE CE FOCUS: Implant Dentistry

## All-On-Four Implant Maintenance (AO4) for Registered Dental Hygienists

by Kirsta Herring, BCH, RDH

This course to addresses the fundamental foundations for suggested All-On-4 (AO4) hygiene maintenance appointment best-practice protocol when carried out by registered dental hygienists. An overview of the anatomical features AO4 prosthetics, step-by-step cleaning procedures, as well as patient education talking points will be discussed.

## Peri-Implantitis: Its Diagnosis and Management

by Dr. Giacomo Tarquini

The course offers a comprehensive overview of peri-implant diseases and conditions, starting from peri-implant health to peri-implant mucositis and peri-implantitis. It covers the biological rationale and surgical protocol underlying peri-implant therapy, emphasizing the evaluation of multi-level risk factors and conducting a thorough differential diagnostic analysis.

## One-Step Alveolar Ridge Preservation Without the Need for a Membrane

by Dr. Timothy F. Kosinski

This course presents a series of simple, cost-effective and predictable clinical uses for bone regeneration focused on one-step alveolar ridge preservation using novel composite graft/collagen materials. Cost-effective surgical techniques for both everyday tooth extractions as well as innovative surgical procedures for ridge preservation, sinus lift and grafting around immediately placed implants will also be reviewed.

## Treatment Planning and Restoring Implants in the Aesthetic Zone

by Dr. John Nosti

Dr. Nosti discusses from start to finish the rationale behind material selection, achieving the ideal shade match, and the importance of setting the tissue up for the definitive restoration, including the ideal impression technique. See exactly the what, why and how of mastering implants in the aesthetic zone.

## Guided Surgery vs Freehanded

by Dr. Isaac Tawil

This program covers the basics of full-arch guided surgery for applications utilizing cutting-edge implant therapy, and shows the benefits for performing full-arch implant therapy with surgical guides versus freehanded implant treatment.

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Increase your brainpower with Dentaltown's more than 500 online continuing education courses. We release new ones every month at **dentaltown.com/ce**.

## Diode Lasers in Periodontal Pocket Therapy

NEW COURSE

by Dr. Bob Convissar

Diode lasers are ubiquitous in dental offices and are routinely used for periodontal pocket therapy with the goal of reducing pocket depth. This course will provide a science-based protocol for successful diode laser periodontal pocket therapy.

LASER DENTISTRY

## Osseous Resective Surgery

NEW COURSE

by Dr. Giacomo Tarquini

Osseous resective surgery is dedicated to the removal of osseous deformities and the creation of a physiologic parabolic contour; a physiologic osseous form will mimic the final anticipated gingival architecture and this osseous contour will be conducive for pocket elimination and maintenance of physiologic gingival architecture.

PERIODONTICS

## Dental Implants From Planning to Restoration

FEATURED SERIES

by Dr. Charles Schlesinger

This is an 11-part comprehensive series of CE courses on implants that covers all aspects of implants from treatment planning, surgery, grafting, immediate vs delayed loading, restorative and surgical guides.

IMPLANT DENTISTRY

## Mastering Adult Minimal Oral Sedation

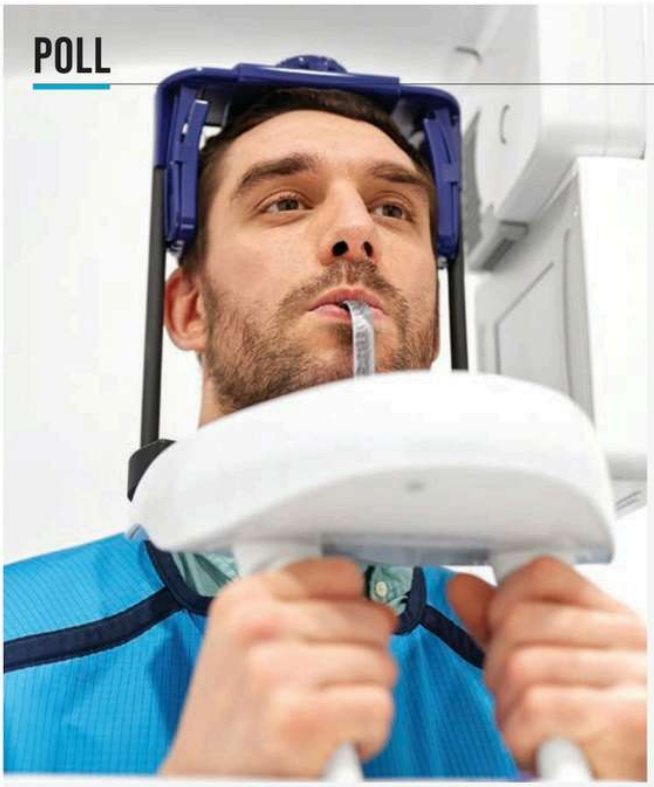
FEATURED SERIES

by Drs. Mark Donaldson and Jason H. Goodchild

Minimal adult sedation training is online exclusively on Dentaltown! Delivering 19.5 CE hours, this continuum meets the number of didactic hours and patient experiences outlined by the current ADA teaching guidelines.

ANESTHESIA

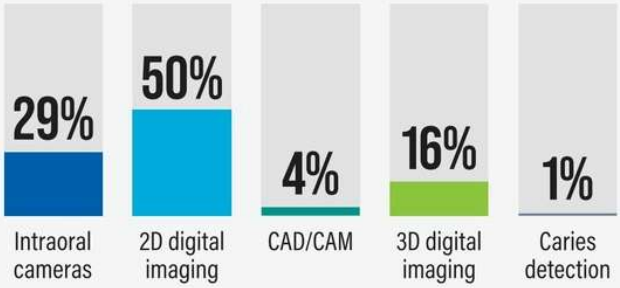
POLL



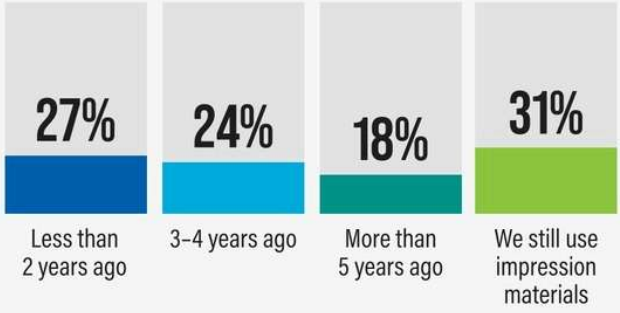
Dentaltown's monthly poll helps you see how other practices operate—what's working, what isn't—and how dentistry is evolving. This poll was conducted from Feb. 7 To Mar. 12 on Dentaltown.com.

# Digital Imaging

## Which imaging platform plays the biggest role in your practice?




## When did you start using a 3D scanner for taking impressions?




## If you have not started using CAD/CAM, what is the primary reason?


## Do you still use film?


## Do you use a DSLR in your practice?


## Do you believe the ROI on CAD/CAM or 3D digital imaging is worth the cost of purchasing the technologies?


**Scan here to take this month's poll!**

Hold your phone's camera over the QR code at left to go straight to this month's poll questions about orthodontics & sleep dentistry. The final tallies will appear in the May issue of *Dentaltown* magazine.

## MESSAGE BOARD 1

# Three Things That Have Noticeably Improved My Integration Rates

**billschaeffer** *Post: 1 of 53* 2/19/2025

Many of you will know that I've been placing implants for a while now (29 years this year) and that I have posted extensively about both my successes and my failures.

Well now I'm going to post the three things that I have changed recently that have led to a very significant drop in my implant integration failures (I'll call them "early failures" from here on).

I cannot tell you which of these specific changes has been effective as I changed them all at the same time—but my early failure numbers simply dropped off a cliff after starting them. I do nothing but place implants and I have now had only one early implant failure since May 2023. Previously I would have expected to have 10 or more over the same time with the numbers I'm placing.

So what have these changes been?

Having drilled the osteotomy and just before I place my implant, I flush out the hole very thoroughly with lots and lots of sterile saline.

I place a long curette beneath the palatal/lingual flap to reflect the flap and ensure that the flap cannot possibly touch the implant as it is screwed into the osteotomy.

I don't touch any of the different drills with my gloves. I pick them up with sterile gauze to put them into and out of the handpieces.

About tip number 3, don't brush this one off too quickly. I too wear sterile gloves when placing implants, but the moment they touch the patient, they are no longer sterile! You can get in the habit of doing this very quickly and all it involves is putting some additional packs of small gauze on the trays—it's very easy to do.

I got these tips from my business partner, Guy Barwell, who until recently has always had the best integration rates of all the clinicians in our implant centers. After many years of feeling jealous of his numbers, I finally started watching what he did to get them!

Many of you will already be doing some or all these things already—but for many years, I wasn't—so some of you might find this useful.

If you have any additional tips that you have found to noticeably improved your implant integration rates, then feel free to add them. ■

**Henry Mulla** *Post: 2 of 53* 2/19/2025

Thanks for sharing your recent changes that have significantly reduced your implant integration failures. I must say, I've only been consistently doing one of the things you mentioned, which is rinsing the sockets thoroughly with sterile saline before placing the implant.

However, I'm definitely going to take your other two tips into consideration and start implementing them in my practice. I'm particularly intrigued by the idea of using sterile gauze to handle the drills and avoiding touching them with my gloves.

Interestingly, I've noticed an increase in failures since I started using guided surgery, and I think it's because I may have become a bit too reliant on the technology. One thing that I have found to be crucial when using guided placement is rinsing thoroughly after each drill. It's easy to get lazy with this step, but it's so important for reducing the risk of contamination and failure.

# MESSAGE BOARD 1

I'll definitely report back after incorporating your tips into my practice and see if I notice an improvement in my integration rates. Thanks again for sharing your expertise and experience! ■

**billschaeffer** *Post: 3 of 53* 2/19/2025

Thanks Henry.

I think that guided surgery has two main issues that can lead to a reduced integration rate:

1. Reduced cooling of the drills. You're using longer drills where the tip of the drill is shielded from the cooling irrigation by the long guide tubes. Many will use a much slower drill speed to counter this.

2. Reduced vision and feel. You can't see or feel what's happening when you drill using a guide and that can lead to problems.

But having said all of that—I love guided surgery. ■

**lernerimplants** *Post: 9 of 53* 2/19/2025

Great, right? But what happens if you have an extremely guilty conscience and can't sleep for two days after a failure. What happens if you go from five failures a year to 60 failures! Yup, you go crazy, become difficult to live with.

So I hired an assistant and installed a second operator light arm but put a video camera on it. I had the new assistant record every single implant placement for two years (yes, I am crazy). When I had a failure, I pulled the tape for that day (yes, tapes were kept and dated and yes, there were tapes. This was 28 years ago).

1. The tongue is strong and fast. You won't believe how often that pink snake whips out and licks your implant as it's going in (before my guided days). I never saw that coming, only slow motion revealed it.
2. There are often teeth adjacent to the implant site. Did you bump into it or slightly floss it with the implant? You won't notice until you watch in slow-mo. Shoeshine the adjacent teeth with a gauze and oral disinfectant.
3. Immediate placement post extraction does have a noticeable increase in failure.
4. Healing abutment placement on short implants at time of surgery or implants with low primary stability increase failure rate.
5. Running coolant and expecting it to cool off the drill or bone if the drill is not completely out of the bone (hint: nothing gets cooled off while drill is in bone. The coolant can't reach it).
6. I got to be a failure expert and was contacted by others. Do not have your least experienced staff member clean and sterilize the kit. You would go out of your mind if you saw all the funny chips still on the drill after the autoclave with a new indirectly supervised, inexperienced person. Have more than one kit and be on top of it! Have someone inspect every drill before it goes into the autoclave.
7. Slow down the RPM.
8. Run the handpiece into a gauze before the surgery. Your assistant has oiled it (I hope) and guess where the oil goes if you don't run it and wipe it down with alcohol—Your drills.
9. No blood in the osteotomy. No blood, no implant. Sometimes the osteotomy is dry. This is after cleaning it and curetting. Wait! Let it fill with blood. If it doesn't fill or isn't pink at least inside the osteotomy then the implant will fail! This, I learned from my mentor Norm Sheppard. Genius guy and taught me a lot. He told me to close it and let the patient know that the reason they were using me is experience—I know from experience that this will fail. So, no placement, no charge. Tell the patient to come back in six weeks and the osteotomy will be full of nice bleeding tissue. Then curette it and place the implant.

The others that Bill and others mentioned are higher up on the list but now you don't have to watch video of failed implant surgeries.

Thank you, Bill! ■

## MESSAGE BOARD 2

# How to Schedule Multiple Hygienists Without Chaos for Dentist Doing Exams and Remaining Productive?

This Townie seeks advice on staying productive while managing a schedule with three full-time hygienists

**mah1** *Post: 1 of 30* 2/19/2025

We are planning to expand our hygiene staffing to three full-time hygienists and would appreciate ideas on how to schedule them so that the dentist/dentists working/doing exams can still be productive in their own schedules.

Thank you in advance for your ideas/response! ■

**CnW** *Post: 4 of 30* 2/19/2025

Do only exam one-time per year when bitewings are taken unless patient has cc or specifically requests to see you. Reduce recare to one-time per year for unprofitable insurance patients that have good oral hygiene. ■

**davidpalmer** *Post: 5 of 30* 2/19/2025

Ah, the inexecutable problem in general practice dentistry. Tread carefully my friend.

While you are trying your best to do real dentistry (restorative, endo, emergency care), you are about to be interrupted three times every 45 minutes!

That's a lot for one dentist, especially when doing procedures where there is no good "stopping point." Many of these hygiene patients will want to talk your ear off and/or have a little problem with their partial that they saved for just now "since I was coming in anyway."

I ran three columns and fought adding a third hygienist for many years. After COVID, my partner convinced me to hire another hygienist to "catch up." Now all three are busy.

If you can keep it to two instead of three, do it. The op used by that third hygienist is valuable. Virtually any dental procedure performed in that op is more profitable than a prophy. Working on a patient in pain should not be thwarted because you have three hygienists occupying three ops.

There is no good answer. Running too many hygienists can reduce production and collections because the dentist cannot do enough dentistry. ■

**eeznogood** *Post: 7 of 30* 2/19/2025

Very true.

I did it for a while and my production suffered, or I suffered. I only did it in order to grow the patient book and integrate an associate.

Then we moved up to four hygienists for two dentists and now we are about to integrate our fifth hygienists, we will also integrate a third dentist and I will cut my hours. The goal is to reach six hygienist full time and three dentists full time and me zero time. All in 11 ops.

So, it is good to grow but only if you have the space to do it right. If you are going to reduce your own productivity due to lack of speed and space, then you might not want to do this.

# MESSAGE BOARD 2

If you have space and can eventually add an associate, then it makes sense.

And what to do if you have too many current patients and new patients, and no space to grow and no desire to expand physically? Increase your fees. Start with 10% and add five to 10% every six months until the volume becomes manageable. Your profit will skyrocket. You will increase your joy by leaps and bounds without increasing your stress. ■

**DocH6** *Post: 8 of 30* 2/19/2025

I'd run the third hygienist appointments on half hour instead of on the hour. Gives you an extra 30 minutes between the first two and the third. So have two start at 8:00, and the third start at 8:30. ■

**pjmop** *Post: 9 of 30* 2/19/2025

Do yearly exams instead of every six months unless there's an issue.

Have any dentist do any exam at any time after X-rays. If a patient requests a specific doctor, OK get them, but don't ask the patient who they want.

If the exam is complicated, re-appoint the patient with a doctor.

Pay the associate doctor for the exam so there is some incentive to do it.

This is how we've done it for years at a 10-operatory practice. ■

**Kevin Tighe** *Post: 10 of 30* 2/20/2025

Suggestions:

1. Stagger hygienist appointments so exam times don't overlap.
2. Train hygienists to signal when a patient is ready for the exam.
3. Use a roaming assistant to update the dentist on patient status and move them between rooms efficiently.
4. Avoid overbooking. ■

**eeznogood** *Post: 11 of 30* 2/20/2025

Another way to do it is to do the exam when you can.

This means that hygienists must take X-rays and do the probing and anything else needed for the exam ASAP at the beginning of the appointment and expect to be interrupted and be ready to have you do the exam.

Then you can choose to numb a patient and go right away for the exam, while the numb patient waits a bit for the numbing to take, and before the scaling and polishing is done.

You can do some of the exams at the beginning and some at the end, and sometimes in the middle, when your workflow allows it. Sometimes there won't be an exam which helps.

This might require a bit of planning at the beginning of the day, but it quickly becomes doable on the fly, as you get used to it. We do this on the fly. When I see that I have too many exams, I numb my patient and go do a couple of exams and come back to do my work, then I do another exam at the end and so on.

Ultimately, your patients will get used to your style. Most are happy and will return if things are generally well controlled. If one patient complains about waiting or about the flow of their appointment, as long as it is a rare complaint here and there, you might not need to change your system and just lose the one or two who do not like it. Keep in mind it is impossible to please everyone. Once you accept this, you will see that you will be better able to please most. ■

## Post your take online!

Townies, we want to hear from you! Visit this message board and share how you manage the hygiene department in your practice—scheduling, compensation, team structure and more. Your insights can help fellow dentists improve efficiency and patient care. Join the conversation today! **Head to dentaltown.com/magazine.**


# GrandioSO

## The ultimate toothlike composite

Voco's GrandioSO redefines what a universal composite should be—delivering unparalleled longevity, aesthetics and performance that mimic natural dentition. With an exceptional filler content of 89% by weight, GrandioSO offers remarkable strength, low polymerization shrinkage and superior wear resistance, making it one of the most durable composites on the market.

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Beyond durability, GrandioSO delivers exceptional handling and aesthetics. It offers a smooth, non-sticky consistency that allows for effortless sculpting, ensuring optimal adaptation to cavity walls with minimal effort. Its nano-hybrid formulation ensures excellent polishability and long-term gloss retention, providing a lasting, natural-looking finish.

Clinicians can also count on GrandioSO's advanced infection and humidity control, thanks to its ISO-pak packaging, which preserves material integrity in any environment.

For restorations that last longer, look better and perform like natural dentition, Voco's universal toothlike composite is designed for ultimate reliability and aesthetics.

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**PRODUCT PROFILE** PARTNER CONTENT

# Glidewell Simply Natural Partials

## The SLM method: A better fit for partial dentures

Producing partial dentures that fit comfortably in the patient's mouth and spread occlusal forces in a physiological manner is a well-known challenge for dentists and technicians alike. Fortunately, recent advancements in laboratory technology at Glidewell Labs have made the production of partial frameworks more accurate, leading to greater patient comfort and shorter seating times.

Key among these advancements is a process called selective laser melting (SLM) that combines digital design and 3D printing for a level of predictability that was never before achievable. This advanced method builds up the metal support frameworks layer by layer. The result of this technique is a chrome-cobalt alloy that is much denser than traditional casting methods. Additionally, the SLM method eliminates the need for a manual wax-up and the creation of a refractory model. Instead, after the initial model is poured and scanned, the data is sent to a CAD designer who designs the framework using custom software.

"The SLM process reduces defects while increasing precision for more durable and accurate partial frameworks—one layer at a time," said Steven Laguna, general manager of Glidewell Labs' Combo/Partials laboratory department. "The final product is a partial denture that is thinner, stronger and better adapts to the patient."

Glidewell

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# Collaborating with Confidence

## Keys for improving communication between dentists and radiation oncologists

BY DR. JARED R. ROBBINS, DR. J. BRETT MANGUM AND RILEY M GOLDSMITH

### Purpose

The purpose of this article is to provide dentists with tools and information to help improve collaboration and communication between dentists and radiation oncologists in the management of head and neck cancers (HNCs). This article will highlight key principles of HNCs, radiation oncology treatment paradigms, important points about the multidisciplinary management of HNC patients, and provide a framework for dentists regarding what questions they should ask radiation oncologists. By fostering collaboration, improving the basic understanding of modern radiation therapy and knowing the questions to ask, dentists can confidently mitigate the risks of radiation-related dental complications.

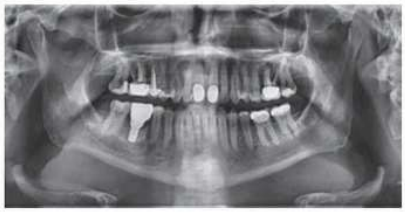
### Case report

The following case report highlights the quintessential nature of collaboration between dentists and radiation oncologists. In particular, the following case explains why it is essential for dentists to possess a basic understanding of the field of radiation oncology and know the types of questions to ask when managing a patient being treated with radiation therapy for HNCs.

A 70-year-old male patient presented as a new patient to a dental office with a chief complaint of a loose maxillary left second premolar. The patient's medical history was significant for human papilloma virus positive (HPV+) squamous cell carcinoma of the left tonsil. It was treated with radiation therapy (RT) 1.5 years previously. Previous dental records were requested and reviewed with the following pertinent items:

- A pre-radiation exam showed a periapical lesion on tooth #14 at the mesial-buccal root with a "hopeless" long-term prognosis (Fig. 1).

**Fig. 1:** Pre-radiation panoramic radiograph, showing a periapical lesion on tooth #14 at the mesial-buccal root with a "hopeless" long-term prognosis.



- The periapical radiograph of #14 and a panoramic radiograph would be sent to the radiation oncologist to determine whether the oncologist wanted the dentist to remove the tooth. No further communication was received, and the tooth was not extracted. The patient wanted to save the tooth.
- The chart notes that radiation treatment would likely start in a week.
- The patient presented 1.5 months later with pain and radiation-induced mucositis. Magic mouthwash, Hurricaine spray, and prescription-strength fluoridated toothpaste were recommended. The need to extract tooth #14 was mentioned in the chart, and grade II mobility, recession and furcation involvement were noted during every follow-up care visit, every four months, for one year after radiation. A referral was made to a periodontist for treatment of tooth #14.
- One year after the completion of RT and in conjunction with the advice of the community radiation oncologist, but with no actual reference to the radiation plan, the patient had hyperbaric oxygen therapy (HBO) followed by extraction of tooth #14 and bone graft. After healing, an implant was placed.

The patient's immediate concern was pain and mobility of #13, just anterior to the implant site, and he wanted treatment options for that tooth. A call was placed to the radiation oncologist (RO), but twice, the call was lost when transferred to the treatment personnel. A message was left, but not immediately returned. Eventually, the receptionist gave the dentist the radiation oncologist's cell phone. Throughout the call, the dentist made a concerted effort to ask specific and informed questions about the radiation. During the discussion regarding treatment options for #13, the RO mentioned that he liked HBO, but knowing that the risks of osteoradionecrosis and the benefits of HBO were dependent on the radiation dose to the area of concern, the dentist specifically asked if the RO would mind looking up the treatment plan to help determine how much radiation dose the left maxilla had received near #13. The RO was a little resistant and reiterated that he liked HBO, but eventually relented and looked at the radiation plan. Upon review, it was discovered that the area of tooth #13 (and tooth #14, which was previously extracted after HBO) had received less than 5 Gy of radiation, which would make it very low risk of complication after extraction. Given this information, it was decided that HBO would not be necessary for the extraction and subsequent treatment of #13.

**Every patient warrants multidisciplinary discussion. It is important to understand the association between delayed treatment and overall survival.**

No further mention was made about the previous 6-week course of HBO therapy, which was likely not necessary or extraction, bone graft, and implant placement that had previously been done for #14. In this case, knowing what to ask, understanding the basics of radiation-induced dental complications, and being diligent and proactive spared the patient unnecessary treatment and assuaged the dentist's fears and anxiety regarding post-radiation extractions.

## Introduction to head and neck cancers

The most common risk factors for the development of HNCs are tobacco, alcohol, viral infections such as human papilloma virus (HPV), Epstein-Barr virus (EBV), and poor oral/ dental hygiene.[1] Squamous cell carcinoma (SCC) accounts for the largest subgroup of HNCs, which can be further subdivided into HPV+ and HPV- SCC. This delineation is not without clinical significance as the presence of HPV+ SCC changes staging, treatment and overall prognosis.

In the late 1980s, about 17% of oropharynx cancers were HPV+. Presently, nearly 70% of oropharyngeal cancers are now HPV+. It is important to note that HPV+ SCC is associated with a favorable overall survival (OS) and generally affects younger individuals. Together, this data suggests the management of these patients must now be considered in terms of decades rather than years, and treatment protocols need to account for not only efficacy but toxicity and longevity.[1,2]

Patients with HPV+ tumors will likely need long-term dental solutions and effective preventative strategies to mitigate the related dental risks even years after cancer treatment. Effective collaboration between medical and dental professionals is thus imperative in anticipating and managing treatment-related sequelae for these otherwise long-living patients.

Primary tumor locations for HNCs are the oral cavity, oropharynx, larynx, nasopharynx and sinus. Lymph node involvement can be unilateral or bilateral with coverage increasing the radiation field and subsequent radiation delivered to nearby healthy tissues. The more extensive the spread, both locally and to the regional cervical neck lymph nodes, the more volume of normal tissue will receive high doses of radiation therapy, which can impact long-term xerostomia, chewing, eating, speaking and swallowing.

In terms of radiation management, the general treatment regimens are as follows: definitive treatment with organ preservation representing about seven weeks of treatment, post-surgical sterilization of the tumor bed corresponding to about six weeks of radiation, and palliative treatment in the setting of pain and functional debilitation ranging anywhere from one treatment to two and a half weeks. The anatomic location and stage guide whether radiation is indicated and whether it will fall into the neoadjuvant (before surgery), adjuvant (after surgery) or definitive (no surgery) setting.

Every patient warrants multidisciplinary discussion. However, it is important to understand the association between delayed treatment and overall survival. A systematic review of nearly 51 studies indicates that increased time from diagnosis to treatment is associated with worse overall survival for HNCs.[3]

Excessive delays for dental evaluation and pre-radiation dental procedures can allow the cancer to grow and spread, which can impact cancer outcomes. Therefore, efforts to improve communication and collaboration and expedite dental evaluation and treatment will not only decrease post-treatment toxicities but also improve outcomes like survival.

## Introduction to radiation oncology

The following terms and definitions are to establish a common vocabulary when discussing the treatment of patients:

- **Grey** is the unit of measure that is used in modern times to denote the amount of radiation that is given.
- **3D conformal** is the old technique of radiation delivery which is less conformal than modern techniques; in turn, delivering more radiation to surrounding healthy tissues. This would be considered archaic for most radiation treatment plans today with limited exceptions. This is what was typically thought of as treatment fields.
- **Intensity-modulated radiation therapy (IMRT)** is a complex radiation technique that limits high doses to surrounding structures through innovative technological advances that utilize complex beam arrangements and automated modulation techniques. (Volumetric arch therapy (VMAT), rapid arc and tomotherapy are newer variations of IMRT.) This technique uses photons/X-rays to target the cancer cells.

**Fig. 2:** Dose volume histogram (left) depicts each target/organ-at-risk based on the volume that receives a specific dose. Isodose lines (right) delineates the dose to various anatomic structures using lines to depict the dose overlaid on a CT scan.

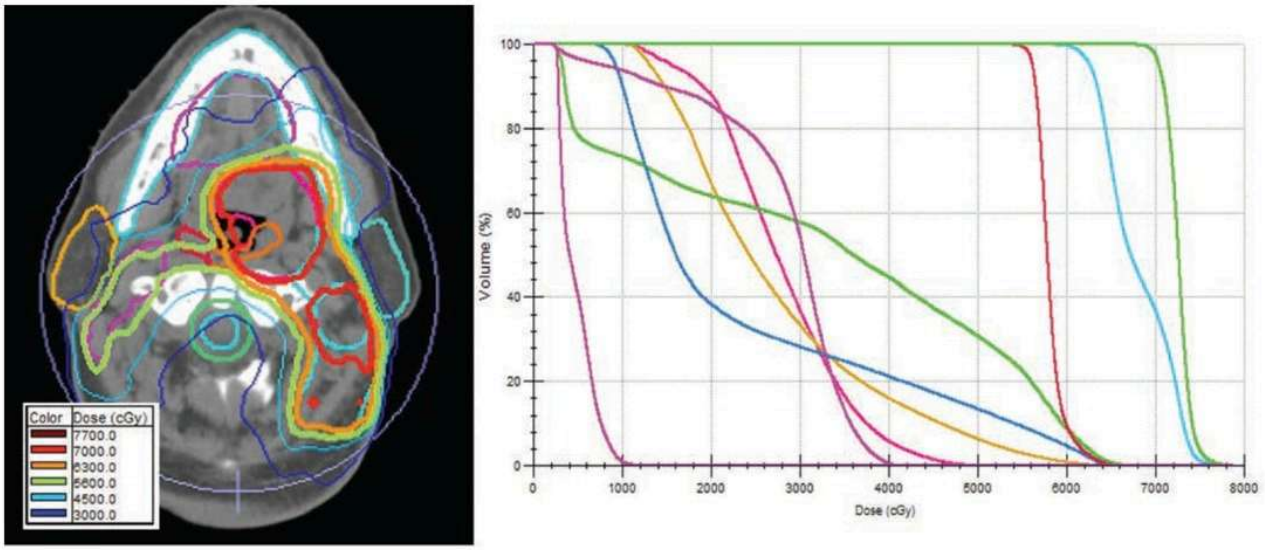
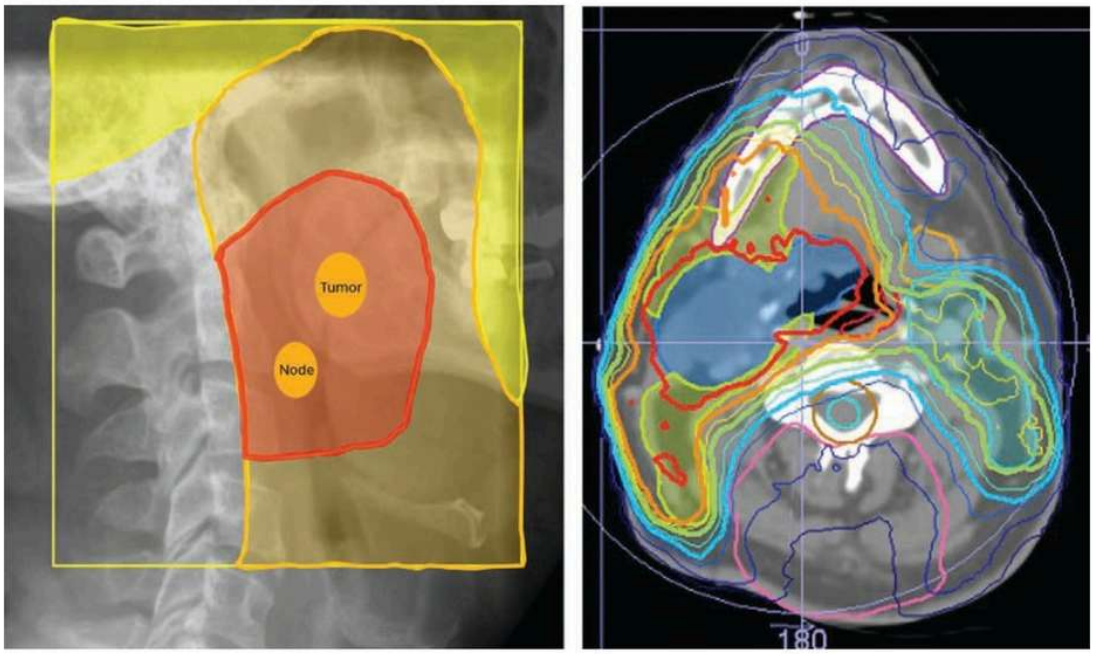


**Fig. 3:** Fields vs volumes: Treatment plans for T2N1 tonsil squamous cell carcinoma. 2D radiation fields (left) 2D field based on plain film imaging and bony anatomy. The initial field is blocked out in yellow, with subsequent shrinking fields of orange and then red as a final boost. Minimal critical structures were spared. IMRT plan (right) shows the delineated tumor volumes covered conformally with high-dose radiation and risk-based coverage of at-risk lymph nodes with sparing of normal organs.




This is currently the standard of care at most radiation centers. It focuses on treatment volumes and limiting doses to normal structures.

- **Intensity-modulated proton therapy (IMPT),** or proton therapy, limits exit dose past the target of interest, which spares normal tissue. This is accomplished by using proton (positively charged) rather than photon/X-ray energy sources. This is a newer and much more expensive therapy that is only available at 45 centers in the U.S. Early studies suggest it may help reduce radiation toxicity for HN patients.
- **Isodose lines** refer to lines used to delineate the dose of radiation to specific locations. They are typically generated by overlaying the radiation treatment plan over a CT scan of the patient. It is viewed like a topographical map with various lines or colors reflecting the dose to that area. These help the RO ensure the tumor coverage and sparing of normal structures (Fig. 2).
- **Dose-volume histograms** are graphical depictions of what volume of the tumor/target or normal structures receive a specific radiation dose. Through rigorous studies, various doses to specific volumes are associated with a specific outcome. For example, the volume of the mandible that received more than 60 Gy correlates with the risk of osteoradionecrosis, so the radiation oncologist will use metrics, such as less than 15% of the mandible should receive 60 Gy, to try to limit the risks to the patient. These are part of the medical chart and can be reviewed to evaluate the dose to various structures related to dental management and the associated risks (Fig. 2).
- **Fraction**, in general, refers to the number of treatments for each radiation plan. Thirty fractions means that the patient will come 30 times to the office to receive radiation.

The differences between new and old radiation modalities can be distilled into a general theme of selected volumes receiving specific radiation doses while sparing nearby critical organs compared to fields covering areas delineated from bony landmarks on plain film X-rays.

The general principle regarding modern radiation plans is based on creating 3D volumes based on the patient's anatomy and tumor location with CT imaging and then using multiple beams and dose modulation to cover the target and avoid critical structures (Fig. 3).

## Questions to ask your radiation oncologist (before and after treatment)

The intent of providing background on HNCs and radiation oncology is not only to create a shared dialogue in the multidisciplinary setting but also to create a framework for anticipating and responding to the dental needs of radiation patients. Understanding the types of questions that will maximize the oral health of a patient in the pre-and post-radiation setting is important as there is no consistent protocol for the dental management of radiation patients. Indeed, while individual papers have suggested protocols, there is not a clear consensus in the literature regarding how to optimize oral care to minimize radiation sequelae.[4]

Therefore, it is of paramount importance to discuss individual patients on a case-by-case basis with a radiation oncologist. The following paragraphs introduce questions that may guide treatment.

## Questions to consider asking before radiation treatment

### *Where is the tumor located?*

Tumors of the oral cavity, oropharynx, nasopharynx and paranasal sinuses typically have the most dose to the mouth, mandible, teeth and salivary glands, and are at higher risks for dental-related complications. Radiation treatment of other anatomic sites may also contribute to dental complications, particularly if the volume is large and multiple lymph nodes are involved (Fig. 4).

### *Are lymph nodes involved? Unilateral vs bilateral?*

The extent of lymph node involvement and the necessary treatment with radiation to the unilateral or bilateral neck determines the side effects of treatment. The greater the number of involved lymph nodes and the larger the radiation treatment volume, the higher the potential toxicity.

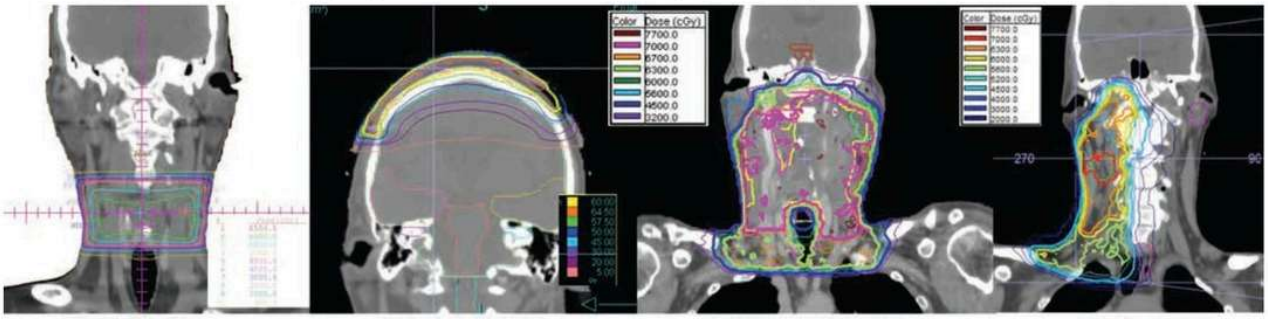
### *What will be the intended treatment modality for this patient (surgery, radiation chemo, etc.)?*

Each additional treatment modality increases the potential toxicity from the treatment.

### *What is the radiation dose to the mandible and what will be the risk of osteoradionecrosis (ORN)?*

Simply asking, "What is the dose" is not sufficient to understand the risks to the mandible. The typical dose

**Fig. 4:** All radiation plans are unique to the patient's disease and have varying degrees of risk of toxicity to normal structures based on the treated volume. The early larynx and advanced skin cancer cases have almost no risk of dental complication as the sites of disease are far from nearby organs at risk. However, the two tonsil cases have dramatically different toxicity profiles, despite their shared primary anatomic location because of the differing tumor extent, lymph node involvement, and the treatment volume.




to the tumor or post-op bed will be 60-70 Gy, but the dose to the mandible varies based on proximity to the site of the tumor and coverage of surrounding lymph node regions. This is an important distinction, as areas that received 25-30 Gy have less risk for surgical complications after radiation, while areas with more than 50 Gy are at risk for ORN with the risk increasing substantially with doses between 60-70 Gy.

### *What is the prognosis or five-year survival rate for my patient?*

Understanding a patient's prognosis from cancer is essential for developing an appropriate dental plan. Patients with low-risk HN cancer, like low volume HPV+ tumors, will likely survive their cancer (90% five-year survival) and will need proactive long-term dental care, while for those with more aggressive tumors establishing a rigorous five year dental plan may not be as important. Particularly when the radiation plan is palliative in nature and the goal is symptom relief, rather than cure, the risks of long-term dental complications are very low because of the lower overall radiation dose and limited life expectancy. Regardless of the prognosis and radiation plan, symptomatic teeth or those at very high risk of infection need to be addressed, but the methods and the aggressiveness of the treatment should reflect how long the intervention needs to last and the risks associated with it.

### *When will radiation begin?*

This is paramount, as the risk of extractions is typically lower before radiation. Arranging dental evaluations as soon as possible and expediting dental treatment helps ensure the best outcomes. After extraction, patients need time to heal before starting radiation, and excessive delays can result in inferior cancer outcomes.

### *What is the risk of post-treatment xerostomia (dose to the salivary glands)?*

Salivary glands are sensitive to the effects of radiation therapy. There are four major salivary glands and multiple minor ones. The parotid glands produce the stimulated saliva flow before and during meals, while the submandibular glands supply the basal salivary flow. Both are impacted by radiation and are the major cause of xerostomia. Sparing some of the salivary glands with IMRT improves quality of life and function.

## Post-treatment questions

### *To what area was the radiation delivered? Where did the tumor originate?*

The treating radiation oncologist should be able to look at the radiation plan, identify areas of concern and relay specific doses to those areas. This can be used to assess risk and guide therapy.

### *What was the dose to the tumor and nearby organs at risk? Specifically, what was the dose to the mandible?*

Assessing the risk of developing ORN is important, as clinical suspicion for this long-term toxicity is an important first step in treatment. The current options for treatment include nutritional support, oral saline irrigation, antibiotics, pentoxifylline and vitamin E, hyperbaric oxygen, and in some cases, surgery.

## Conclusion and survey

Basic knowledge of head and neck cancer treatments and the principles of radiation oncology, coupled with knowing what questions to ask, allows dentists to confidently collaborate

with radiation oncologists to improve dental-related complications and overall survival. Efforts to improve collaboration and communication improve patient care and reduce provider angst. Tools are being developed to help dentists and radiation oncologists communicate more effectively. Until then, don't hesitate to pick up the phone and call the radiation oncology team. Use the information and questions in this article to enhance your interactions and improve patient outcomes.

To further augment collaboration between radiation oncologists and dentists, we are conducting a survey-based study that was approved by the University of Arizona Institutional Review Board and is non-commercial. The survey was developed to better understand dentists' perspectives regarding head and neck radiation. With the results, we hope to develop better tools for communicating radiation data to dentists and improve our treatment alliance. Please complete the 5–10-minute survey by scanning the QR code here. **DT**

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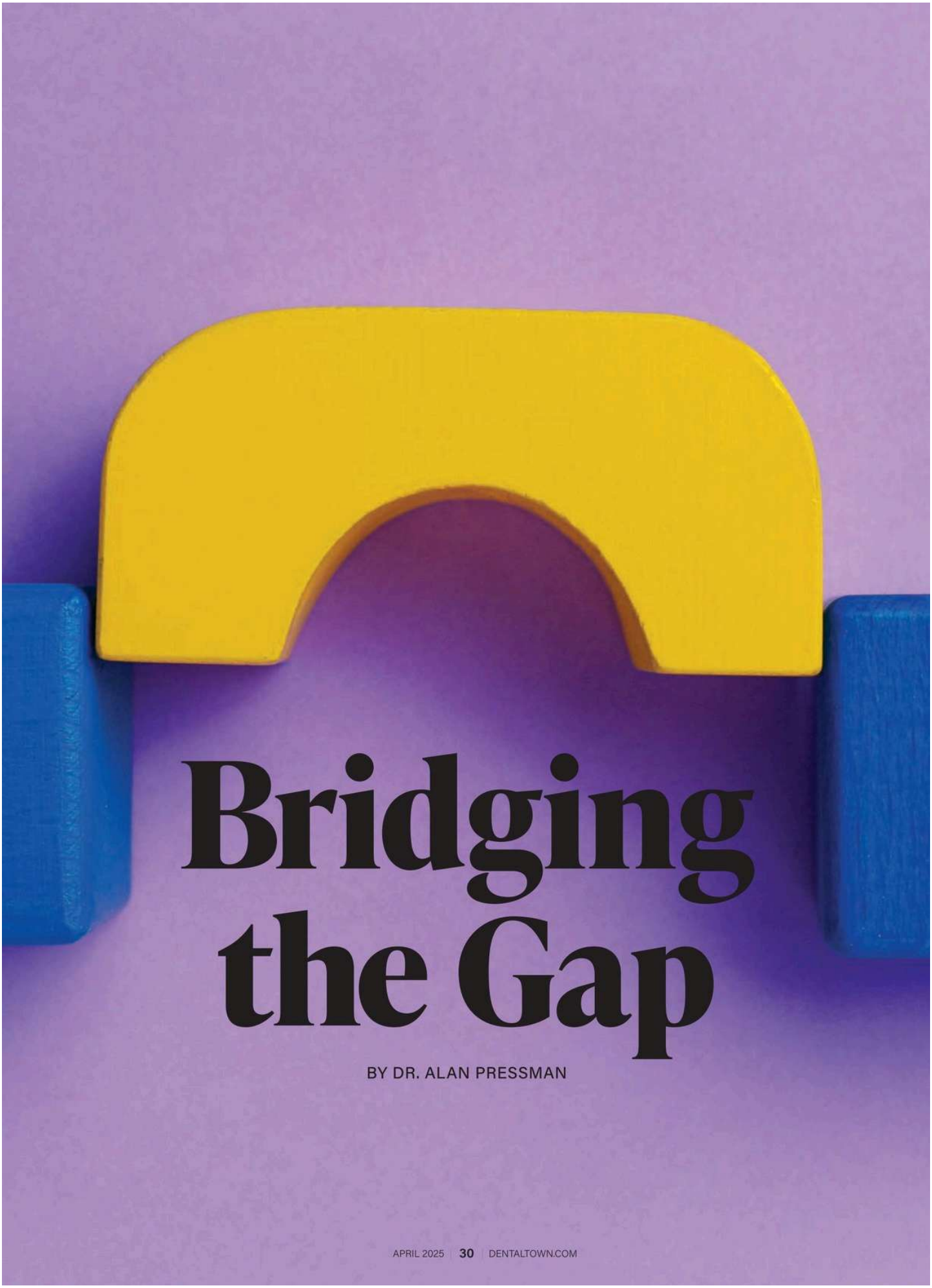


# Bridging the Gap

BY DR. ALAN PRESSMAN

This case study provides insight into a patient's perception of treatment choices for resolving a perio-endo lesion exacerbated by a food impaction site. The treatment plan chosen highlights the problem-solving properties and use of a temporary crown and bridge material.

## Chief complaint and examination

An 81-year-old female patient complained of recurring food impaction and pain in the upper left side of the mouth. She experienced consistent food traps between two upper left posterior teeth and occasionally noticed a bad taste in the area. She was in generally good health, active, and compliant with medical treatment for diabetes and high blood pressure.

An initial clinical exam revealed an 8 mm periodontal pocket depth on the distal of maxillary #13. The presence of slight bleeding and purulence was evident during periodontal probing. A periapical X-ray showed a loss of epithelial attachment and pocketing, which led to endodontic involvement in tooth #13 (Figs. 1 and 2). The tooth also exhibited early grade 2 mobility. Contributing factors included pain on vertical percussion, indicating primary periodontal with secondary endodontic involvement.

Earlier X-rays from the patient's previous dentist showed no visible periodontal problems or open contacts between teeth. The patient had likely been slowly getting food stuck in this upper left quadrant, compromising the epithelial attachment and contributing to the gradual drifting of the teeth.[1]

## Treatment options

The initial treatment plan presented to the patient followed the standard of care for a perio-endo lesion—extracting the tooth and replacing it with a dental implant supported by a bone graft. After discussing the steps involved in the dental implant procedure, the patient was indecisive about the treatment, citing the time to completion and discomfort with the idea of being without a tooth and wearing a temporary partial.

A second treatment plan was presented: extracting the painful second premolar and placing a temporary fixed bridge, which would cover the extraction site and allow healing while a permanent fixed bridge was being made by a dental laboratory.

The patient ended this initial appointment to consider this alternative treatment. After some time, she contacted the office and ultimately chose the fixed bridge treatment plan, pleased that she would not have an exposed "hole in her mouth" and that the procedure would be completed in two appointments, fitting her schedule and seasonal travel plans.

## Treatment procedure appointment

All procedure steps were explained to the patient to ensure she understood the goal of the visit: taking a dental impression, preparing two teeth for a fixed bridge, extracting the compromised tooth, creating a temporary bridge, and cementing it in place as a short-term pain-relieving solution until the permanent bridge was made.

A dental impression of the maxillary left quadrant was made using a temporary quadrant tray with a medium body monophase vinyl poly siloxane dental impression material (Fig. 3). Following the impression, crown preparations were cut on teeth #12 and #14 to prepare them as

**Fig. 1:** Pre-operative X-ray.

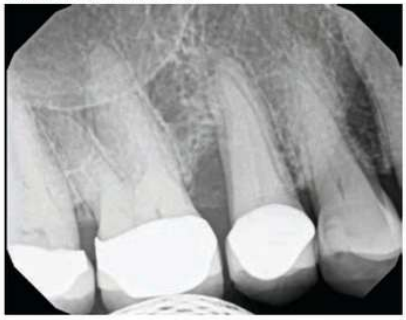


**Fig. 2:** Pre-operative clinical exam.

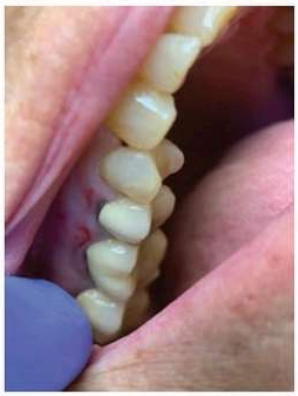


**Fig. 3:** Monophase polyvinyl siloxane impression taken.

**Fig. 4:** Teeth #12 and #14 crown preparations. #13 left intact.

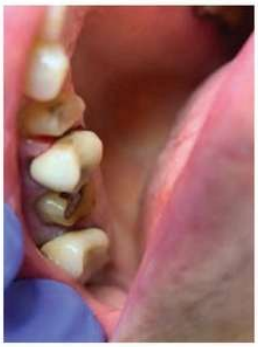


**Fig. 5:** Tooth #13 extracted. Extraction socket protected with a non-toxic hydrogel wound dressing and hemostatic self-resorbing gauze.

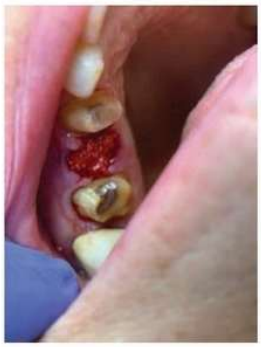
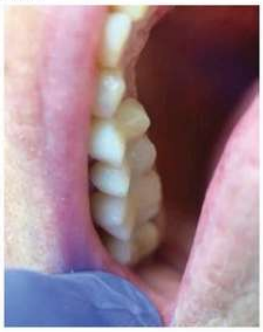


**Fig. 6:** Example of correct application of Access Crown.

**Fig. 7:** Access Crown temporary three-unit bridge seated with non-eugenol temporary cement.

**Fig. 8:** Final seating of Access Crown temporary bridge; labial-occlusal view.



abutments for the temporary three-unit bridge, leaving tooth #13 intact to await extraction after preparation of the abutment teeth (Fig. 4).

The extraction of tooth #13 was successful as its periodontal ligament was already compromised. Following the extraction, an FDA-cleared, non-toxic oral hydrogel wound dressing was applied at the extraction site. A hemostatic self-resorbing gauze was placed on top of the wound dressing to facilitate healing (Fig. 5).

The dental impression taken earlier was dried with moisture-free blown air to begin making a three-unit temporary bridge. Access Crown Temporary Crown and Bridge Material (Centrix, Inc.) was prepared and dispensed directly into the impression matrix from the bottom up, submerging the dispensing tip until the matrix was three-quarters full (Fig. 6). When the impression matrix was ready (within 30 seconds), it was positioned in the patient's mouth. The material was set in place for 60 seconds (90 seconds from the beginning of the mix) and then removed from the mouth.

The Access Crown material's setting consistency is elastic, allowing it to be easily pulled over any undercuts. In this case, there were no nonparallel preparations, so removing the tray was easy; excess flash was trimmed with a diamond bur.

**Time-saving workflow tip:** A void was noticed on the entire mesial of tooth #12, which was not captured in the Access Crown material. This was easily corrected by removing a small amount of the material with a diamond bur, adding a slight amount of Access Crown material, allowing it to set, and then carving it into shape. The result was a perfect repair. The self-additive property of Access Crown has proven to be a time-saving and useful benefit in such situations.

A non-eugenol temporary cement was used to adhere the temporary bridge to the prepared teeth, as non-eugenol cement is easier to remove than resin-based cement (Figs. 7 and 8). The entire appointment took 1.5 hours. The patient scheduled an appointment to return in eight weeks for a digitally scanned dental impression and to begin procedures for a permanent fixed bridge.

## Case outcome

I was highly satisfied with this case. Access Crown was easy to mix, dispense, set, polish and, in this case, carve. In my experience, it has also proven to have high flexural strength, and I appreciate the wide selection of shades. Most importantly, the patient was satisfied and happy to leave the office without a hole in her smile. **DT**

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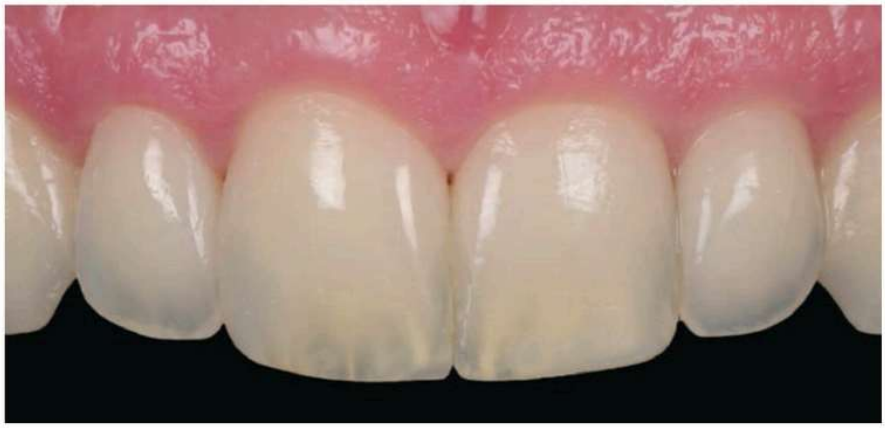


# Enhancing Smile Aesthetics Through Precision Layering

## Showcasing the innovative shade-matching ability of Transcend Universal Composite

BY DR. TOMMASO MASCETTI

When using new-generation dental composites, it's important to understand how the features of the resin matrix and filler composition, size and quantity will affect the material both biomechanically and aesthetically. This case below utilizes Transcend Universal Composite from Ultradent.

### Case presentation

A patient presented with dental misalignment and crowding teeth. A thorough analysis allowed for subtle changes to provide a solution. Examination revealed a Class II subdivision and malocclusion. The patient opted for conservative improvements without major changes (Fig. 1).

Orthodontic treatment was administered via clear aligners by Dr. Camilla Molinari. Planned restorative enhancements were incorporated into the treatment plan and commenced at the end of the orthodontic therapy (Fig. 2).

The goal was to increase the width of teeth #7 and #8 by adding volume to the distal transition lines. Particularly, to match #7 more closely #10. The mesial transition line on #8 was corrected, the incisal edge of #9 was evened out and the incisal margins of both central incisors were enhanced with small direct composite additions. Tooth #10 was reduced in length through ameloplasty on the mesial half of the incisal margin (Fig. 3).

Matrices were placed to protect and separate teeth during adhesive pretreatments, the first of which involves the application of Ultra-Etch etchant for 30 seconds (Fig. 4).

After a thorough rinse, the dental substrate was coated with Peak Universal Bond adhesive. The adhesive was gently agitated for 10 seconds, then thinned/dried for 10 seconds using one-quarter to one-half air pressure. The treated surface should then appear shiny (Fig. 5).

Light curing was performed using the VALO X curing light for 10 seconds (Fig. 6).

Transcend universal composite in both dentinal and enamel shades was then layered (Fig. 7). As illustrated in the layering scheme (Fig. 8), I used dentinal chromatic enamel (A2D and UB shades) desaturated from the cervical third of the teeth in the

Fig. 1

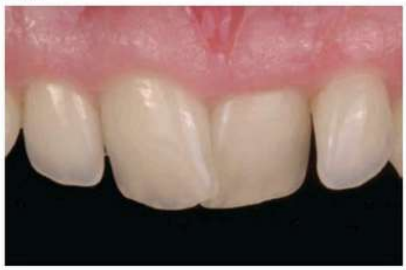
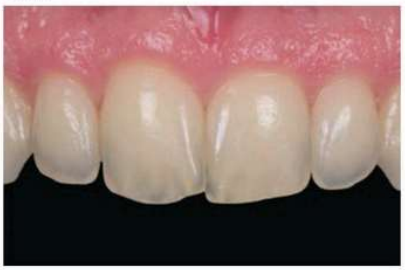


Fig. 2



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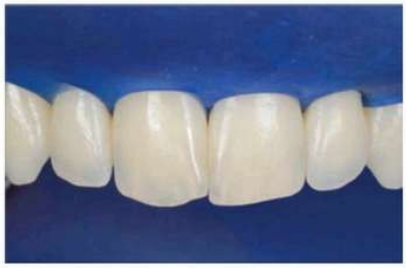

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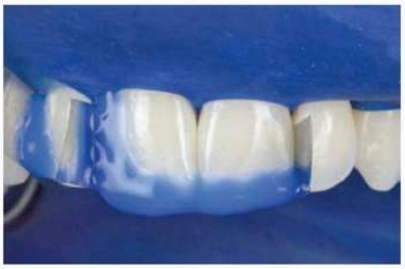

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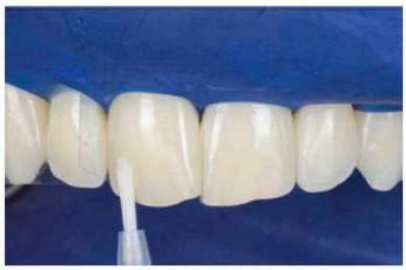

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Fig. 7


Fig. 8

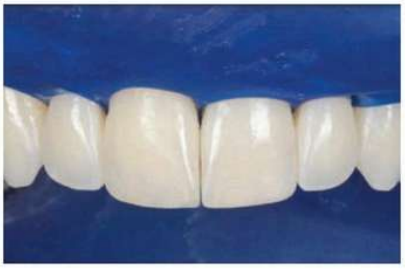
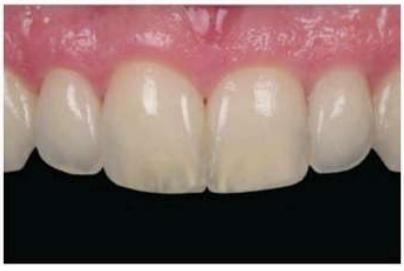


Fig. 9



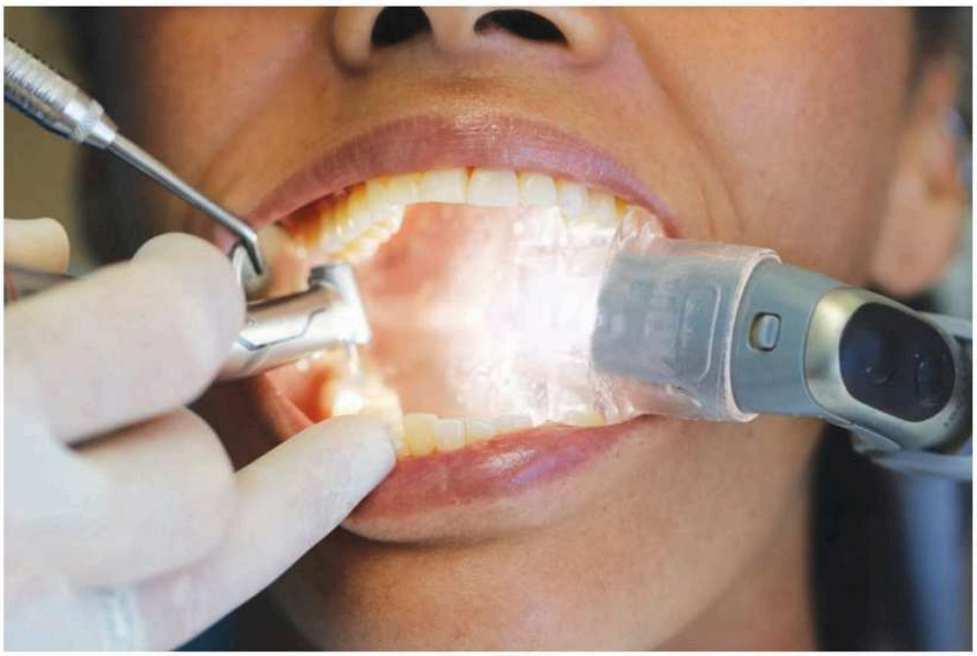
distal areas where transition lines were altered. For the enamel shades, I applied a slightly chromatic enamel (EN shade) in the most cervical areas of the transition lines and to reconstruct the incisal margins. A higher value enamel (EW shade) completed the outermost part of the distal transition lines, adding depth to the restorations without using intensives.

The handling, layering and finishing process was greatly simplified without compromising the overall results in terms of longevity and aesthetics (Fig. 9).

## Conclusion

What impressed me about the Transcend composite was its ease of use. The smart selection of masses offers great versatility for any situation with a minimal number of syringes. Its excellent handling allows for precise modeling of every surface, thus increasing the accuracy of results, especially in multiple restorations.

**Dr. Tommaso Mascetti** has a private practice in Milan, Italy, where he employs his expertise in digital planning, minimally invasive restorative dentistry and aesthetics. As an adjunct professor in restorative dentistry, he's an author and contributor in the publication of scientific articles and books. Mascetti is an international speaker at courses and conferences and the cofounder of Re-Shape, a multidisciplinary ortho-perio-restorative course with a global approach to aesthetic dentistry.



# Why I Started Using Zyris Isolite Pro in My Dental Practice

BY DR. ELAINE BYLIS

As a dental professional, I am always looking for ways to improve efficiency, patient comfort and procedural accuracy. That's why I made the switch to Isolite—a key upgrade in isolation and illumination.

Before Isolite, managing moisture control was a constant challenge. Traditional cotton rolls and suction methods required frequent adjustments, slowing down procedures and making it harder to maintain a clear working field. Patients also struggled with jaw fatigue from holding their mouths open for extended periods.

Isolite solved these issues seamlessly. Its built-in suction and retraction system keeps the field dry, reducing the risk of contamination and improving bond strength for restorations. The integrated LED lighting enhances visibility, allowing me to work more precisely with less eye strain. Plus, the soft bite block helps patients stay comfortable throughout the procedure, making their experience less stressful.

Since incorporating Isolite, I've noticed a 25% reduction in procedure time and an overall drop in fatigue—both for my team and my patients. It has been a notable improvement for efficiency and overall treatment quality. I only wish I had implemented it sooner!

If you're a dentist looking to streamline your workflow and enhance patient comfort, I highly recommend giving Isolite a try.

**Dr. Elaine Bylis** practices general dentistry in a private practice in Glen Burnie, Maryland, with her father, Dr. Paul Bylis. In 2024, she was honored to be named one of *Incisal Edge* magazine's 40 Under 40 for top dentists in the U.S. She is passionate about minimally invasive cosmetic dentistry and lectures about anterior composite artistry.

**Fig. 1:** VeneerNow Injectable Matrix System (Premier Dental Products Co.).


# Using VeneerNow for Easier, More Efficient Composite Veneers

BY DR. JASON H. GOODCHILD

Porcelain veneers offer excellent aesthetics but generally require more than one treatment visit to complete and tend to be the most expensive option. Composite veneers offer several advantages over porcelain, including the ability to be fabricated in a single visit, lower cost, and they typically involve less invasive, potentially reversible preparations. Additionally, composite veneers can be easily re-polished, touched up, modified or repaired over time, ensuring clinical longevity and addressing common issues like staining. This versatility makes them an appealing option for many patients.

The main disadvantage of composite veneers is that their aesthetic outcome relies heavily on the skill and dexterity of the dentist. The freehand application technique requires the dentist to create the correct shape, anatomical features and tooth positioning without the support of a matrix or pattern. After application, the composite material must be polished to achieve a natural, tooth-like appearance. As a result, direct composite veneers can be a challenging technique for dental professionals and may not be offered to patients as frequently.

## Introducing VeneerNow

The VeneerNow Injectable Matrix System is a prefabricated solution designed for easy, one-visit applications. This system streamlines the process of creating anatomically accurate and natural-looking chairside composite veneers and anterior restorations, ensuring a predictable and efficient experience for dental professionals (Fig. 1).

VeneerNow features a customizable, prefabricated injectable matrix system designed to match each tooth's anatomy. This system enables dentists to create durable, aesthetically pleasing veneers with precision and minimal manual intervention. By using injectable, flowable composites within a pre-sized matrix, VeneerNow ensures efficient application without air bubbles or inconsistencies. Additionally, the matrix delivers excellent anatomical shape, requiring little finishing after light curing.

The VeneerNow process is straightforward: the practitioner selects the appropriate matrix size, positions it on the tooth and injects the composite resin material into the matrix mold. The design of the matrix ensures that the composite flows evenly and precisely, helping to reduce the need for adjustments or corrections. This system results in a veneer restoration completed in a fraction of the time required for traditional freehand techniques.

The system provides full anatomic, single-use matrices for maxillary teeth #5–12 in two sizes: small/medium and medium/large. Each mold includes an injection stalk for easy placement of the flowable composite tip. Designed

**Fig. 2:** Features and benefits of VeneerNow Injectable Matrix System.


**Fig. 3:** Case example of tooth #8 restored with the VeneerNow Injectable Matrix system.

to be closed at both the lingual and cervical facial margins, the matrix allows for quick and straightforward injection of the composite. Additionally, the matrices feature side wings for enhanced stability and reduced interproximal cleanup. The side wings are 0.05–0.07 mm thick, helping to gently separate the teeth to maintain interproximal contact (Fig. 2).

The VeneerNow system offers several benefits to clinicians by providing a versatile tool to address common aesthetic and restorative needs, making it suitable for a wide range of patient cases.

From the patient's perspective, VeneerNow offers an affordable restorative option that enhances the overall treatment experience. It reduces procedure time, delivers attractive aesthetic results and involves minimal invasiveness. Patients seeking aesthetic improvements often worry about treatment duration and costs and whether the results will meet their expectations. VeneerNow addresses these concerns by providing durable, natural-looking veneers and anterior restorations that can be completed in a single appointment.

## Case example

A 70-year-old male patient presented to the dental office with a chief complaint: a broken porcelain labial veneer on tooth #8 that he wished to have replaced immediately (Fig. 3). He reported no pain or sensitivity but was concerned about the aesthetics, especially since he was attending his granddaughter's wedding in the coming days. To address his needs, the VeneerNow system was selected to deliver a fast, beautiful, one-visit restoration. After successfully administering local anesthesia, the remaining porcelain veneer was removed. The tooth was minimally prepared and the appropriate VeneerNow matrix was chosen (Palmer Notation System upper right 1┘, size M/L). Phosphoric acid etch was applied to the entire preparation, followed by the application of a universal adhesive.

The VeneerNow matrix was seated and stabilized with finger pressure. The mesial, distal and lingual incisal portions of the matrix were then sealed with Venus ART Diamond Flow composite in shade A2. Next, the Venus ART flowable composite canula was inserted into the facial stalk of the VeneerNow matrix and the material was dispensed to fill the entire space, forming the veneer restoration. After light curing, the matrix was removed, and the final restoration was finished and polished to achieve a lustrous result that matched tooth #9. The patient's occlusion was checked and verified, and upon reviewing the final result, he expressed extreme satisfaction.

## Conclusion

The introduction of VeneerNow highlights a growing trend toward standardization and efficiency in cosmetic dentistry, offering key benefits such as predictability and affordability in a single-visit solution. By integrating advanced material science with a customizable injectable matrix, VeneerNow enables dental professionals to achieve consistent, aesthetically superior results while minimizing procedural time and stress. As more practitioners adopt the VeneerNow system, it has the potential to broaden treatment options for high-quality anterior restorations and become an essential tool in both general and aesthetic dentistry.

**Dr. Jason H. Goodchild** is the vice president of clinical affairs at Premier Dental Products Company. He maintains a busy general practice in Elkins Park, Pennsylvania. He can be reached at: JGoodchild@premierdentalco.com.

## OFFICE VISIT

Dentists spend most of their working hours inside their own practices, so they usually don't get many opportunities to see what it's like inside another doctor's office. *Dentaltown's* recurring Office Visit profile offers a chance for Townies to meet their peers, hear their stories and get a sense of how they practice.

# Dr. Anna Berik

## Inspired by her daughter, this dentist created Bubble, an aquarium-themed pediatric practice welcoming neurodiverse children

BY LECKSI SHUSTER, ASSOCIATE EDITOR

**Dr. Anna Berik** didn't always envision herself in dentistry. She was initially set on a path toward medical school, when an enthusiastic friend already enrolled in dental school shifted her trajectory. A transformative visit to see him studying anatomy sparked her passion, forever changing her career plans. Today, she's not only built a successful adult specialty practice but also launched Bubble, a pediatric dental office designed specifically to reshape how children and families experience dental care.

Beyond clinical excellence, Berik attributes much of her success to embracing business education. Early struggles with purchasing and revitalizing a troubled practice led her to invest heavily in professional consulting, first with Pride Management and later with Practice Growth Institute, fundamentally reshaping her approach to practice management, patient care and efficiency.

In this exclusive *Dentaltown* Q&A, Dr. Berik shares her remarkable journey—from overcoming early business missteps and personal challenges to innovatively designing Bubble, a pediatric practice inclusive of neurodiverse children, inspired deeply by her daughter Sam.

PHOTOGRAPHY BY GEORGE ANNAN JR.

# OFFICE VISIT

## OFFICE HIGHLIGHTS

**NAME:**
Dr. Anna Berik

**GRADUATED FROM:**
Tufts University School of Dental Medicine

**PRACTICE NAME:**
Bubble Children's Dentistry and Orthodontics
bubbledentistry.com

**CITY, STATE:**
Newton, Massachusetts

**PRACTICE SIZE:**
21 operatories

**TEAM SIZE:**
15


BUBBLE

## OFFICE VISIT

### How did you find your way into dentistry?

I was majoring in biology and chemistry and was headed for med school. A friend of mine, who was a year ahead of me, applied to dental school during his senior year and needed help getting through all the paperwork and meeting deadlines. I had never really thought about dental school before this—it wasn't even on my radar. He was accepted into dental school and we kept in touch. During his first year, he was so enthusiastic when we spoke on the phone. He loved anatomy and dental anatomy. He invited me to visit during a break and couldn't wait to show me his cadaver and dissection. It had a huge influence on me. I never ended up applying to med school—only to dental school.

### How did you navigate the business challenges of starting your own practice, and what practical lessons or advice would you share with others looking to do the same?

I had no idea what I was doing. I bought an existing practice from three dentists who, unbeknownst to me, had major issues with each other. They had stopped communicating, and although they were making money, they had let the business drift. I bought a business nightmare.

I knew I was in over my head and didn't know what to address first, as everything was broken. The existing staff had a terrible culture and were divided into factions from the previous owners. I was at the office 24/7 trying to manage payroll, purchase supplies, meet and treat patients, and collect significantly overdue accounts receivable. I was sinking and knew it wasn't sustainable.

I spoke to the VP of Matsco, the bank that had loaned me the money to purchase the practice. She was a great lady and very smart. She could have panicked about the bank's money, I suppose, but she didn't. Instead, she suggested I speak with her friend Jim Pride. Jim was a former dentist who had started a consulting company called Pride Management.

I got on the phone with Jim, told him every detail of how bad the practice was, and admitted to him that I was running in circles and

> **Working alongside specialists over the years has unquestionably made me a much better diagnostician and clinician.**

desperately needed advice. I spent $52,000—money I wasn't even sure I had—on a two-year program with Pride Management. It saved me and the business. It was the best investment I've ever made. Since then, I've invested a significant amount of money into the practice and professional consulting services. I'm currently with Practice Growth Institute, formerly known as Scheduling Institute.

My advice to young dentists is to invest the money. We invest heavily in growing our clinical skills, which is important, but few dentists invest in learning the business side—learning how to run a company. It makes all the difference in the world.

### What kind of clinical work do you like to do?

I have two offices: one specializing in pediatric dentistry and orthodontics, and another adult specialty group practice. I love full-mouth reconstruction and high-end cosmetic work. I have a trademarked procedure called B.A.M. for accelerated orthodontics with Invisalign—that's mostly what I do. I believe in specialized care, so my office includes an oral surgeon, endodontist, prosthodontist and periodontist. Additionally, three general dentists specialize in restorative dentistry, Invisalign orthodontics, TMD and sleep medicine. The pediatric practice has a pediatric dentist and an orthodontist.

I've learned so much and have become skilled by consistently doing a few things at a very high level. Working alongside specialists over the years has unquestionably made me a much better diagnostician and clinician.

### What key lessons have you learned from managing multiple businesses that other dentists can apply to their own practices?

I have learned to get down to the transactional level. Go see what's going on yourself. I also learned that you can't know every detail. It's too much and will swallow you up. You must hire capable people that you trust to delegate to and save room for the things that only you as owner/CEO can do.

### What inspired you to start a pediatric office?

Kids in general dentistry often become an afterthought—not because dentists don't try their best or lack good intentions toward young patients—we

## TOP PRODUCTS

**iTero Lumina**
We love the iTero Lumina for its high-resolution digital scanning, which eliminates messy, uncomfortable impressions. This technology ensures more accurate orthodontic treatment plans and enhances patient and parent education by providing real-time visuals throughout the process.

**Dexis NOMAD Pro 2**
This offers exceptional portability, allowing us to quickly capture high-quality images without moving patients to a dedicated X-ray room. This technology also minimizes radiation exposure and improves overall patient comfort.

**Invisalign**
We use Invisalign for our teen patients because the clear aligners offer a discreet, comfortable alternative to traditional braces. They help teens maintain confidence and an active lifestyle. The removable aligners also make it easier for teens to maintain proper oral hygiene throughout their treatment.

**3M Digital Bonding**
Its precise bracket placement leads to more accurate, efficient treatments. It also reduces application time, decreasing our doctors' chair time and improving productivity.

**Dental Intelligence Engagement**
We chose this platform because it streamlines patient communication and consent-form management in one secure, user-friendly system. This modern solution enhances patient engagement through convenient digital tools such as texts and emails while simplifying administrative tasks, saving our team hundreds of hours of front-desk work.

do. My goal is to change the way people view dentistry, dentists and their oral health in general. Most people only consider their oral health when problems arise.

The inspiration for my pediatric practice came from reflecting on a favorite business principle of mine: What do you do and for whom? I had ample time to think during the early lockdown stage of the pandemic. I realized my adult specialty practice had a quiet, elegant atmosphere like a Ritz reception area, which was wonderful if you were an adult but terrible if you were an 8-year-old.

In other words, you can't excel while catering to everyone. My patient base consists of adults (and teens) who want to invest in themselves. So, questions came to mind: What if it didn't feel terrible to take your child to the dentist? What if it were a place kids looked forward to visiting? What would that look like? How could we transform the industry? And so, Bubble was born.

### Designing an office is one thing, but you also had the task of building an aquarium. Tell us a bit about the design process for Bubble.

Fish don't live as long as you think. I really went all out—we have a live moon jellyfish tank and two additional 1,200-gallon saltwater tanks. I had no idea I'd be installing saltwater-making equipment and hiring the company that worked on the New England Aquarium. I had no idea what the caretaking would involve.

I learned that we were right—that the model works. Children don't want to leave, and they are excited to come back. Adults ask if they can come. I learned that it truly was worth the thought experiment.

We welcome children of all ages and embrace neurodiverse children. (I have a daughter on the spectrum.) Not just "we will treat you" but "we get it," and you are welcome here. It's different here. It has resonated with people.

### When it comes to the animals themselves, who are some of the fan favorites amongst your patients? What kind of impact have you noticed these animals have on the treatment experience for your patients?

Amongst the living sea creatures, we have surprisingly found our giant clam was a big hit. The starfish and our red shrimp are popular too. Everyone likes the "Dory" fish (blue tang fish) and the jellies too. The sea anemones are very relaxing to watch billow in the tank's current.

### How did having a daughter with autism inspire you during the process of starting Bubble?

My daughter Sam has taught me so many things in life and about people. This girl gets up every morning in a great mood and ready to go out into the world even with her almost debilitating anxiety. I have learned that we are all the same in most ways that matter. Her anxiety is the same as mine only heightened. Having raised Sam, I can tell you that it's not easy for parents. I wanted to make a way better experience for these kids as the world is a little harder for them to navigate. And just as much, I wanted to give their parents a break—come somewhere where we understand you and your child. It's OK here. There are just so many little things one can do to make it better and easier for families.

### Since accessibility is still an emerging field, what's been your learning experience, and how could dentistry improve its approach?

I'd say they just need to pause and really think about it. Dentists are some of the brightest people I know—seriously invested in their


work and lifelong learners. All it would take is an afternoon spent learning about neurodiversity and common challenges, such as sensory sensitivities. Imagine if the entire industry took just a little time to make dental care processes easier for children. There's no way that wouldn't lead to improvements and better service overall.

### What's the biggest change you've seen in your industry, and how do you see it evolving?

I think most of my colleagues would agree that insurance challenges are hurting our industry across the board. Whether you're in private practice or a dental service organization, GP or specialty, inadequate reimbursement is a significant issue. Payments have steadily decreased while business costs keep rising. Insurance companies, driven by profit, continue tightening their grip—reducing payments while increasing patient enrollment costs, leaving dentists to bear the burden.

In the future, I anticipate fewer private practices and more public clinics, which is unfortunate because private practices have historically been a positive part of their communities.

### You've mentioned wanting to inspire change—what are the most important improvements you'd like to see in pediatric dentistry?

As practitioners, we need to truly embrace that children are not just mini-adults—their needs are different. We should honestly consider whether we, as GPs, are best suited to serve them. A deeper understanding of the neurodiverse community would not only improve care for those children but also enhance how we relate to neurotypical children. We can learn so much from these young patients, insights that extend beyond dental care and positively impact the broader community. It's all connected.

### You poured so much passion into Bubble—what advice would you give someone starting their own practice about successfully integrating their passions into their business?

Be honest with yourself—take some quiet time to reflect on what truly matters to you. Start by asking questions or envisioning your end goal: what do you want to be known or remembered for? It all begins with introspection—understanding clearly what you want and who you aim to serve, recognizing your strengths and weaknesses, and deciding how you'll address them.

### Now that you're established, is there anything you'd do differently looking back?

There are many things I'd change, which I think is natural when you learn from experience both good

and bad. I would have implemented written systems and processes earlier in my career. It might sound dull, but building predictability and consistency—though not exciting—is essential to achieving excellence.

### What's your favorite patient story?

The biggest takeaway in my career has been realizing the real impact we have on the people we meet. Some might say reconstructive cases are good business, but that's not how I see it—and haven't for a long time. Anyone can be a dentist, but what I do changes lives. That's worth dedicating a lifetime to, and it's why I'm not burned out.

One of my first full-mouth cases involved a recovering bulimic patient whose teeth were severely damaged from stomach acid and anxiety-induced grinding. She told me candidly, "Even though I've recovered, left an abusive relationship and am now happily married, when I look in the mirror, I still see the bulimic." After her treatment, she said I changed her life—she no longer sees the painful past she lived.

As dentists, we have an incredible opportunity to make a genuine difference for those who trust us with their care. It's not about teeth; it's about people. This patient truly transformed how I see the meaning of my work.

### Give us a snapshot of your life outside of dentistry.

I raised three children as a single mom and have giant dogs called Leonbergers that I can't live without. I'm a weightlifter, an avid reader and a big MMA fan. I also love the NFL and attending live sporting events. My husband and I enjoy boating around New England—I absolutely love the ocean.

I was born and raised in Washington, DC, where my mom and brother still live. My mom is the best; at 81 years old, she's still running her own business and redefining what aging looks like. **DT**

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# The In-House Marketing Manager

BY JACLYN NONA

Your community is scrolling, searching and choosing their dental care based on what they find online. They compare Google listings, read reviews and check social profiles before making decisions about their care. It's time to join the thousands of other businesses investing in an internal employee to manage brand recognition and public perception. When patients see and hear from you consistently through social channels, they build deeper trust than what's possible with just twice-yearly visits.

Rather than outsourcing to expensive agencies, identify a talented team member who already knows your practice's voice and values. Even small private practices can start by dedicating just three to five hours weekly to marketing efforts. This in-house advocate, chosen for their communication skills and passion for your practice, becomes your constant campaigner—something external agencies or AI simply cannot replicate.

Ten years ago, I was hired as a treatment coordinator and I set to work filing charts and confirming appointments. I suggested that I would be happy to have a hand in updating our Facebook page. What started as posting a couple of times a week led to other lateral moves like creating an Instagram profile and YouTube channel. As the practice grew, this gave way to full-blown marketing campaigns. We told our own story through a name change, brand redesign, practice acquisition and staff additions.

After years of taking these chances and growing together, we found ourselves to be a trusted authority in our community. Suddenly, we were writing articles in regional publications, our YouTube videos were popping up in local living rooms and our social media was reaching tens of thousands of potential new patients. To quote our office manager, "It blew the doors off our practice."

I've found that, while this can be easily implemented—and despite practice size—our industry has fallen behind. Dentistry seems to be stuck in an outdated model of outsourcing marketing. I'm shocked that the idea of tailored, internal marketing isn't commonplace, *yet*. Our industry moving in this direction is just a matter of time.

> **An in-office marketing manager is not a luxury anymore—it's a necessity for strategic practice growth.**

## First steps

Start by identifying the right employee within your practice to take on marketing responsibilities. Look for someone who demonstrates loyalty, shows genuine interest in marketing, understands social media and has earned your trust. The ideal candidate will possess key characteristics that set them up for marketing success:

- **Well-spoken.** Able to respond to reviews and comments quickly and professionally while maintaining your practice's voice.
- **Creative.** Has an eye for design and can spot meaningful moments worth sharing, from smile transformations to team milestones or celebrations.
- **Self-sufficient.** Can plan and execute content, organize community events and build relationships with vendors and local media without constant oversight.
- **Eager to learn.** Excited to master new skills and marketing tools that benefit the team and keep your practice current.

## Initial part-time responsibilities

With only a few extra hours a week, your chosen employee can handle the essential marketing tasks: ensuring your practice website and Google listing are updated and accurate, managing review responses, and creating basic social media content a few times a week. Posting three to four times a week allows you to maintain a solid relationship with your existing patients as well as welcome new ones. This can be as simple as provider profiles with original photos, patient testimonials (with consent), service explanations or giveaway contests.

Community opinion of your practice is too important to leave unchecked. Practice owners and decision-makers can't overlook the value of having someone in-house who owns responsibilities such as: requesting and responding to reviews, controlling how your brand is projected and perceived on social media, and updating your website and business listing any time there is a change in staff, hours or services.

There are unseen benefits of hiring in-house that can be seen in moments of crisis, for instance. Even the best offices will receive a negative review or public social media complaint. As much as patients are reading through reviews, they're equally interested in how you respond. Your internal hire has the advantage of speaking to you directly and immediately. They are armed with knowledge of the patient, dentistry and HIPAA protocols—and can handle all of this while you focus on dentistry.

Even in this part-time capacity, results can be measured through new followers on your social profiles, how many people are engaging with your content through likes, shares and comments, and improved review frequency. As for your budget? Consider giving your well-deserving, promising employee a bump in hourly pay in accordance with these new responsibilities—it shows your confidence in their abilities and nurtures their passion for personal and practice growth.

## The evolution

As this role and your practice grow together, your team will naturally progress beyond these fundamental tasks into more sophisticated strategies. Your marketing manager will

take on expanded responsibilities, including ongoing community engagement, creating and maintaining a consistent brand voice both online and offline, managing digital advertising and targeted campaigns, tracking platform analytics and developing more complex video and educational content.

As you take these next steps, invest in professional development for your marketing team member through certifications and dental-specific education. Social profiles, business profiles on Google and LinkedIn, website management and content creation remain free or low-cost. By investing internally instead of outsourcing, you'll achieve more authentic results while spending less on your marketing efforts.

## Proven results

When we took the time to be intentional and consistent with marketing, the changes in our practice were immediately noticeable and positive. We witnessed an explosion of practice growth, deep loyalty among existing patients, and engagement rates we wouldn't have dreamed of in the past. We expanded our staff from eight employees to nearly 30 to meet the needs of our increasing patient growth. We have more than 11,000 followers across social media platforms. We purchased three additional practices and expanded our services and hours in ways that served both our patients and staff.

In addition to measurable growth, our relationships with local charitable organizations and businesses flourished, resulting in ours becoming a resounding voice in our local landscape. Much of this was made possible by dedicating marketing responsibilities to an internal member of our staff. Engaging with your community, capturing milestones and special moments, and responding immediately to feedback is easier when a team member is committed to these responsibilities.

## Final impact

There is not a single dental practice or business that won't benefit from marketing. Providers are understandably focused on clinical care and patient management, so the default has become outsourced marketing. Most practices don't realize the value and need for internal marketing. While the role is currently rare in dentistry, I find it crucial for survival and growth. This approach proved so successful that our team—including our doctors/owners and practice manager—formed the first internal marketing program designed specifically for the dental industry.

An in-office marketing manager is not a luxury anymore—it's a necessity for strategic practice growth. Implementing a flexible, evolving marketing role in your practice will drive patient acquisition, retention, revenue and overall practice recognition. Investing in your staff and incrementally expanding marketing capabilities and responsibilities is both a cost-effective and dynamic approach. It's never been easier to take the first steps toward practice and industry advancement. **DT**

**Jaclyn Nona** is the CEO and cofounder of Clever Dental Co., an educational and creative platform designed to help practices excel with authentic internal marketing strategies. Nona has been operating in the dental industry since 2013 and works alongside talented doctors and practice management professionals in Indiana. She's a member of American Association of Dental Office Management and the American Marketing Association. When she's not helping practices thrive, she enjoys spending time with her wild and active family and their pup, Murphy.

# All on Board

## Seven essential new-hire strategies for efficient onboarding

BY DR. JEFFREY GREENBERG

As a dentist who launched a startup dental practice just six months before the COVID-19 pandemic hit, I know firsthand how critical the onboarding process is to building a resilient team. In those early days, like many small business owners, I had to navigate uncertainty, adapt quickly and create systems that not only worked but also provided a solid foundation for sustainability and growth.

On top of managing my dental practice, I'm also the co-founder of a software startup, Flomo, which helps small- to medium-sized health care businesses streamline their standard operating procedures (SOPs) to create efficient, well-organized operations. These two ventures both depend on having a well-thought-out, supportive onboarding strategy.

Small businesses don't always have the luxury of extra team members or endless resources, which is why an effective and standardized onboarding process can make all the difference.

Here are the strategies I've found essential in onboarding new hires, particularly when resources are tight and you're working to create a lasting, positive impact on your team.

## 1 Create a meaningful atmosphere

First impressions are everything, especially in a small business where the entire team is interconnected. In my practice, we work hard to create a truly welcoming atmosphere for new hires. It's not just about saying, "We're happy to have you"; it's about making them feel like they belong from the moment they step through the door (or log in, in the case of virtual hires).

This starts before their first day with a welcome email, introductions to their future team and an outline of what to expect. We want to ensure that the first day feels organized and positive, rather than overwhelming. For a small practice like mine, where everyone plays a critical role, creating this welcoming space has been essential in building strong, trusting relationships from the start.

## 2 Prepare hires for success

Onboarding doesn't start on the first day. In my dental practice, we make sure everything a new hire needs is ready well before they walk through the door. Whether it's getting their workspace in order, setting up email logins or sharing onboarding documents, preparation is key.

For remote team members, like my virtual assistants, I send video tutorials and helpful resources ahead of time. The goal is to provide enough background information so they can get up to speed quickly without feeling overwhelmed. This step is particularly important in small businesses, where you can't afford a slow start. The better prepared they are, the more quickly they can start contributing meaningfully.

## 3 Lead them to resources

One challenge in any small business is that people are often wearing many hats. This makes it even more important that new hires know where to find answers when they have questions. No one can be expected to know everything on day one, and creating a system where information is accessible is crucial.

In my dental practice, we have a centralized digital folder with all key documents, from office procedures to team contacts. For our virtual team, we use something similar that includes step-by-step guides and frequently asked questions. This system ensures that even when team members are working remotely or outside typical office hours, they know exactly where to turn for help.

## 4 Have a dynamic SOP

One of the best decisions I made early on in my practice was developing an SOP manual. Rather than being a thick, dusty binder, it's digitized, easily accessible and constantly updated. This living document is an essential tool for every new hire, and it helps maintain consistency in how we operate as a team.

Having the SOP manual digitized and cloud-based is particularly important for small businesses, where everyone's time is precious. Instead of relying on verbal instructions or paper-based procedures, every team member has access to the latest protocols with just a few clicks. This allows new hires to feel more independent, and seasoned team members can focus on their tasks rather than spending time answering procedural questions.

In our software as a service (SaaS) business, Flomo, we'll be taking this a step further by helping other small- and medium-sized health care businesses create and customize their own digital SOPs. It's a resource that has made a significant impact in my own practice, and it's something I encourage every small business to invest in.

## 5 Keep your promises

One of the most important elements of onboarding is trust. From the very first conversation, you're setting expectations for what this job will look like—whether that's salary, benefits, job responsibilities or flexibility. Whatever promises you make during the hiring and onboarding process, you need to follow through.

For instance, if you've promised a certain level of flexibility around scheduling or specific training opportunities, it's essential to honor that. Even small broken promises can lead to disengagement or frustration. In a small business, where each team member plays a crucial role, trust is everything. Keeping your word builds loyalty and ensures that your new hire feels valued and supported.

## 6 Tailor your onboarding

One size doesn't fit all when it comes to onboarding (trust me, I've tried). Everyone learns differently, and it's essential to adapt your approach to meet their needs. Some people prefer hands-on training, while others thrive on written instructions or visual aids. By understanding how your new hires learn best, you can help them get up to speed faster and with less frustration.

In my practice, I ask new hires about their preferred learning style and adapt the onboarding process accordingly. Whether it's through video tutorials, written documentation or shadowing a more experienced team member, the goal is to make them feel confident and comfortable in their new role.

## 7 Use emotional currency

In a small business or startup, budgets can be tight—especially when you're just getting off the ground. But you don't always need a big budget to make a lasting impact during onboarding.

What you lack in financial resources, you can make up for with emotion. People want to feel like they matter. This is especially important in a small business where every team member plays a vital role. During onboarding, take time to connect with new hires on a personal level. Ask them about their goals and aspirations, and what they need to succeed. Show genuine interest in who they are, not just what they can do for your business.

For example, in my dental practice, we have structured reviews at three days, three weeks and three months from their starting date to assess how the new hire is settling in and to address any challenges or questions that have come up.

These check-ins are not performance reviews—they're opportunities to have an open conversation about how the onboarding process is going and where additional support might be needed. In a small business, every team member's success contributes to the overall success of the practice, so it's important to invest in their growth. These moments aren't just about discussing job responsibilities—they're about building a relationship and showing that I care about their success.

Emotion can be a powerful motivator. When new hires feel valued and connected to the business on a deeper level, they're more likely to stay engaged and committed, even when resources are limited. It's a small but impactful way to build loyalty and create a strong sense of community in your practice.

## Final thoughts

Whether you're running a dental practice or a startup, onboarding is one of the most important investments you can make. Creating a welcoming atmosphere, preparing new hires for success, providing easy access to resources, and fostering a culture of trust and learning are all key to building a strong, cohesive team.

In a small business, where each team member is crucial, the onboarding process can make all the difference for long-term success. By implementing these strategies, I've seen firsthand how it can lead to better retention, a stronger culture, and ultimately, a more successful practice. **DT**

**Dr. Jeffrey E. Greenberg** is a general dentist and the founder of Sweet Spot Dental, a startup dental practice built on the values of trust, compassion and personalized patient care. Coming from a family of dental professionals, Greenberg has combined his deep-rooted experience in dentistry with his passion for innovative practice management. He is also the co-founder of Flomo, a SaaS platform that helps small- to medium-sized health care businesses create streamlined SOPs for effective, efficient operations. Greenberg's unique perspective as both a health care provider and startup entrepreneur offers valuable insights into building successful, resilient teams in the dental industry.