INSIDE THIS ISSUE: Innovative implant techniques • Handling challenging patients • Key aspects of SDF

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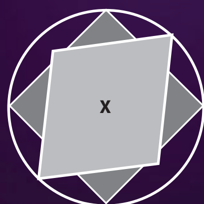

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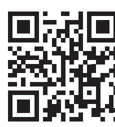

FEBRUARY 2025 VOL. 26, ISSUE 2

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REAL DENTISTRY FOR REAL DENTISTS

Dr. Edward R. Kusek demonstrates laser-enhanced allogenic grafting

Dr. Roopwant Kaur outlines SDF essentials

Dr. Arthur R. Volker presents a complex restoration

Dr. William Jacobson addresses patient behavior

Drs. Stevie Roberts and Robert Johnson explore authentic branding

Drs. Edmund Liu and Chung Lin

From cousins to colleagues: How this duo built a thriving dental practice rooted in trust, teamwork and cutting-edge care.

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OFFICE VISIT

Drs. Edmund Liu and Ken Lin

This month, we spotlight Clarksburg Dental Center in Maryland, led by Drs. Edmund Liu and Ken Lin—cousins who took unconventional paths into dentistry. In our exclusive Q&A, they share how they overcame early business struggles, developed a practice philosophy, and strategically invested in technology and consulting to transform their business into a thriving success.

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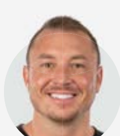
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DR. HOWARD FARRAN, DDS, MBA
Founder and CEO

Set an Ironman Goal—For Your Life and Your Practice

Back in 2013, I decided it was time for a big, audacious goal—one as hefty as my waistline. I was sedentary and out of shape, and knew I needed to change. So, I signed up for the Arizona Ironman triathlon. Yep, a 2.4-mile swim, a 112-mile bike ride, and a 26.2-mile marathon—on a single day. Was I ready? Absolutely not. But that's the point of a goal, isn't it? To stretch you, challenge you and transform you.

The Ironman is held in Tempe, Arizona—a place near and dear to me. I earned my MBA there in 1999 and worked just a few miles away in my dental office in Ahwatukee. The November event's gorgeous weather makes it the perfect backdrop for such a grueling test of endurance. But make no mistake: Ironman's strict time limits are no joke. You must finish the swim in 2 hours and 20 minutes, the bike ride within 8 hours and 10 minutes, and cross the finish line by midnight.

So how did I go from couch potato to Ironman medalist? By hiring experts. And along the way, I learned some lessons about motivation, accountability and what it takes to succeed—not just in Ironman races but in life and business, too.

The importance of a coach (or two)

In dentistry, we all call ourselves "doctor," which comes from the Latin docere—to teach. Well, I needed some teaching, so I hired trainers—two of them, both seasoned Ironman veterans. They showed up at my house every morning at 5:00 a.m. for three years, whipping me into shape. For swimming, which I quickly learned was much harder than I thought, I hired a third trainer. Without their guidance, I never would've made it out of Tempe Town Lake alive—let alone through the chaotic, elbow-filled melee of 2,000 swimmers vying for the same space.

Trainers, consultants, mentors—they're like training wheels. They keep you steady and guide you through the tough parts. But eventually, the best performers—whether athletes or business owners—learn to motivate themselves.

Greatness comes from within

Here's the thing: trainers can teach you the rules of the game, but playing with heart is all on you. They can get you moving, but intrinsic motivation—your drive to succeed—is what keeps you going long after the training sessions end.

It's the same in dentistry. You can hire the best dental consultants to optimize your practice—and I've hired some incredible ones over the years—but they can't want it more than you do. If your office is underperforming, the first place to look isn't your staff, your spouse, or your location—it's the "man in the mirror."

Your practice ironman

Running a successful dental practice is a marathon, not a sprint. It takes time, discipline, and the willingness to adapt and learn. Think your practice is bloated, inefficient or falling behind? Set a big goal to fix it! Hire consultants, invest in your team and focus on delivering exceptional care.

I can tell you this: every dollar I ever spent on a dental consultant came back to me—and then some—within the same year. That's a no-brainer ROI. The best part? Dentaltown offers incredible resources and practice management consultants, including this year's Townie Choice Award winners.

A call to action

If I can go from sedentary to completing three Ironman races, you can reach your goals, too. Whether it's transforming your health, your practice or your life, the steps are the same: set a goal, commit to it and take action.

Thinking about your own Ironman moment? The 2025 Arizona Ironman is scheduled for November 16. Make it your New Year's resolution. Or, if your practice needs a boost, start by visiting Dentaltown and find the perfect trainer for your needs. Change starts with the person in the mirror. You've got this! **DT**

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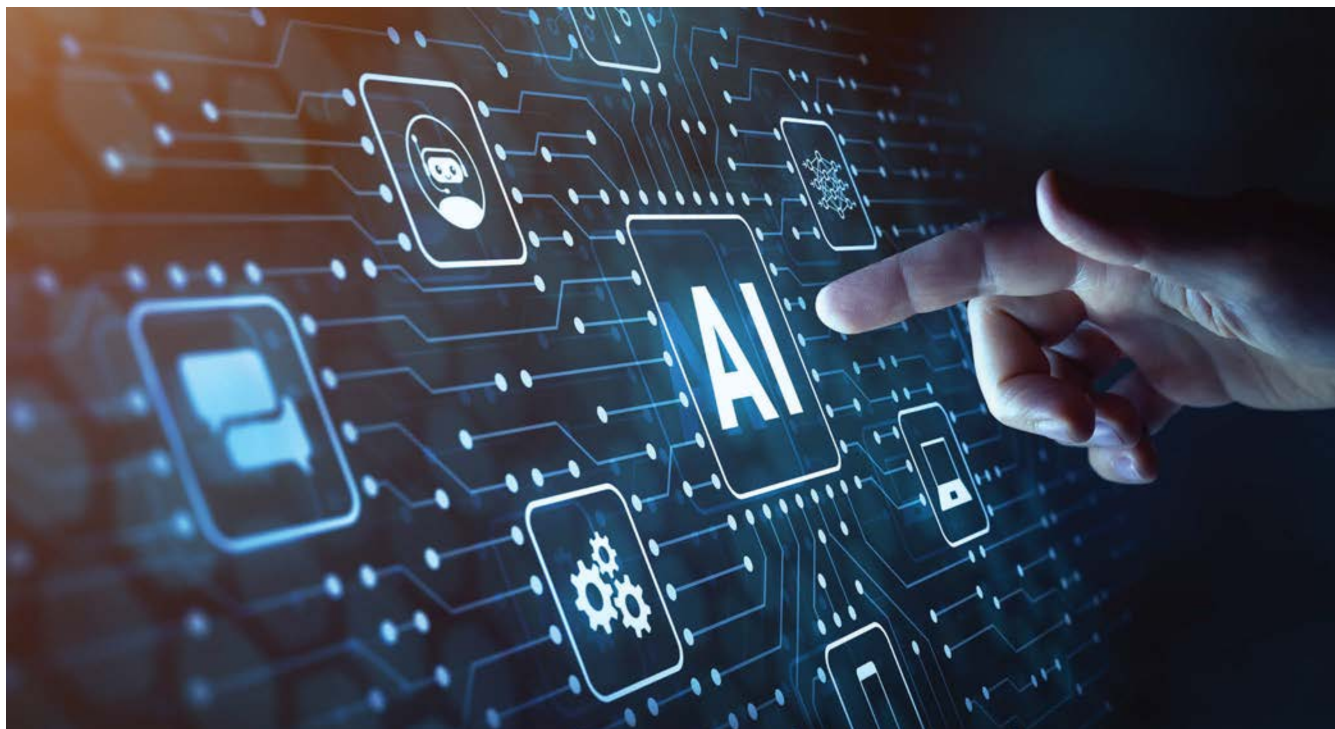

AI: Let's Have Some Fun

The most basic progression of technology is fire, wheel, steam, electricity, internet and AI. Yes, there were a few things in between as well, but the important message is that AI will become an essential tool in your personal or professional life, just like fire was for cave dwellers. Here, I'll review a few basics and hopefully provide you with the confidence to start incorporating these tools into your daily life. This is technology that takes time to learn and you can only understand the potential when you start to use these tools on a regular basis. Let's start with some brief descriptions of the dominant models that are available for free in some form.

Four AI options

Gemini. Google's Gemini, a relative newcomer to the AI space, combines advanced conversational AI capabilities with integration into Google's ecosystem. Users can rely on Gemini for tasks such as conducting research, generating creative content or automating workflows. For beginners, Gemini's seamless connection with Google services—like Drive, Docs and Sheets—makes it an intuitive choice for managing daily tasks.

ChatGPT. OpenAI's ChatGPT is arguably the most recognized name in conversational AI. With its ability to draft emails, brainstorm ideas and even summarize lengthy articles, ChatGPT has become a go-to for professionals across industries. For beginners, its user-friendly interface and versatility make it a starting point.

Perplexity. Known for its search-centric AI capabilities, Perplexity excels at answering questions and providing concise, sourced responses. Think of it as a supercharged assistant for when

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you need accurate information quickly. While it might not match the depth of ChatGPT for creative tasks, its strength lies in delivering factual and relevant answers.

Claude. Anthropic's Claude emphasizes ethical AI use, particularly for content creation and customer service. It's designed to generate detailed, thoughtful responses while minimizing risks like misinformation.

Guidelines for writing prompts

AI's effectiveness depends on how you engage with it. Writing clear, specific prompts is key to getting good results. Think of a prompt as something more detailed and specific than a Google search. Here are some templates:

Template 1: Task-oriented prompt

"Explain [specific topic] in simple terms suitable for [audience]. Include [specific details or examples]." Example: "Explain the importance of regular dental checkups in simple terms suitable for parents of young children."

Template 2: Problem-solving prompt

"Provide [type of output, e.g., step-by-step instructions or a list] to address [specific challenge]. Prioritize [key considerations]." Example: "Provide interview questions for a new member of a dental front office team. Prioritize questions that will focus on key experiences in previous positions."

Template 3: General purpose prompt

"Act as an expert or take a role as [type of expert or description of a role]. Provide [describe task as if you were explaining it to an intern and give examples with your instructions]. Think deeply about your response. Ask me any questions that would help you provide me with a great answer."

This general-purpose prompt gives you a sense of how detailed you can be with your prompts. If you ask the AI to provide you with some great prompt templates to address a particular problem, you will find other approaches to help you learn the best way to ask questions. The better the prompt, the better the output.

Having some fun: AI competition

Once you have some comfort with writing AI prompts and seeing the results, I recommend you visit lmarena.ai, the brainchild of researchers from UC Berkley. It's a chatbot arena that allows you to evaluate multiple AI responses and vote on your favorites. In the arena you will enter a single prompt and you will see two responses. Once you vote for your favorite you will see the source. The website will show you the leading models based on more than two million votes.

AI in dentistry: today and tomorrow

We know that AI is already popping up in dentistry through various enhancements to digital products we use every day. More will be coming. I encourage you to start using AI in your life so you can better understand the power of these tools. Many experts expect AI to improve productivity in businesses by 20%. Imagine how much that would change your practice. Once you start learning more, I would love to hear more about the things you want AI to improve in your dental practice. Please share your comments on the online version of this article at dentaltown.com or send me an email at tom@dentaltown.com. **DT**

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Cannabinoids: What the Practicing Dentist Needs to Know

by Dr. Mark Donaldson

With the decriminalization of cannabis for medical and recreational use across Canada and much of the U.S., dental professionals face new challenges in addressing the oral health needs of cannabis-using patients. This course offers evidence-based strategies to treat these patients while navigating their unique clinical considerations safely and effectively.

MATE Module 1: Introduction to the MATE Act and the Role of Dexamethasone in Non-Opioid Pain Management

by Dr. Jason H. Goodchild

The first module in the MATE Act series provides a comprehensive introduction to the MATE Act, with a focus on compliance strategies specific to dentists. This session also explores a non-opioid post-operative pain management approach using the glucocorticoid dexamethasone.

50 Shades of Gray—Defining Radiolucency in Practice

by Dr. Parul Dua Makkar

This course explores commonly encountered radiolucencies and delves into the topic of oral cancer. Participants will learn proper screening techniques, treatment protocols and effective patient management strategies. The program also covers predisposing factors for cancer, emphasizes prevention and highlights the importance of patient education.

MATE Module 2: The Perfect Initial Post-Operative Analgesic Recipe

by Dr. Mark Donaldson

This course equips clinicians with essential knowledge to enhance prescribing practices and improve postoperative pain management. It includes a brief review of the MATE Act, aligned with the recently updated CDC clinical practice guidelines for prescribing opioids for pain. The session focuses on evidence-based strategies for selecting initial medications to ensure optimal patient comfort and safety.

White Spot, What Now? An Update on Incipient Caries Treatments

by Dr. Jeanette MacLean

This course examines early interventions and nonsurgical approaches to managing incipient caries lesions. Participants will explore techniques such as the use of topical fluorides, silver diamine fluoride, Icon resin infiltration, and remineralization agents like MI Paste and Curodont.

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This four-part book is a comprehensive guide to dental care standards and how to avoid legal issues while practicing dentistry.

ETHICS, JURISPRUDENCE AND MALPRACTICE

AI in Dentistry: Will Dentists Survive?

NEW COURSE

by Dr. Peter Fritz

Will dentists thrive in the age of AI? This course explores how advancements in artificial intelligence—from diagnostic algorithms to automated treatment planning—are transforming the field of dentistry. Learn how to leverage AI's potential, mitigate its risks and position your practice for success in an AI-driven future.

ETHICS, JURISPRUDENCE AND MALPRACTICE

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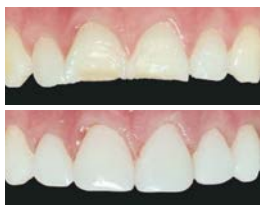

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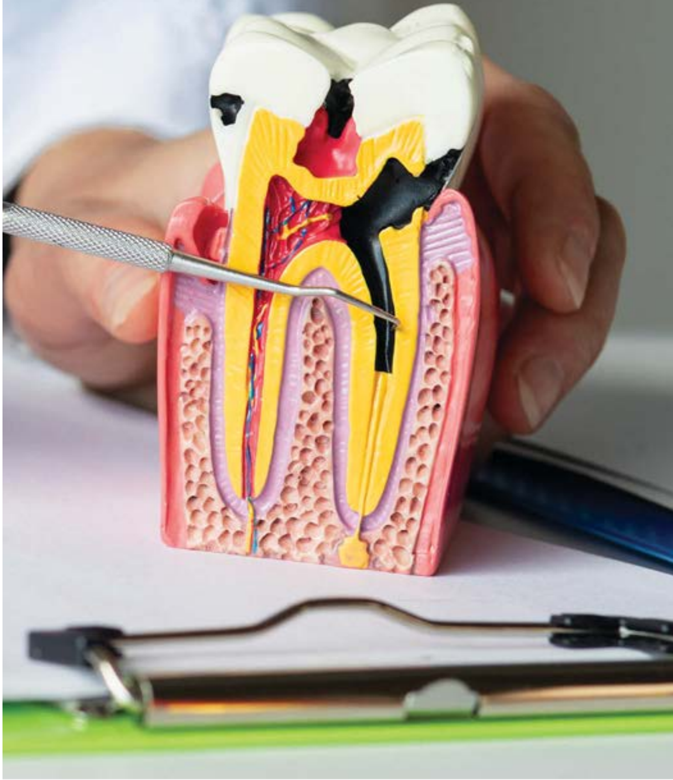
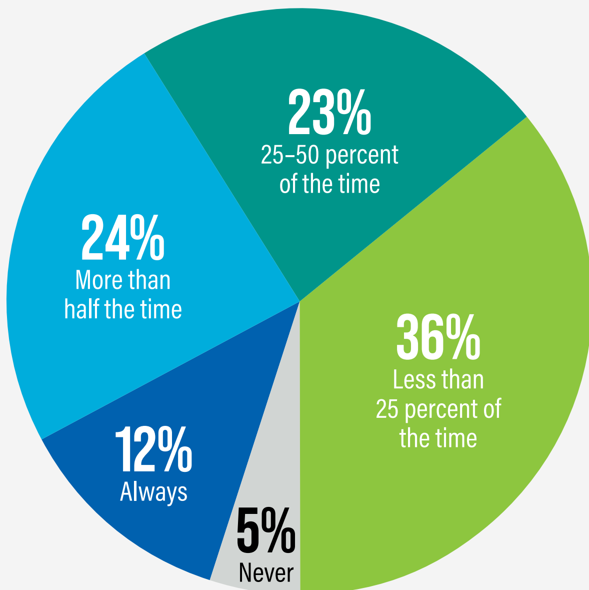
Dentaltown's monthly poll helps you see how other practices operate—what's working, what isn't—and how dentistry is evolving. This poll was conducted from Dec. 26, 2024 to Jan. 7, 2025 on Dentaltown.com.

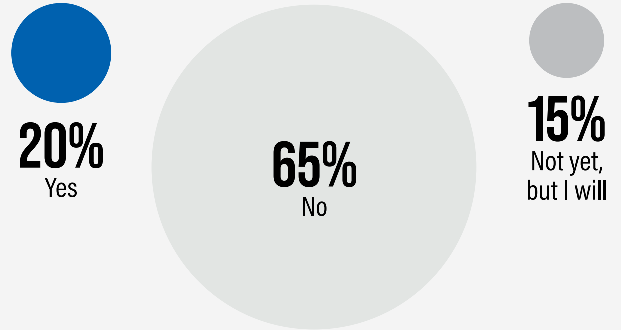


Endodontics

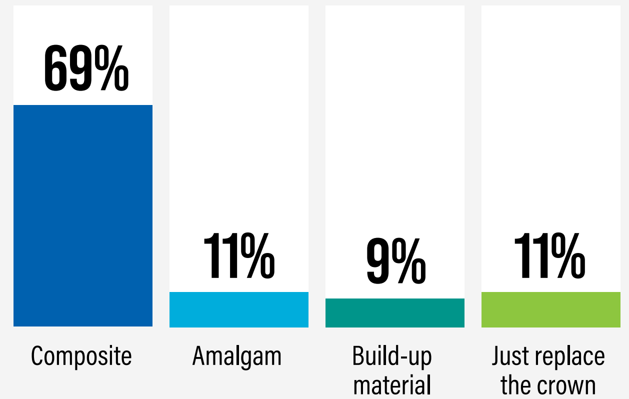
How often do you refer out endo-related procedures?



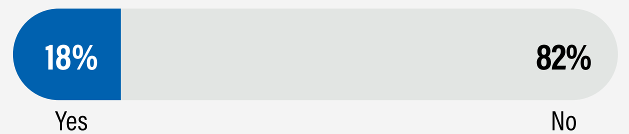
Have you taken any endo-related CE this year?



How do you fill an endo access opening through a crown?



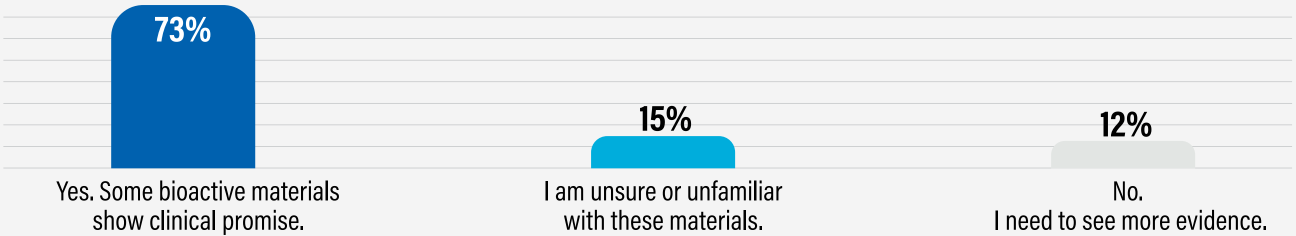
Does your local endodontist place implants?



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 human resources. The final tallies will appear in the March issue of *Dentaltown* magazine.

Do you believe bioactive materials will play a larger role in endodontics as time goes on?

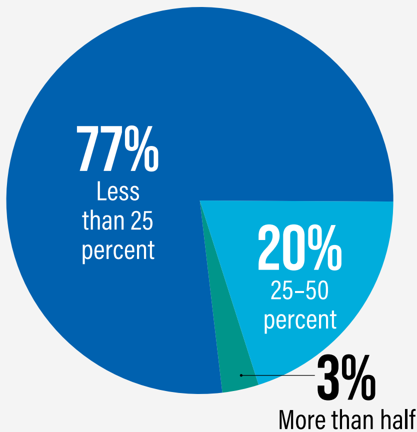


Yes. Some bioactive materials show clinical promise.

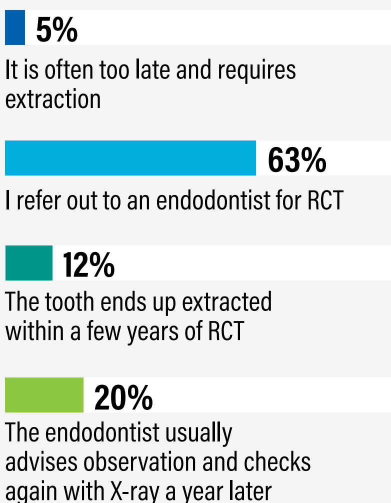
I am unsure or unfamiliar with these materials.

No. I need to see more evidence.

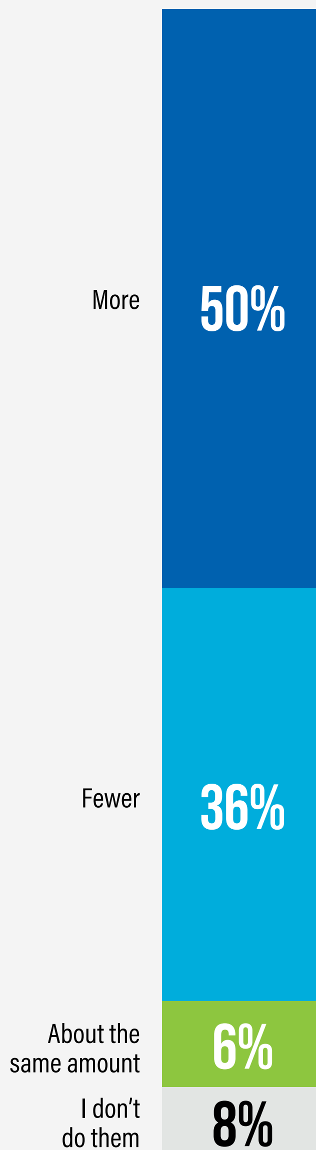
What percentages of teeth that require RCT have a diagnosis of cracked tooth syndrome?



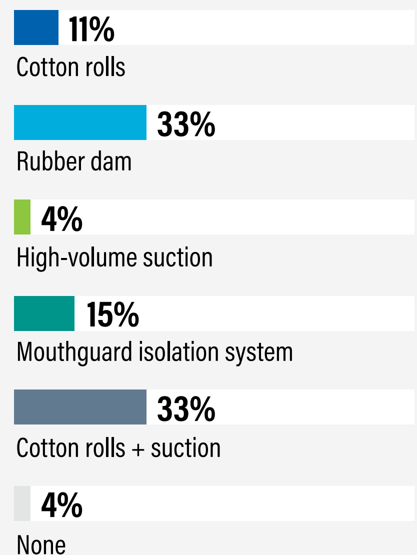
When I identify a tooth with internal resorption ...



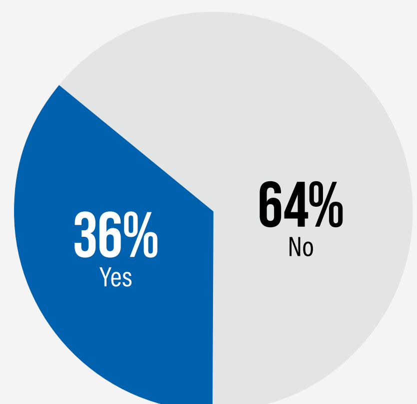
Do you do more or fewer endo procedures since you started practicing?



What is your preferred method of isolation?



Do you use an electronic pulp tester during endodontic diagnosis?



Reducing or Eliminating White Spots

Townies share tips and techniques for reducing white spots on teeth

djr Post *1 of 60* 2/21/2023

Has anyone had good experiences with Icon in reducing white spots on patients' anterior permanent teeth? Tried it more than 10 years ago and was not thrilled with the results. ■

jbm24 *Post 2 of 60* 2/21/2023

Yes, I've had really great outcomes with it.

I always make sure to go into it letting the patient know that I cannot guarantee results, but that it is a good "starting point" to see if we can camouflage white spots. "If we cannot achieve ideal results through Icon, then we can try more invasive techniques." Patients are usually more than willing to give it a go even without a guarantee.

I let the resin sit on the tooth for up to 10–15 minutes sometimes with operatory lights off/dimmed, if the lesion looks deep. Luckily, I've yet to have a case that I was disappointed with the results. I'm a big fan of it! ■

Dent 2012 *Post 3 of 60* 2/21/2023

Al Munk recommended using muriatic acid and pumice. I tried it, and it worked great. Ordered from Amazon. You have to be very careful with it though. ■

DocGrassy *Post 12 of 60* 5/22/2023

What code are people using for the in-office procedure with etching and MI paste? And what sort of fee are you charging? ■

DrMarta *Post 14 of 60* 5/22/2023

Mixed results, but always with improvements.

I had one post-orthodontic patient with white spots that, by using the etch and MI paste chairside protocols in one application, I was able to eliminate the white spots completely.

I had another patient with both brown and white spots. I used the same protocol followed by several months of daily MI paste application and saw significant improvement. Her personality did a flip switch—it was great to see her so happy to smile!

To optimize the results, you need to do one or two chairside sessions with take-home treatment.

Suggestion: Make sure your treatment plan clearly states a disclaimer that if the patient has an allergy to milk or casein, the treatment is contraindicated. ■

barstoolpigeons *Post 15 of 60* 5/22/2023

I've done the etch for two minutes then pumice then MI paste for a couple of patients with fluorosis. Might have had them use MI paste in a tray at home, don't remember.

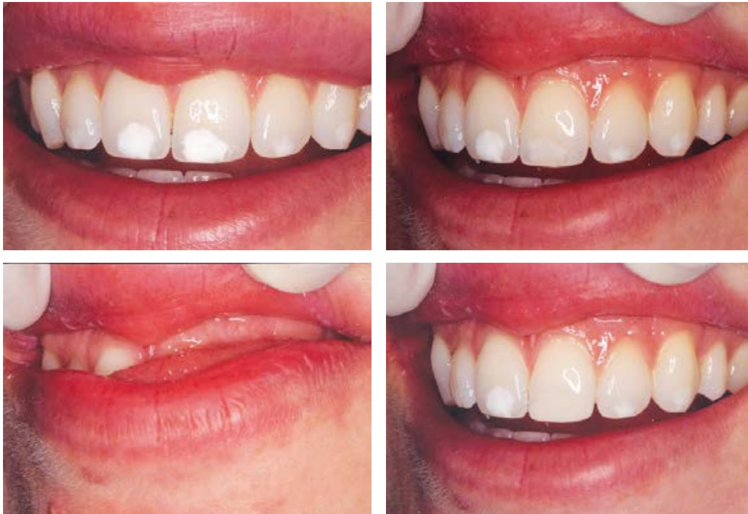
One mild case looked much better, and one moderate case turned to mild. Think it took a couple of rounds. They were actually identical twins, so N=2 but a twin study! Charge for your time. ■

rbertolotti *Post 18 of 60* 9/12/2024

No need to use dangerous muriatic acid. Just use phosphoric acid gel mixed with alumina in a dappen dish. A prophy cup makes a mess, so use a Q-tip instead to "burnish."

Probably five minutes for most white spot removals. Stop at the "half-removed" point and allow rehydration for a few minutes before further abrasion.

This young patient is doing the rehydration with his tongue. Let's treat tooth #9.



odell060 Post 20 of 60 9/12/2024

Nice. Can you walk me through this a bit more?

Etch gel with alumina, scrub for a few minutes, rinse, repeat again if needed. Do you dry and apply an unfilled resin if it looks good after rehydration? Air dry sufficient or dry with alcohol?

Thanks in advance.

rbertolotti Posts: 21 and 22 of 61 9/13/2024

After having successful removal of white spot, if you dry with air the white spot reappears. So just leave it as is. I have been doing this procedure for many years and have zero problems. Tooth Moose is used by some friends after treatment as above.

Perhaps someone can help me better understand what the white spot is. I have been told that it is porosity below an intact layer of enamel.

I advise two rubber dams with some sodium bicarb toothpaste between the two. Safer is to use phosphoric/alumina as in my previous post.

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Patient Threatening to Sue for Work Done at Previous Practice

Townies discuss navigating legal threats in dental practice ownership

Tooth Decay *Post: 1 of 75* 12/3/2021

So, this is an interesting case. I'll start with the backstory. I purchased a practice on 8/16/2019. There is a patient that had crowns done on teeth #8 and #9 by the previous owner and treatment was started 11/2018 and completed 05/2019. Payment for the service was completed in 12/2018. Patient has had a few adjustments on the crowns in 2019, before my acquisition on 8/16/2019. I saw the patient once in January 2020 and the selling doc was working as an independent contractor. I had the patient reappointed to see him for consult/adjustment. The patient's husband is now demanding me to refund the cost of the crowns and buildups, about $3,000, because they are unhappy with them. I've pretty much told him to pound sand because a separate corporation was paid and provided treatment. No balance from this patient was in the accounts receivable. Patient told me today they are going to take me to court. Anyone have any crazy PITA patients like this before? ■

drwalrustooth *Post: 2 of 75* 12/3/2021

I would tell them that while you are sympathetic to their problems, they are barking up the wrong tree.

Direct them to the former doctor. ■

Tooth Decay *Post: 4 of 75* 12/3/2021

I did that and I have talked to the doc that provided the treatment. They both refuse to talk to each other and only communicate through me. Told the patient to file a complaint with the dental board for mediation as this would also save him legal fees. He wasn't having any of it and insisted that when I purchased the practice that I also bought all his liabilities. Dude is out of his mind. All I can think of is if I can counter sue for time off if I go to court and get a court order for not being able to leave negative reviews online for services I did not provide. ■

Orange Tang Clan *Post: 6 of 75* 12/3/2021

Difficult situation because, although you likely did an asset purchase agreement, you still want to have the former doctor's back. I've bought a few dental practices, and I redo things for free from time to time to protect the seller.

The question is: Can you make these people happy by redoing the work, or is it a lost cause? Most states have some sort of statute of limitations for filing a lawsuit. In my state, it is two years. ■

Tooth Decay *Post: 9 of 75* 12/3/2021

I have redone some work at no charge and do go out of my way to keep patients happy and in the practice. This patient is one that I would not touch with a 10-foot pole. The first conversation I had with them in 01/2020 they said they had a consult with a "real dentist and the crowns are the wrong material, the previous dentist removed gold core buildups to pocket the gold, and there was no reason to redo the crowns." I have CEREC and could redo these for less than a $100 material fee, but there is no trust and there is no way I'm touching those teeth with anything but the overhead light. ■

DDS'06 *Post: 10 of 75* 12/4/2021

Why on Earth would you suggest to the patient to file a board complaint against previous owner? In cases like this, the less you communicate the better.

Just inform the patient you are not liable for this, and they are free to do whatever they wish to do. That's it. It's not going to go anywhere from here. ■

Tooth Decay *Post: 11 of 75* 12/4/2021

Sorry I misspoke on that. The previous owner told me to tell them to go to the state dental association for mediation. ■

Gr82thDoc *Post: 12 of 75* 12/4/2021

Contact your malpractice insurer for advice. I don't see how you could be remotely responsible for any of this. Let him file whatever he wants to and if it involves you as a named party let your malP insurance deal with it. Since he has threatened legal action all communication between you and him is over. He is simply trying to score some cash in my opinion. We as dentists will see more of this in the future. It's unfortunate. Best to you! ■

ricky-ticky-tavy *Post: 13 of 75* 12/4/2021

Don't ever communicate with anybody over a situation that is not your responsibility. You told the patient, "I can't help you." You being the mediary between these two isn't kosher. Not your problem, don't make it so. ■

Bonded *Post: 16 of 75* 12/4/2021

Something I learned from non-dental corporate businesses: If someone threatens a lawsuit, you inform them that you/your office will now only converse with them through their lawyer (and they are no longer patients at the office). ■

Zombieking *Post: 17 of 75* 12/4/2021

I had something similar happen. When I purchased, I did not purchase his corporation… just assets and goodwill. The patient got nasty with me (had already left the practice before I purchased), and I basically told her imagine that she bought something at a Target, and it closed and Walmart moved into that location. Walmart isn't taking back a Target purchase (although they might because they are crazy).

Just because you got something at the same physical location and it's the same type of business doesn't mean it's the new business's responsibility.

Telling them to file a board complaint is ridiculous. Having them go through you is ridiculous.

I would give the patient the old owner's direct number and say good luck, but our relationship is over the day you talk lawsuit. I will provide emergency services only for 30 days until you find a new doctor and all records will be provided free of charge.

Put everything in writing! ■

dm1898 *Post: 20 of 75* 12/4/2021

If the patient wasn't a lunatic, I'd probably just do it for free. ■

Thomasaurus *Post: 21 of 75* 12/4/2021

At least you know he's not a lawyer. By the way, how bad were the crowns? ■

depdoc *Post: 22 of 75* 12/8/2021

All excellent replies. To add emphasis on some points made:

1. You didn't do the crowns, you didn't own the practice when they were done—you have no liability what-so-ever.
2. No board action would be taken against you. If they file a board complaint, you (or better, your malpractice company) responds simply with, "I was not the owner or employee at this location when the crowns were done. I didn't do the crowns. I didn't provide any services on these crowns. The complainant was a patient of the former practice owner."
3. Doubtful that any lawyer would take the case in the first place, but once all the records were received, he'd realize that the treating dentist would be the one to go after. A case against you would be thrown out. He could be liable for your attorney fees (your carrier's fees), and a complaint against him could be filled by you to the bar (as he would be bringing a case against a party never involved in the case).
4. Once the patient threatens a lawsuit, don't talk to them again. Send a certified dismissal letter and refer them to the local dental society for a referral to anther dentist, or let them go to the dentist who said it wasn't right in the first place.
5. If the patient posts a negative review, respond to the review simply stating that the practice she is complaining about was the previous owner and you have never provided treatment to this person. It's too bad that anyone can post a negative review with impunity. But I think more people are beginning to realize that reviews are usually useless. ■

Tooth Decay *Post: 24 of 75* 12/8/2021

Thanks for all the posts, everyone. I'll be sure to keep this up to date with any letters and outcomes (should be pretty entertaining). This patient also owes about $350 for a recall and composite from 8/2019 that they have refused to pay. I'll provide the bill in court or we're waiting to send to collections until this is resolved. ■

almunk *Post: 27 of 75* 12/9/2021

Those of you who have bought and sold practices, is there a clause or an allowance for the new doctor to redo work that fails within the first few years? Is it common for the old doctor to provide a fund for these redo's? I bought a practice years ago and the seller would not guarantee a thing he did. ■

tricuspid *Post: 28 of 75* 12/9/2021

There wasn't when I bought my practice, but the previous owner had passed away.

It makes sense to include a provision like this, as it helps both parties. The buyer is incentivized to just fix issues that come up instead of throwing the seller under the bus or simply saying, "It's not my fault, talk to the seller." This hopefully helps nip issues in the bud before they become legal issues for the seller.

And the buyer has some compensation to help these cases out. I did some free work on a few patients to help smooth things over and retain them as a patient. It would have been nice to get paid something for my efforts. ■

JeffreyKrantz *Post: 29 of 75* 12/9/2021

There is no way you are responsible for the money, however, since the selling dentist worked for you—even as an independent contractor—you may be on the hook (continuation of care) if they legitimately sue. (I am not condemning you. I am just enlightening you.) Did your buy contract include provisions for redoing work, or the seller's responsibilities?? That is absolutely the seller's problem. ■

tomba *Post: 33 of 75* 12/9/2021

I sold just under two years ago. We had a clause for redo work: one year for fillings, 18 months for crowns and implants. The buyer was to contact me and give me the option to come in and do the work or have the buyer do the work at a 70 or 80 percent fee. I didn't hear a peep from my buyer. I actually hoped to be consulted about some of my patients' care (I liked dentistry), but I had zero communication with my buyer. Now I'm off the lease, free and clear.

I did hear from a few of my patients about their dental issues. I tried to give them careful advice and not throw my buyer under the bus. ■

Tooth Decay *Post: 46, 47, 52 and 55 of 75* 8/3/2022

I think they thought they were too long or something. The statement of them being done improper would not stand because they would need an expert testimony for that to get considered. Then they said it was made of the wrong material, which is also not a valid claim, because the lab receipt that was in her folder is for a PFM. I never would have done a PFM, but on the pictures, there were cast post and cores in the teeth so I guess that was used to block those out.

Update after numerous delays. I was originally requested to be present for a hearing for dismissal on 11/07 and that has been moved to 12/19 by the plaintiff. There are numerous reasons to dismiss this case, the biggest one is that the person filing the suit is not the patient (it's the husband). Other reasons for dismissal are that they claimed the final crown materials were not appropriate ...

[Editor's note: This post—and many more—continues online.] ■

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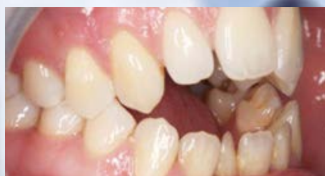
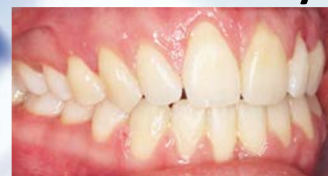

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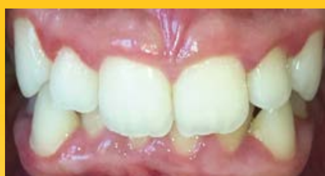

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1. Lawson NC, Frazier KB, Bedran-Russo AK, Khajotia SS, Park J, Urquhart O. Zirconia restorations. J Am Dent Assoc. 2021;152(1):80-81.e2.
2. Walton JN, et al. A survey of crown and fixed partial denture failures. J Prosthet Dent. 1986 Oct;56(4):416-21.
3. Gordan VV, et al. A clinical evaluation of a self-etching primer and a Giomer restorative material: Results at 8 years. J Am Dent Assoc. 2007;138:621-627.

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BY DR. EDWARD R. KUSEK

Fig. 1: CBCT.

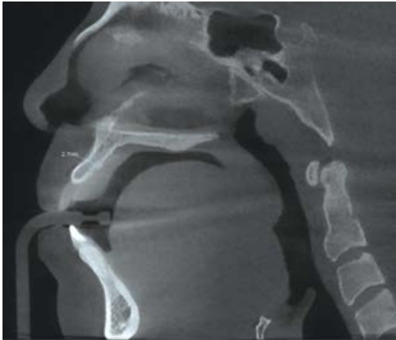


Fig. 2: Pre-op photo.

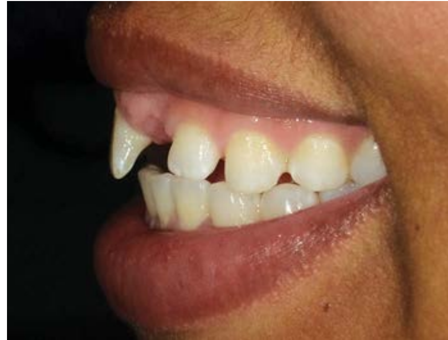
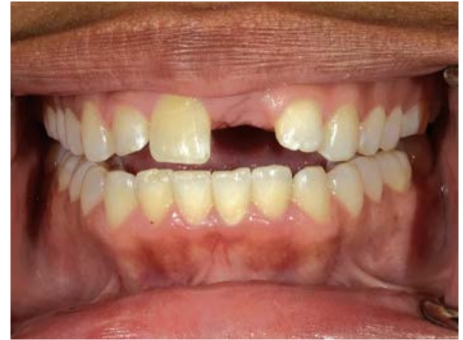


Fig. 3: Pre-op photo.



Introduction

This case involved a 35-year-old female who lost tooth #9 because of an accident when she was 10 years old. She wore a provisional appliance and was ready for a permanent solution without destroying more dentition. The patient was motivated as she was getting married in a year. At presentation, the patient had a thick biotype: hard and soft tissues were within normal limits, no popping or clicking of the temporomandibular joint and no pain from the muscles of mastication. Maximum opening was 40 mm. A CBCT was taken to determine if there was adequate bone in the site #9 in terms of width, height and depth. On evaluation, it was found that the height was adequate, but the site lacked width (approximately 2 mm) (Fig. 1). Thus, implant placement would be compromised.

The use of osseodensification drills was contraindicated, as the implant site could still work more to the facial aspect than toward the palatal site. Bone spreading is a possibility, but for this clinician, not a viable approach. Block grafting from an irradiated vertebral block was chosen instead of an autogenous block graft, which eliminates a second site of surgery.[1]

The CBCT was sent to a maxillofacial radiologist to evaluate the radiograph to determine if there was any pathology that this author did not diagnose.

Records taken for the patient included a full CBCT (Fig. 1), photographs of the oral cavity (Figs. 2–3), a scan of the maxilla and mandible with bite registration, shade matching with a Vita shade guide of A-1, Oral DNA bacterial testing (to determine if the patient was susceptible to periodontal disease), and the fabrication of an Essex appliance (to take forces away from the block graft during the healing stage and from the implant placement).[2]

The maxillofacial radiology report showed the following: moderate to severe mucosal thickening in the maxillary sinuses, nasal cavities showed no abnormalities, no airway abnormalities, both temporomandibular joints were well visualized and no abnormalities were detected. The site of #9 showed completely healed bone with no radiographically remarkable dental or osseous pathology detected. The report also suggested an ENT assessment for the moderate to chronic sinusitis and indicated no contraindication for the lateral ridge augmentation needed to create more bone volume for implant placement.

Treatment plan

1. Vertebral block graft (VBG) (Rocky Mountain Tissue Bank) in the site of #9, using an Erbium laser 2780 nm (Biolase) to decorticate the bone, trim the block to the site and fixate the block with bone screws. Place shavings from the cortical block around the periphery of the block, cover with pericardium and then PRF. This procedure is to be done under IV sedation.
2. Treat the site with high-intensity level therapy (Deka Nd: YAG 1064 nm) to stimulate bone growth.[3] The settings will be applied in three visits, with the intensity of laser therapy adjusted per the protocol set by Alessandro Bizzarri.
   - First treatment: 60 mJ, 250 µs, 30 Hz, 2.4 W for 20 seconds.
   - Second treatment: 80 mJ, 250 µs, 30 Hz, 2.4 W for 20 seconds.
   - Third treatment: 100 mJ, 250 µs, 20 Hz, 2.0 W for 20 seconds.
3. Remove 3.0 PTFE sutures in 10–14 days, depending on healing.
4. Take a CBCT at 2.5 months to determine if the graft is healing.
5. Perform implant surgery at the 3+

month interval under IV sedation with PRF.
6. Uncover the implant using a 10600 nm CO_2 laser, place the scan body and take a radiograph to confirm the scan body is seated at the base of the implant. Scan the full arch for a custom gold-colored Atlantis abutment.
7. Seat the abutment, tighten to 35 N ×2, and cement the crown, making necessary adjustments.
8. Perform a post-op bite and tissue check.
9. Schedule maintenance.

Treatment considerations

- A salivary diagnostic test (Oral DNA Labs) to determine if the patient has bacteria that can contribute to periodontal and/or systemic issues.
- High-intensity laser therapy (HILT) treatments to decrease inflammation, increase bone formation and accelerate healing time.
- Use of an erbium laser (Biolase) to create decortication and a regional acceleratory phenomenon (RAP)[4], which can increase bone-to-implant contact.
- Use of a CO_2 laser (Deka) to flap the tissue during the initial surgery for placing the block graft, during the placement of the implant and finally during uncovering.
- Use of aqueous ozone[5] (Biosure) to disinfect the osteotomy site at the uncovering of the scan body and healing abutment.

Case report: block grafting

The patient was treated surgically to place a vertebral block graft from Rocky Mountain Tissue Bank to increase width and enable implant placement in the correct position for optimum aesthetics in site #9. IV access was completed in the patient's right antecubital fossa, where blood was drawn to obtain sufficient samples for centrifugation to create PRF, which would aid in healing by using the patient's own bone morphogenic proteins.[6]

Drugs administered:

- 20 mcg of dexmedetomidine
- 5 mg of midazolam
- 50 mcg of fentanyl
- 8 mg of dexamethasone sodium phosphate
- 40 mg of depo-solumedrol (IM)
- 1 g of cephalosporin in total upon completion of the sedation

Flap reflection was performed from the #11 mesial area to the mesial of #7 using a 10600 nm CO_2 laser (Deka) with a 0.5 mm spot size, no water, for about 30 seconds, with no vertical releasing incision and an entirely sulcular incision. Elevation was performed to expose the defect. An erbium laser (Biolase) (Fig. 4) was used to prepare the graft site and decorticate it for placement of the VBG (5 × 10 mm). The VBG was trimmed with a high-speed surgical handpiece and Rongeurs forceps. The block was then soaked in plasma from the PRF for one minute and fixated with two bone screws (Fig. 5). Shavings from the trimming of the VBG were placed around the corners of the graft. Pericardium (15–20 mm) was placed over this, and a PRF membrane (Fig. 6) was placed over the pericardium.

The site was closed with 3.0 PTFE sutures. The tissue was de-epithelialized with an erbium laser (5.0 W, 40/0). The site was then stimulated using HILT (100 mJ, 20 Hz, 250 μs) for

Fig. 4: Erbium laser and site preparation.

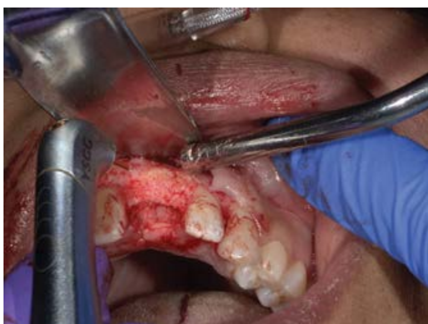


Fig. 5: Bone screws placed.

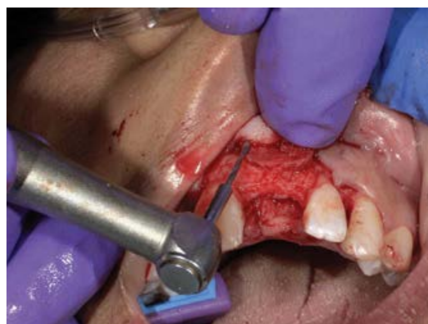
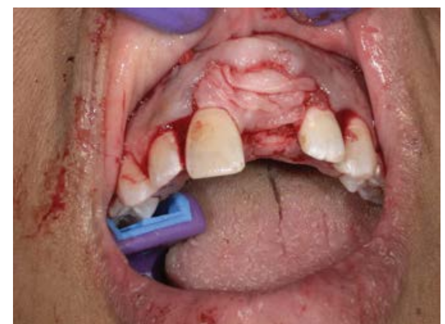


Fig. 6: Pericardium and PRF placed.



one minute, along with stimulation of four lymph nodes in the head and neck region (right and left submandibular and right and left subclavicular lymph nodes).

Post-op instructions

- Use saltwater rinses twice daily.
- Take a combination of NSAIDs (2 × 200 mg) with acetaminophen (2 × 500 mg) every six hours for four days.
- Take Keflex 500 mg, 15 tablets, three times daily until finished.

The patient was seen two more times for HILT (100 mJ, 20 Hz, 250 µs for one minute) and for suture removal at two weeks using the same settings. The patient experienced some swelling and minor discomfort during the first four days.

Post-op check

At the three-month healing check, a new CBCT (Fig. 7) was taken to evaluate bone growth and plan for implant placement. The width had expanded to more than 6 mm, which was adequate to place a 3.75 × 13 mm Ditron implant. Tissue health appeared excellent, and the patient was scheduled for implant placement in one month.

Implant surgery

IV access was again established in the right antecubital fossa (RAF). Blood was drawn to obtain sufficient samples for PRF, and the following drugs were administered:

- 20 mcg of dexmedetomidine
- 5 mg of midazolam
- 50 mcg of fentanyl
- 8 mg of dexamethasone sodium phosphate
- 40 mg of depo-solumedrol (IM)
- 1 g of cephalosporin upon completion of sedation

Flap reflection was performed using a 10600 nm CO_2 laser from the mesial of #8 to the mesial of #10, with a sulcular incision from the mesial of #7 to the distal of #10 and no vertical releasing incisions.

Upon reflection, bone screws fixated during the first surgery were not visibly apparent. After scraping the bone and using a surgical handpiece, the bone screws were revealed, showing more than 2 mm of bone growth over them.

The appropriate drill sequence was used to prepare a 3.3 mm-wide osteotomy. The osteotomy site was decorticated with an erbium laser (Fig. 8) to improve implant-to-bone contact and disinfected with aqueous ozone (30 cc, Biosure) (Fig. 9).

I seated the 3.75 × 13 mm implant at the facial of the bony crest. PRF membranes were placed over the implant, and the site was closed with 3.0 PTFE sutures. The site was again treated with an erbium laser to de-epithelialize (Fig. 10) as described earlier and then rinsed with 10 cc of aqueous ozone. The site was stimulated with HILT (60 mJ, 30 Hz, 250 µs) for 20 seconds on the four lymph nodes as previously described and then on the facial and lingual aspects of the surgical site. Post-op instructions were the same as discussed earlier.

Fig. 7: New CBCT.

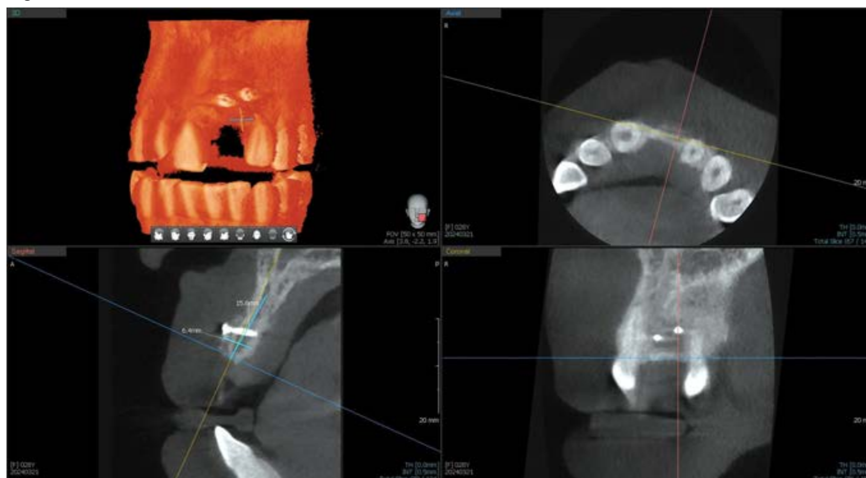


Fig. 8: Erbium laser used to decorticate.

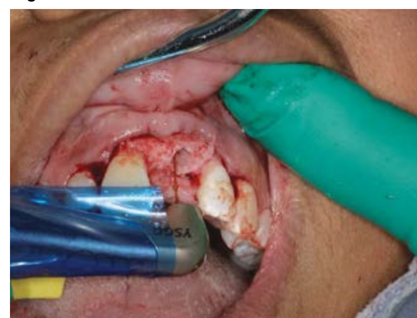


Fig. 9: Aqueous ozone.

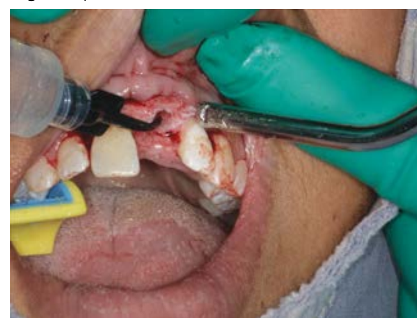


Fig. 10: Deepithialized with erbium laser.

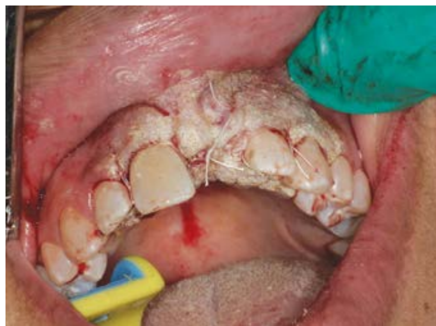


Fig. 11: Atlantis abutment placed with first plug in the access.

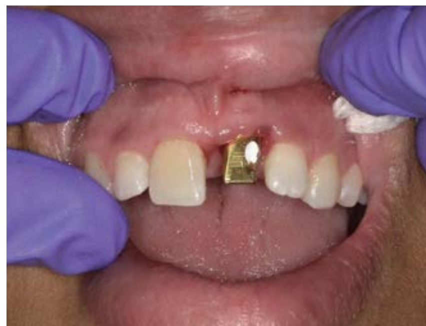
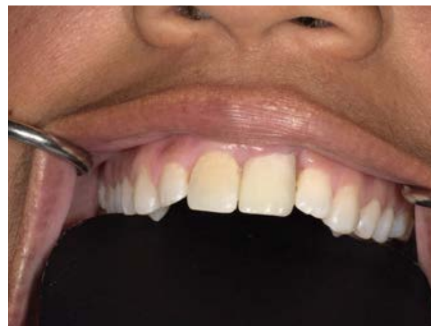


Fig. 12: Final crown.



Uncovering implant and scanning case

After three months of healing, the patient was scheduled for implant exposure. Topical anesthetic was applied, followed by administration of 0.5 cc of 20 mg lidocaine with 10 mcg of epinephrine and 2.0 cc of 40 mg Septocaine with 5 mcg of epinephrine. A 10600 nm CO_2 laser was used to make a vertical incision palatal to push attached tissue to the facial, followed by a horizontal cut to leave attached tissue on the adjacent teeth, creating an "H" appearance.

A TruAbutment scan body was placed, and a radiograph was taken to confirm proper seating of the scan body on the implant. A full-arch scan of both the maxilla and mandible, including the bite, was completed using the Trios 4 scanner.

The case was then emailed to the lab (Caldent) for the fabrication of a gold-colored Atlantis abutment with a facial margin 1 mm from the base of the implant body. A healing abutment was placed after being soaked in aqueous ozone and the exposed gingiva around the implant site was flushed.

After three weeks, the abutment was soaked in aqueous ozone and seated with 35 N of force, torqued into place twice. The access was sealed with First Plug, and a photo was taken of the access site (Fig. 11). Contacts were checked, and the case was cemented using eCement (Bisco). Excess cement was removed, and a radiograph was taken to confirm all cement was cleared. The bite was checked, adjusted, and polished (Fig. 12).

A follow-up occurred two weeks later to ensure the bite was correct and tissue health was good.

Conclusion

This case demonstrates several steps taken to achieve optimal results. Using high-intensity laser therapy (HILT) increased bone volume more than this author has previously observed when performing block grafting. Studies have shown that HILT can enhance bone and cartilage formation. Aqueous ozone can disinfect bacteria and viruses within 15 seconds.

It is crucial to evaluate the outcome and then work backward to determine the necessary steps to accomplish treatment. A true implantologist must possess knowledge in oral surgery, prosthodontics and periodontics and be able to evaluate health histories that may compromise patient treatment. **DT**

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SDF Essentials

A quick guide for general practitioners

BY DR. ROOPWANT KAUR

Silver diamine fluoride (SDF) has emerged as a highly effective tool in modern dentistry, offering several advantages, from halting the progression of dental caries to providing clinicians with greater flexibility in treatment options. Additionally, SDF provides opportunities for increased revenue through billable services, making it a valuable asset for dental practitioners. This article outlines key aspects of incorporating SDF into your practice, including essential considerations for diagnosis, restoration, staining, insurance coverage and the learning curve associated with its use.

My hygienist found a lesion!

The early detection of carious lesions by dental hygienists is a vital step in preventing further tooth decay and preserving oral health. When a carious lesion is identified during a routine examination, it is important to confirm the diagnosis. Instruct your registered dental hygienist (RDH) to immediately apply SDF to arrest the progression of the lesion. SDF is a potent compound that combines antimicrobial silver ions, remineralizing fluoride and stabilizing ammonia to effectively halt caries in their tracks (Horst et al., 2016). By doing so, you gain valuable time to plan definitive treatment, particularly when working with challenging cases, such as children or patients with limited access to dental care. Adult patients will almost always be reappointed for the restoration. SDF ensures the lesion will not progress until they return.

Why restorations are almost always needed

While SDF is highly effective in arresting the progression of caries, it is important to recognize that restorations are usually necessary to restore tooth function and aesthetics. SDF serves as a temporary intervention that prevents further decay but it does not repair or replace lost tooth structure.[1] Restorations should be planned and executed once the caries process has been arrested. For patients who are young, uncooperative or have special needs, SDF offers a way to control the lesion until definitive treatment can be administered. For adults, because many patients do not return as prescribed, SDF provides flexibility and safety until they return for the restoration.

Can I use my trusted composites?

Yes, you can certainly continue using your preferred composite materials for restorations after applying SDF. However, consider integrating glass ionomer cement (GIC) into your restorative protocol. GIC offers significant benefits because of its chemical bond to the tooth structure, its fluoride-releasing properties and its ability to prevent further caries progression at the margins of restorations.[2] When combined with SDF, GIC enhances the caries-preventing effects and provides an additional layer of protection.

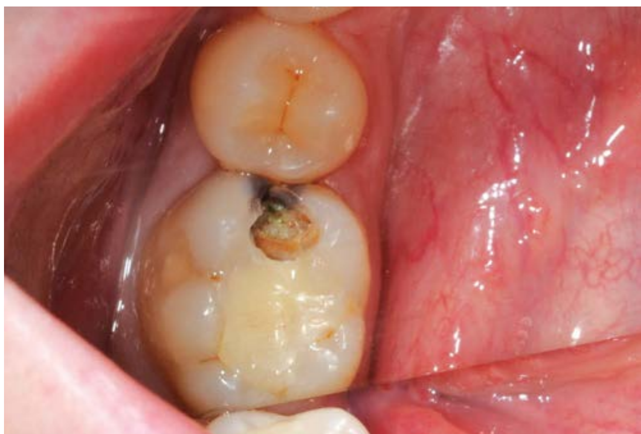
Should I add a GIC layer?

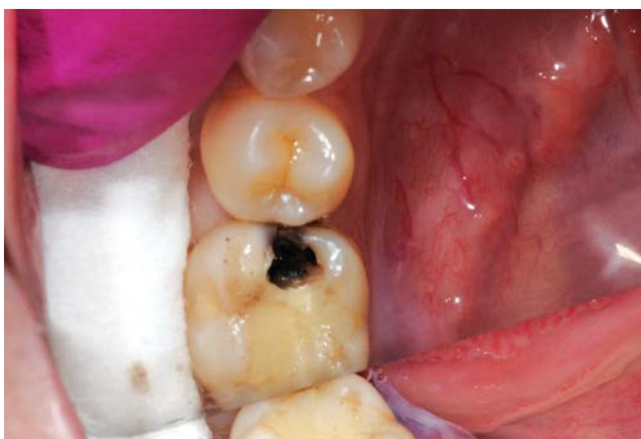
Integrating a layer of GIC before placing composite restorations can improve the longevity and effectiveness of the restoration. GIC serves as a sealant and provides sustained fluoride release, which helps prevent secondary caries. This combination is particularly beneficial in areas prone to recurrent decay, ensuring that the restoration is both durable and resistant to future cavities.[2] The use of GIC in conjunction with SDF creates a more comprehensive, preventive treatment approach.

What about staining?

One of the most common concerns with SDF is its potential to stain decayed or demineralized tooth structure. The silver ions in SDF can cause dark discoloration of the lesion (active, decayed), but not the tooth itself. While this staining is purely cosmetic and does not affect the tooth's health or function, it can be a concern for patients.[3]
It is crucial to manage patient expectations by providing clear, informed consent regarding the possibility of staining, as well as the final aesthetic result after restoration. Selecting appropriate cases, such as those where aesthetics is less of a concern or where the decay is located in less visible areas, can help mitigate these concerns (Figs. 1a–1b, p. 38). Since most lesions need to be restored, especially for adult patients, the final restoration will completely cover all discoloration.

Figs. 1a and 1b. Many adult patients find the application of SDF on posterior teeth acceptable.





Is SDF covered by insurance?

Insurance coverage for SDF varies by payer, but it is typically coded under the Current Dental Terminology (CDT) code D1354, which corresponds to the application of a caries-arresting medicament. It may also be billed under other codes depending on the clinical application, such as D9910 for desensitizing medicament or D9110 for palliative treatments.

To ensure reimbursement, always include detailed clinical notes and narratives explaining the necessity of the SDF application. This documentation can help justify the use of SDF as part of a comprehensive treatment plan.

Below are key CDT codes for SDF application, their clinical scenarios and insurance implications:

D9910: Application of desensitizing medicament

- **Application**: In-office treatment for root sensitivity.
- **Details**: Typically reported on a per-visit basis for applying topical fluoride.
- **Not to be used for**: Bases, liners or adhesives under restorations.
- **Insurance**: Suggested to include a narrative describing the patient's sensitivity. Generally billed per visit. This can be done on all teeth or specific teeth.
- **What to do:** Be aware that reimbursement is often not provided, and patients may need to pay out of pocket unless PPO providers are prohibited from charging separately for the procedure.

D9110: Palliative treatment of dental pain—per visit

- **Application:** Treatment that relieves acute/spontaneous pain but is not curative.
- **Details:** Used for alleviating the patient's acute or spontaneous complaints/problems. It serves as an interim step in the restorative process—providing comfort while preventing disease progression if restoration cannot be completed immediately.
- **Not to be used for:** Definitive care.
- **Insurance:** Includes a narrative describing the patient's complaint and actions taken to relieve discomfort. Reimbursement can vary by insurance plan, with fees based on time spent and the complexity of the procedure.

D1355: Caries preventive medicament application—per tooth

- **Application:** Used for primary prevention or remineralization without an active carious lesion.
- **Details:** Applied for preventive care on high-risk patients, including root surfaces, pits and fissures, and demineralized areas.
- **Insurance:** SDF is considered a medicament, not a topical fluoride. This code may

apply if SDF is used for primary prevention on root or coronal surfaces without an active lesion.

D1354: Application of caries arresting medicament—per tooth

- **Application:** Used for conservative treatment of active, non-symptomatic carious lesions by applying a caries arresting or inhibiting medicament, such as SDF, without mechanically removing sound tooth structure.
- **Details:** Effective for arresting active decay, particularly with 38 percent SDF. Reapplication is often recommended at least annually, preferably biannually.
- **Insurance:** Coverage varies by plan. A strong narrative justifying the use of D1354 over a definitive restoration—based on caries risk assessment and clinical necessity—can support the claim. If reimbursement is denied, resubmit with an emphasis on the elevated caries risk and medical necessity.

D1206: Topical application of fluoride varnish

- **Application:** Used for caries prevention.
- **Details:** This code can be used for fluoride varnish treatments typically applied during a recall visit to all teeth for general caries prevention.
- **Insurance:** Likely reimbursed for children but often not for adults, unless a moderate to high caries risk assessment is reported. Fees may be passed on to the patient.

Tips for navigating insurance and SDF coverage

- **Document the patient's caries risk assessment**. A thorough risk assessment that identifies the patient's susceptibility to dental caries can help justify the use of SDF, particularly in states or insurance plans that are more restrictive.
- **Narrative and justification**. Always provide a well-documented clinical narrative detailing why SDF was the appropriate choice, particularly in situations where it is used instead of more invasive restorative procedures.
- **Check with your state Medicaid office**. Medicaid coverage for SDF can vary even within states that have approved its use. It's important to check the local Medicaid provider manual for specific policies and reimbursements.
- **Consider a pre-authorization request**. In some cases, submitting a pre-authorization request with detailed clinical notes can help ensure reimbursement for SDF applications, particularly in situations where there is uncertainty about coverage.

Keep in mind that SDF is cost-effective: the cost to the office is typically around $1 per patient.

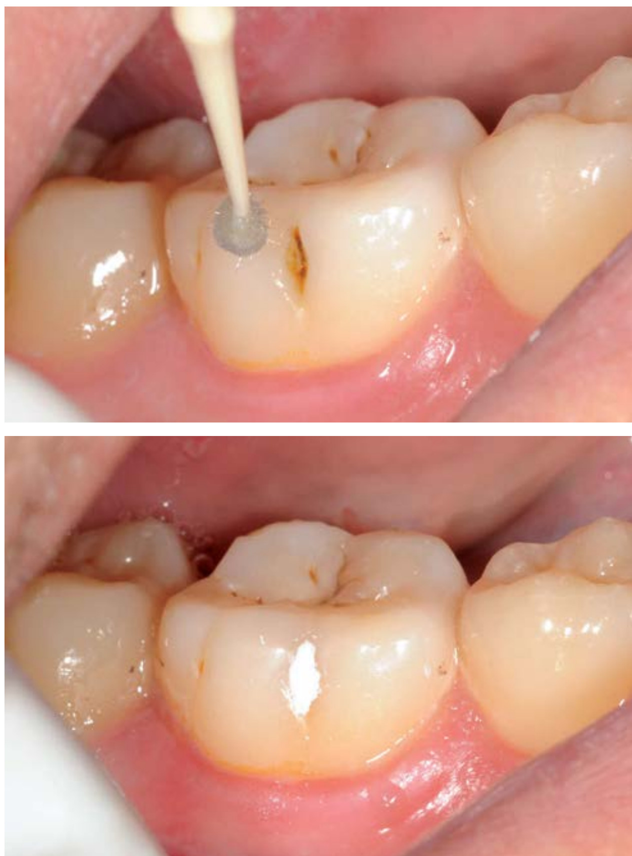
What is the learning curve?

One of the major advantages of SDF is its simplicity and ease of use. The learning curve for applying SDF is minimal, and it is a straightforward procedure that can be incorporated quickly into your practice. The process involves isolating the affected tooth, drying the area and applying the SDF solution with a micro brush. The entire procedure can be completed in just a few minutes, making it a time-efficient option for busy practices.[4] Training your dental team to understand the protocol and ensure proper application is key to integrating SDF successfully into your workflow.

SDF: From diagnosis to restoration

- **Step 1: Confirm the diagnosis**
  Upon detecting a lesion, confirm the diagnosis and instruct your RDH to immediately apply SDF. This swift action arrests the decay and prevents it from worsening, buying you time to plan a more definitive treatment. It is beneficial to treat a high-risk patient with fluoride varnish post-SDF, as it will also help mask the metallic taste the patient may feel after SDF application.

Figs. 2a and 2b. Lesion after SDF treatment is masked with Tempit temporary filling material (Centrix, Inc.) before final restoration.



- **Step 2: Reappoint for two to four weeks**
  Schedule a follow-up appointment within two to four weeks to reassess the lesion. This follow-up allows the SDF to fully arrest the decay, providing an opportunity to plan the final restorative treatment. Reappointment is optional if the patient cannot return because of their schedule or financial reasons.
- **Step 3: Restoration with usual materials**
  During the follow-up visit, proceed with restoration using your usual materials. Consider incorporating a GIC into your protocol for additional protection against future decay.
- **Step 4: Fast and easy learning**
  The SDF application process is quick and easy to learn. Familiarize yourself with the steps and educate your team to ensure smooth and efficient incorporation of SDF into your practice.

Insurance coverage

Understanding how to properly code and document SDF applications is crucial for maximizing insurance reimbursement. Make sure to include appropriate clinical narratives and adhere to CDT codes to ensure that your use of SDF is reimbursed. Regularly reviewing the ADA's guidelines for caries risk assessment can help reinforce the medical necessity of this treatment in your records.

Temporary restorative materials

In some cases, it may be helpful to use a temporary restorative material, such as Centrix Tempit, between the initial SDF application and the final restorative procedure (Figs. 2a–2b). These materials help manage both function and aesthetics while preventing further decay progression.[5] This approach can be particularly useful for patients who need a stopgap solution before definitive restoration.

Clinical applications of SDF

SDF has several key clinical applications, including:

- Arresting dental caries in pediatric patients, uncooperative individuals and those with special health care needs.[6]
- Preventing caries in geriatric patients or those with limited access to dental care.[7]
- Arresting dental caries in general restorative patients to prevent progression of the lesion between diagnosis and the restorative appointment.
- Desensitizing root surfaces and preventing secondary decay in patients receiving restorations.[8]
- Using SDF as a disclosing solution to assess the presence of decay.[9]

SDF is an FDA-cleared Class II medical device for the treatment of dental hypersensitivity,

with well-documented off-label uses for caries arresting and as an interim step in the restorative process when restorative treatment cannot be performed right away.

Conclusion

Incorporating SDF into your dental practice provides a valuable, versatile tool for managing dental caries. It enhances patient care by offering a non-invasive, cost-effective option to arrest decay while you plan and execute definitive restorative treatments. The learning curve is minimal, and with proper insurance coding and documentation, SDF can help increase revenue opportunities. By adding SDF to your clinical toolkit, you enhance both the quality and scope of care you provide to your patients. **DT**

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Dr. Roopwant Kaur, an associate professor and assistant dean at East Carolina University's School of Dental Medicine, leads in the cariology and operative dentistry curriculum. Kaur serves on multiple national and regional executive boards, and her accolades include the ADEA Leadership Institute Award, the Heraeus Kulzer Research Award and the Health Sciences Author Recognition Award—reflecting her dedication to dental education and research in caries risk assessments and student learning methodologies.

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Using the Isolite Pro for a Difficult Posterior Restoration

BY DR. ARTHUR R. VOLKER

Introduction

The need for isolation is of primary importance for the execution of high level operative dental procedures. This article demonstrates the restoration of a large multi-surface direct composite restoration which was facilitated using an Isolite Pro (Zyris) isolation system.

Methods of isolation

Cotton rolls are often the quickest and least costly option for isolation. They can provide isolation and can be effective, especially in primary molars.[1,2] Issues arise if the rolls become saturated with fluid, as excess can then leak and contaminate the operative field. Rolls may also need to be replaced frequently during a procedure, which can also result in contamination of the field.

Rubber dams are considered the gold standard for isolation.[3] They provide isolation from crevicular fluids. By using proper inversion techniques in conjunction with a heavy dam, papillary tissue can be retracted, allowing better access and visualization of subgingival areas.[4] This is useful in procedures where the interproximal emergence profile of the tooth needs to be altered, such as in a diastema closure or a black triangle resolution. There can be a potential for an allergic reaction with the use of a latex dam.[5,6] It is recommended that a non-latex option be used.

Isolite Pro, attached to a dedicated suction line, provides isolation, illumination, visualization and suction in a single-use mouthpiece. Additionally, it provides a mouth prop to the patient and acts as an airway protector. The Isolite demonstrates less leakage than cotton roll isolation and is more comfortable than rubber dam isolation.[7]

Case presentation

The patient, a 63-year-old woman in good general health presented with a complaint of a "chipped tooth" on the upper right. A periapical film of the area was taken (Fig. 1). An examination revealed a mesio-occlusal-palatal fracture of tooth #2 with caries (Fig. 2). The patient was made aware of treatment options, including the possibility of root canal and full coverage. It was decided to attempt a direct restoration on tooth #2.

The patient was anesthetized with 3% mepivacaine. A small Isolite mouthpiece was placed. Caries excavation was initiated with a carbide round bur (Fig. 3) and caries indicator (Snoop, Pulpdent). Though deep, no pulpal exposure was noted. During the excavation process, caries were present subgingivally, resulting in bleeding from the area (Fig. 4). At this point, a rubber dam clamp was to be placed. However, the short inciso-gingival height of the tooth as well as the extent of the cavity preparation precluded placement of the clamp. It was then decided to place a Greater Curve matrix band (Greater Curve) in a Tofflemeyer retainer with a wooden wedge. Once hemostasis was obtained, a liner (Activa, Pulpdent) was placed over the deepest dentinal areas (Fig. 5).

Using a total-etch protocol, the area was first conditioned with phosphoric acid, and a bonding agent was placed (Fig. 6). A dual cure restorative material (Anchor, Apex Dental) was placed in a single increment to fill the remainder of the cavity (Fig 7). The Anchor was adapted with a hand instrument (Fig. 8) and cured. Excess material was removed with rotary instruments (Fig. 9). Occlusion and contacts were verified. Figure 10 demonstrates the final restoration, and Figure 11 shows the post-operative radiograph.

Conclusion

There are multiple methods for isolation available to the clinician. In areas where a rubber dam clamp may be untenable, such as in a multi-surface Class II on a terminal tooth—especially if the tooth is short and cannot hold a clamp—or if the clamp interferes with the restorative matrix, the Isolite Pro can help facilitate a predictable outcome.

Fig. 1: Pre-operative periapical radiograph.

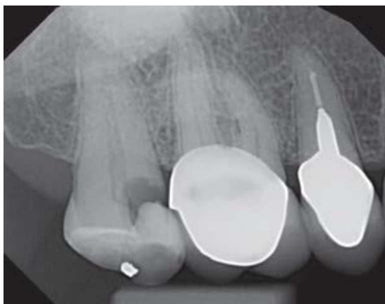


Fig. 2: Pre-operative clinical presentation.

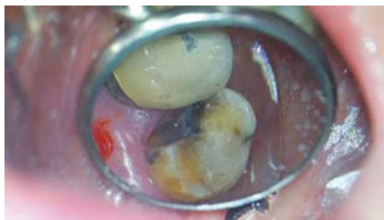


Fig. 3: Caries excavation with a round bur.

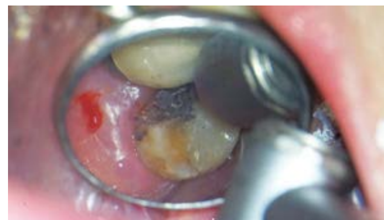


Fig. 4 : Bleeding from subgingival preparation.

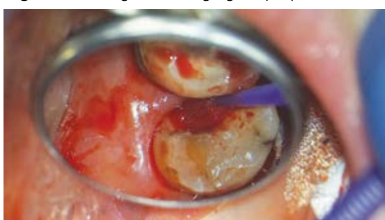


Fig. 5: Placement of RMGI liner and Greater Curve matrix band with wedge positioned.

Fig. 6: Placement of bonding agent.

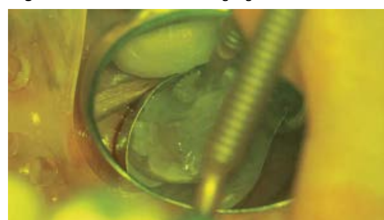


Fig. 7: Filling of cavity with Anchor.

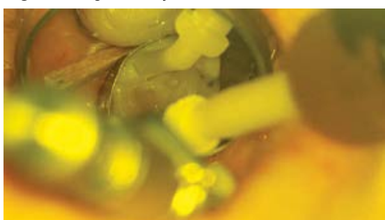


Fig. 8: Adapting Anchor with a hand instrument.

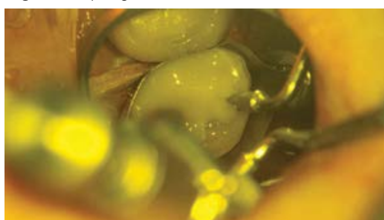


Fig. 9: Trimming excess material.

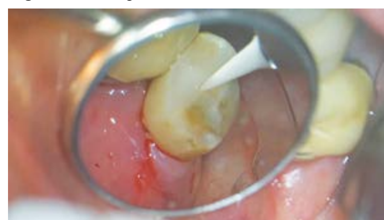


Fig. 10: Completed restoration.

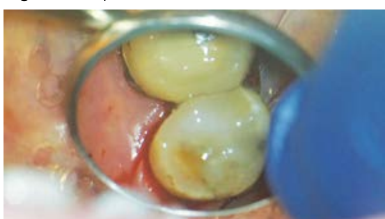
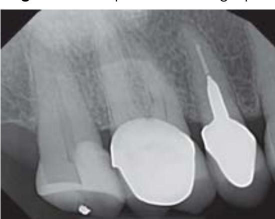


Fig. 11: Post-operative radiograph.



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Dr. Arthur R. Volker graduated from the Columbia University School of Dental and Oral Surgery. He is a member of the continuing education committee for the New York State Academy of General Dentistry. Volker is a diplomate of the World Congress of Minimally Invasive Dentistry, and is a fellow of the Academy of General Dentistry and the American College of Dentists. He has also published articles and lectures on such topics as cosmetic dentistry, minimally invasive dentistry, dental materials and dental implants. Volker is also a member of the *Dentaltown* editorial board. He practices in Sunnyside, New York.

Better Behavior

Effective approaches to handle angry outbursts, dental anxiety, treatment refusals and inappropriate behavior from patients

BY DR. WILLIAM JACOBSON

Dentistry is a social job. We treat people, not just teeth. On occasion, we encounter challenging interactions. While we are highly trained to diagnose and treat dental disease, our training in managing tough interactions often falls short. Many resources exist on pediatric patient management but what about adult patient management?

I will address some common challenging patient behaviors and scenarios and provide guidance. This guidance is based on my experience and the experiences shared with me while working at Community Health Centers, teaching at various dental schools, advice from colleagues and my research as the course director for Behavioral Dentistry at the University of Maryland School of Dentistry. I hope you find this useful. Comment on the article online with any advice you would also like to share.

Angry patients

Anger often masks fear, and half of the adult population in the U.S. has moderate levels of dental fear. Anger can be prevented with clear communication. A well-informed patient is less likely to be upset. For example, warn a patient ahead of time that the tooth they believe only requires a filling may need a root canal, buildup, crown lengthening, crown or extraction.

De-escalation tips:

- Actively listen, maintain a calm demeanor and acknowledge the patient's feelings.
- Use nonconfrontational language, maintain empathy and avoid reacting defensively.
- Maintain a safe position so that you are not trapped or cornered.
- Agree or agree to disagree. Try to find common ground with the patient.
- Set clear limits. Inform the patient about unacceptable behaviors and potential consequences, such as calling law enforcement.
- In serious cases that endanger you and/or others, try to isolate the aggressor, evacuate everyone from the building and contact law enforcement.

In my clinical experience, empathy goes a long way. Sometimes a patient just wants to vent. I'm always aware of my physical position relative to the patient. I recommend facing the patient at eye

Fig. 2

level (not looking down at the patient), remaining calm, listening without interrupting and providing both non-verbal and verbal communication to validate their feelings (Fig. 2). Verbal validation can include, "I would be frustrated too," and summarizing the problem upsetting the patient so they know they are being heard.

Lastly, with angry or rude patients, a friend shared with me the acronym QTIP, which stands for "quit taking it personally." There are many reasons patients may be rude to dentists, including pain, fear, jealousy (assuming dentists have easier lives and are rich), sexism, prejudice, insecurity, competitiveness, undiagnosed or untreated mental illness, poor coping skills, emotional immaturity, distrust of health care workers, unhappiness, stress, disliking figures of authority and more. So, make eye contact. Remain calm. Breathe. Stay professional and remember: QTIP.

Anxious patients

While dental fear is common, it is not the same as dental phobia. Dentophobia, which falls under the "injury type" of phobia category in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)*, causes extreme distress. People may be aware that their fears are irrational, but this doesn't make them any less real or debilitating. Telling a patient, "Just relax," is not going to be effective.

Two airplane analogies:

1. Picture boarding a flight and seeing a pilot who appears nervous and insecure. Now, picture boarding the flight again, but this time you see a pilot projecting confidence as she welcomes you aboard. Which pilot would you trust with your life?
2. Picture a flight with severe turbulence and no warning from the pilot. Now, imagine a different flight where the pilot warns you ahead of time, "We will experience a bumpy flight for the next five minutes, and then smooth sailing from there." Would you prefer a warning?

The takeaway from the first analogy is the importance of projecting confidence; if you seem anxious, this can make the patient even more anxious. The takeaway from the second analogy is warning your patients about what sensations to expect along with the duration

Depending on the severity, anxious patients may be managed pharmacologically and/or non-pharmacologically.

Pharmacological options include nitrous sedation, oral sedation (pill or liquid), oral conscious sedation (a combination of nitrous and a pill or liquid), IV sedation (i.e., "twilight sedation") and general anesthesia.

Non-pharmacological options include:

- **Assessment**. Identifying specific triggers and avoiding them.
- **Sharing information and reducing uncertainty**. However, the amount of information patients want may vary.

- **Signaling**. Example: "Raise your left hand if anything feels uncomfortable or if you need me to stop. Don't raise your right hand, as I don't want you to bump into any sharp instruments." Or "Use this frog clicker if you need me to stop" (Fig. 3). This helps me as I tend to get tunnel vision with my loupes and may not see a hand being raised.
- **Tell-show-do**. Demonstrating each step of the procedure.
- **Distraction**. Using audiobooks or music.
- **Cognitive modification**. Focusing on positive outcomes. Example: "I'm so happy you came in, and we are cleaning out this cavity today so that we can save your tooth."
- **Providing emotional support**. Having a warm, friendly personality.
- **Physical tools**. I like to provide a stress ball for patients to squeeze during injections, which some find helpful (Fig. 4).

Fig. 3

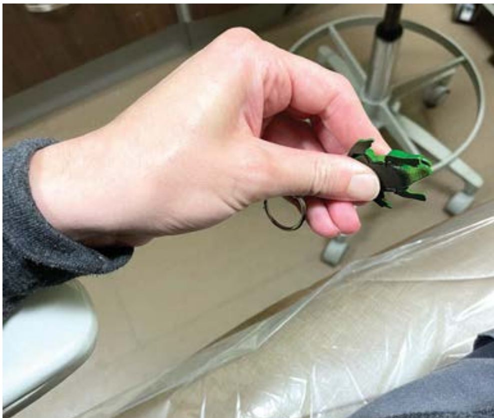

Fig. 4

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Fig. 5

- **Retrospective control**. Provide a debriefing after the appointment. Example: "Is there anything you would like me to do differently at your next visit?"

Dictating patients

Patients will sometimes try to tell the dentist what to do and not do. As dentists, we must be able to diagnose and treat disease. If a patient is not allowing you to diagnose, e.g., take radiographs, perio chart or cold test a tooth (Fig. 5) and/or treat active disease (e.g., root canals, extractions, scaling and root planing, fillings), then this puts both the patient and your dental license at risk. Patients cannot consent to substandard care.

If the patient says, "Doctor, I don't want X, Y, Z," it is your job to seek out and understand their rationale. Is it fear-based, financial-based, a lack of understanding or a lack of time? Some things are optional, like cosmetics, orthodontics, certain tooth replacement options or material selections. However, there are many other things that are not optional and are non-negotiable, including having a patient complete a health history form, taking diagnostic chartings, tests, or radiographs, or treating disease.

If you allow a patient to skip something in the non-optional category, you are providing substandard care that is considered supervised neglect. Furthermore, you're putting the patient's health—and your dental license—at risk. Dismiss the patient.

Inappropriate behavior

Inappropriate questions from patients may include:

- "Are you married?"
- "Are you single?"
- "Are you from here?"
- "What time do you get off?"
- "Can I take you to the zoo?"
- "Any plans for Friday night?"

If you ignore flirtatious comments, they often escalate. You must be direct and emotionally mature (i.e., do not giggle or act shy). Revealing any information about your personal life will not help and is none of your patient's business.

Useful one-liners:

- "I keep my personal life and work life separate. So, what is going on with your teeth today?"
- "We are not here to discuss my personal life."
- "You are here for a dental exam. Any concerns about your teeth?" **DT**

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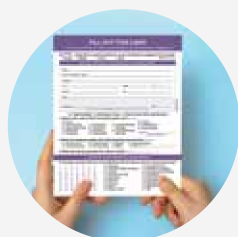
Dr. William Jacobson is a general dentist, clinical assistant professor, curriculum consultant and the author of *Clinical Dentistry Daily Reference Guide*, a book to help dental students and dentists with day-to-day decision-making for a myriad of clinical scenarios. The book is available on Amazon. Website: williamjacobson.net. He is also a member of the *Dentaltown* editorial board.

AD INDEX



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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.

A Bond Beyond Dentistry

Cousins Edmund Liu and Chung Lin turned a family bond into a thriving practice

BY KYLE PATTON, EDITOR

Drs. Edmund Liu and **Chung (Ken) Lin**, first cousins, not only attended the University of Maryland School of Dentistry together but also graduated in the same year. Their parallel paths didn't stop there. Years later, they teamed up to open Clarksburg Dental Center in Germantown, Maryland, where they've built a thriving practice rooted in trust, teamwork and cutting-edge care.

Beyond their clinical skills, Liu and Lin credit much of their success to their commitment to ongoing education. Taking courses from the Productive Dentist Academy (PDA) and Breakaway Dental Seminars transformed how they approach practice management, patient communication and efficiency.

In this *Dentaltown* exclusive Q&A, the duo shares their journey—from navigating the challenges of practice ownership to relocating just months before the COVID-19 shutdown—and the lessons they've learned along the way.

PHOTOGRAPHY BY KIRTH BOBB

L-R: Drs. Edmund Liu and Chung Lin

OFFICE HIGHLIGHTS

NAMES:
Drs. Edmund Liu and Chung Lin

GRADUATED FROM:
University of Maryland School of Dentistry

PRACTICE NAME:
Clarksburg Dental Center
clarksburgdentalcenter.com
Germantown, MD

PRACTICE SIZE
3,500 sq ft; 10 ops

TEAM SIZE:
13

"Of course, we each see our own patients and handle our own cases during a typical day," Liu says. "But we also frequently consult with each other when it comes to treatment planning. It's great to have a partner you can trust for input."

Both doctors are fond of performing LANAP and restorative procedures.

What inspired both of you to get into dentistry?

EL: My journey into dentistry started with a painful lesson! Back in high school and college, I was addicted to Coca-Cola, which led to a really bad cavity with some serious tooth pain. I ended up seeing a dentist for a root canal, and it cost me all the money I had at the time: $600. Even though it wiped out my bank account, I was so thankful for the relief he gave me. Afterward, I thought to myself, "I just gave this guy everything I had, and I'm still so grateful. What a cool job!" That's when I started thinking about dentistry as a career.

KL: What attracted me most to dentistry was its profound ability to positively impact patients by improving their confidence and quality of life. As a child, I loved building models and collecting miniatures, which sparked my appreciation for precision and creativity—qualities that dentistry embodies. It's one of the few professions that seamlessly blends science and art. Whether performing restorative or cosmetic procedures, dentists have the unique opportunity to craft outcomes that are both beautiful and functional.

What led you to team up and start a practice together, and how did your family dynamic play into that decision?

EL: Ken and I came to the U.S. around the same time and stayed at our aunt's house together for a few months. We spent a lot of time hanging out in college and even ended up in the same class in dental school. Over the years, we got to know each other well, and it was clear we had similar personalities and a lot of trust in each other. Teaming up to start a practice felt like a natural next step.

KL: This is a long story, but I'll keep it brief. Edmund and I are first cousins through our mothers. I was born in Taiwan and moved to Argentina at the age of 9, while Edmund grew up in Hong Kong. We never met until we both moved to the U.S. and stayed at our aunt's place. It was during this time that we became very close, bonding over the shared challenges of adjusting to American life. The funny thing is, after graduating from college, we both independently decided to apply to dental school—and ended up at the same school, in the same year. Our friendship deepened as we supported each other through the intense first and second years of dental school. We cherished the final two years together before going our separate ways after graduation. Then, fate brought us back together when Edmund chose Clarksburg to start a practice from scratch and invited me to join him on that journey, which has led us to where we are today.

When you started out, what was the one area of practice management you underestimated?

EL: We underestimated how important it is to have solid systems in place from the start. It wasn't until almost 10 years into running our practice that we took business management courses, like the Breakaway Seminar and PDA workshop, and realized how much easier things could've been if we'd done that earlier. My advice? Take courses like those as early as possible—ideally before or right when you're starting your practice. It'll save you a lot of headaches down the road!

KL: My recommendation to anyone considering opening their own

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practice is to invest in these courses early on. Two programs we highly recommend are the Productive Dentist Academy (PDA) and Breakaway Dental Seminars. We continue to take courses from PDA to stay updated on the latest changes in dentistry and to continually improve patient care. These programs have been instrumental in shaping the success of our practice, and we encourage others to explore them.

PDA provides invaluable knowledge on structuring a practice for greater efficiency and productivity, while maintaining a patient-first approach. This approach emphasizes building deep, trusted relationships with patients by delivering care tailored to their individual needs, fostering both trust and satisfaction.

Relocating around COVID sounds like a nightmare scenario. How did you retain patients and stabilize operations during that upheaval?

EL: We relocated our office in October 2019, a few months before the COVID shutdowns hit. At the time, we had so many bills to cover—buildout costs, a mortgage, new equipment—you name it. So, when we found out we had to close, we were definitely scared. We set up detailed safety protocols, held thorough infection control training for the team and even made videos to show our patients exactly what we were doing to keep them protected. We wanted them to feel confident that it was safe to visit the dentist, even during the pandemic.

KL: Relocating during the COVID pandemic was an experience we wouldn't want to live through again—it was incredibly stressful, as we were uncertain how long our capital could sustain the practice. Despite the challenges, we made it a priority to keep all our team members on payroll without any layoffs. We also stayed in close communication with our patients, reassuring them that we were just a phone call away and available for emergency care.

How has your practice philosophy evolved?

EL: At the start of my career, my focus was on providing the best clinical care for patients. Over time, my philosophy has evolved. Now, I want to provide

the best possible overall experience—not just clinical care. That means thinking about every little detail, from how our website looks, to the first phone call, to how patients feel when they walk into the office, how we escort them to the clinical area and even how we follow up afterward. It's all about creating a seamless, positive experience from start to finish.

KL: Our practice philosophy evolved as our team grew closer and more unified. One positive outcome of the COVID pandemic was the unexpected time it gave us to restructure and improve our practice together. In the busy daily life of a dental office, time is always a scarce resource. However, the months we spent closed provided a rare opportunity to meet regularly with our team, address areas of the practice that needed improvement and implement meaningful changes. When we reopened, we returned with a stronger, more cohesive team and an improved practice, ready to deliver even better care to our patients.

How did your view of case presentations and patient communication evolve?

EL: From working with PDA, I learned that it's not just my job, but my obligation, to share everything I see with my patients and recommend all the treatments I think they need. Our goal is to do everything we can to help our patients get as healthy as possible. That's what comprehensive dental care is all about. Working with AcceptCare has also been a game-changer. It gives us the ability to offer more affordable payment options, even for patients who may not have the best credit. This way, they don't have to delay treatment or compromise their health just because of financial concerns.

KL: PDA elevated our practice to the next level. It emphasized the importance of building deep relationships with our patients and establishing trust. By showing them that we are true advocates for their dental health, we were able to communicate

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effectively and educate them about the risk factors impacting their oral health. This approach allowed us to create personalized treatment plans tailored to each patient's needs.

How do you two divide clinical work?

EL: Of course, we each see our own patients and handle our own cases during a typical day. But we also frequently consult with each other when it comes to treatment planning. It's great to have a partner you can trust for input. As for what we love doing, we both really enjoy performing LANAP and restorative procedures.

KL: Edmund and I share the same clinical philosophy and prioritize taking continuing education courses together, ensuring that we can perform the same procedures at a high level. We also have a shared understanding of the procedures we prefer not to perform, such as root canal treatments. For those cases, we partner with exceptional specialists in our area to ensure our patients receive the best care.

How do you approach educating patients about advanced treatments or tools without overwhelming them?

EL: We make sure to use simple, easy-to-understand language when educating our patients. We focus on explaining the problem, the possible solutions and how the treatment we recommend will benefit them. We also use an app called DDS GP, which features simple graphics and cartoons. It helps make patients feel more comfortable and less nervous about the treatment.

KL: Taking the time to truly listen to patients and understand their concerns is essential. This approach not only builds trust but also creates an opportunity to educate them about the benefits and value of treatment, ultimately helping to improve both their oral and overall health.

For dentists considering partnerships—whether with family or not—what's one key lesson you've learned about navigating disagreements?

EL: Disagreements are going to happen, whether you're partners with family, friends or anyone else. In the office, the key question I always ask myself is: What is our mission and vision? Everything we do should be focused on supporting those goals. When disagreements happen between Ken and me, I remind myself that it's never personal. It's about finding a way to solve the

issue while keeping our mission in mind and staying on track.

KL: Partnerships with family and friends can be unpredictable. It's essential to truly understand each other—not just in terms of personality but also practice philosophy. Aligning on core values and approaches to patient care is crucial, as differing philosophies can make it extremely challenging to build and sustain a successful practice together.

When disagreements arise, we make it a priority to step back, listen to each other and work toward a resolution. While we may not succeed every single time, we manage to come to an agreement about 98% of the time.

We both understand that our decisions are always guided by what's best for our patients, our practice and our team members.

Give us a snapshot of your life outside of dentistry

EL: Outside of dentistry, I'm really into soccer and play a couple of games each week. I love spending time with my family and traveling with them whenever we can. I'm also a big fan of watching shows on Netflix. Recently, I've started running, and my goal is to complete a half marathon in May 2025!

KL: Outside of dentistry, I cherish spending quality time with my family and friends. My wife, Amy, and our kids, Kyle, 17, and Reina ,15, share a love for travel, exploring the diverse cultures and cuisines of different parts of the world. On weekends, I still enjoy playing video games with friends—it's a fun way to keep my manual dexterity sharp and my mind young. Additionally, I have a passion for collecting motorized miniature trains, which has become a favorite hobby of mine. **DT**

Brushing Up on Branding

The art of building a genuine brand for your dental practice

BY DRS. STEVIE ROBERTS AND ROBERT JOHNSON

You never get a second chance to make a first impression is a cliché that is as true of social encounters as it is of patients, potential hires and your community discovering your dental practice. Your brand is an expression of the identity of your business that communicates value and serves as the foundation for that lasting first impression.

As clinicians, the brand of our practice is an extension of ourselves and our personality, which makes building a brand a deeply personal process. It's also a ton of fun!

In this article we explore the power of building genuine brands and what to expect when working with a brand designer.

Our story

Our story as husband-and-wife dentists we began in Boston at Tufts University School of Dental Medicine, where we first met in the throes of dental school. Dr. Stevie Roberts is from Philadelphia and the daughter of two dentists. Dr. Robert Johnson is from Seattle and a third-generation dentist. Dentistry has always been a part of our identity and family life. Roberts' parents spent most of their careers practicing out of their family home, a brownstone in Rittenhouse Square, and Johnson grew up working in his dad's dental practice in the same building where his grandfather practiced.

Fast-forward to today, and Roberts is a general dentist and the owner of Dentiste in Kirkland, Washington, while Johnson is an oral surgeon practicing at Maring & Johnson Oral Surgery and Dental Implant Center in Seattle. We are fortunate to also be co-founders of Duo Toothpaste, a tablet toothpaste company that we started with friends to address health and sustainability problems in the monopolized toothpaste market.

Naming the company "Duo" captured the mission of dual benefits: oral and systemic health, personal care, planetary care and two minutes of brushing.

Creating a brand from scratch

Our first brand-building project was Duo Toothpaste. We approached a brand designer when we had a prototype tablet (created after months of pressing tablets in our garage) but otherwise did not have a company name or any branding—we were building a consumer-packaged goods brand from scratch.

The first step in the design process was to communicate the mission and purpose of the company in the context of our target audience. We created Duo with a commitment to science and to also elevate the brushing experience with beautiful, recyclable bottles, clean ingredients and added supplements such as vitamins D3 and B12, bridging oral health and systemic wellness. While we were clear in our mission as a company, we had not sold any products and therefore had to hypothesize about our audience.

Our belief at the time was that millennials would resonate with our mission to improve oral health with a product that was eco-friendly and an elevated departure from crusty plastic toothpaste tubes filling up landfills and gooping up bathroom countertops.

With our mission and audience defined, we created mood boards to visually communicate our vision with clippings from comparable brands, cultural references and anything else that inspired feelings we wanted our future customers to experience. We then presented this information to our brand designer during an introductory meeting, where she also asked us open-ended questions to get a sense of us and the company.

The importance of a good name and a good logo

The next step was to come up with a company name. Our designer took what she learned in that meeting and carefully processed the information before proposing several names that captured the essence of the company.

We landed on the name Duo, which we felt captured our mission and the dual qualities of our product: providing toothpaste and functional ingredients, oral health and systemic health, personal health and planet health, and the two minutes of brushing we all try to promote for our patients.

Next came the logo. A logo must bring the name to life and be adaptable to all mediums, including digital, print and swag. At this stage in the process,

Logo selection was a thoughtful and collaborative journey, narrowing down from seven designs to the perfect one.

seven grayscale logos were presented. We found that we were quickly able to eliminate four of the possibilities, but deciding between the final three was a prolonged and emotional experience between the four co-founders. We all came to appreciate the value in taking time to digest the information and all our opinions changed several times over the course of many productive conversations with each other, our designer and with confidants outside of the company.

Once the logo was established, we entered the final stage of the brand creation process, which is brand expression. Brand expression is the look and feel of the brand and includes the color palette, typography, photography and illustration styles. The final product is a brand guidelines document that includes the name, logo and brand expression that is referenced for website design, physical signs, marketing and wherever else branding is needed. This provides consistency across mediums to promote brand recognition.

Building a brand is only the start. Our brand continues to evolve as we learn more about our customers and the value they find in our products, but building a brand that is genuine to the company and founders that is well-articulated has been fundamental to our success.

Rebranding a dental office

Roberts worked at Dentiste for a year as an associate before acquiring it from a woman who had started the practice out of dental school 18 years prior. Dentiste is a four-operatory boutique practice in an affluent suburb of Seattle with an all-women staff and family-centric patients. Our rescue dog, JoJo, goes to the office every day, making for a wonderful and welcoming patient experience and working environment.

Given that Dentiste had brand recognition in the community, Roberts decided that she would keep the name but that a rebrand was necessary to make the practice her own and to update a brand that was developed in the early 1990s. Notably, the logo featured a frog. To this day, we still don't know where or how the frog came to be associated with a dental brand.

We approached the same designer that we worked with previously to start the rebrand. Similarly, the mission of the company was clear: Dentiste is a dental practice that offers exceptional cosmetic and family dentistry in a vibrant, efficient and welcoming environment to a community that values exceptional service. However, unlike our previous experience, we also knew our audience to be the people of Kirkland who value personal care in a boutique setting.

Although we were able to skip the name-finding step of the process, the branding process was very similar to our previous experience. We also found it easier to create mood boards and to visually present the business given that there was a physical space that could be captured in photos and an existing website and brand to build from.

Roberts also found it to be a valuable team-building exercise to involve her staff in the branding process. After the rebrand was complete, the staff provided a stream of suggestions for swag, window decals, building signs and had a general sense of pride for their workplace.

Growing the brand of a legacy specialty practice

Johnson graduated residency and joined another husband-and-wife dentist team, oral surgeon Dr. Thomas Maring and periodontist Dr. Susan Maring, at Maring Surgical. The Marings have been pillars of the Seattle dental community for more than 25 years and have built a brand that exudes excellence and expertise, but this raised the challenge of rebranding

to promote an additional provider (with a different last name).

There are also differences in the audiences between a general dentistry practice and a specialty practice. The end-consumer and intended audience of a general dentistry practice is most often the patients, whereas specialty practices must consider referring dentists as well as patients. Given the longstanding recognition of the Maring name in the community and the desire to promote Johnson's name as a new oral surgeon, we decided to proceed with Maring & Johnson, a business name that both promotes the individuals and communicates legacy, like a law firm.

However, Maring & Johnson could not stand alone as the business name, for fear of being confused with said law firms. We wanted to communicate what sets us apart from other oral surgery practices, which is that we have oral surgeons and a periodontist practicing under one roof. So, today we are Maring & Johnson Oral Surgery and Dental Implant Center.

With the name decided, we moved on to the logo. Fortunately, there were no frogs involved and the logo that the Marings had designed in the 1980s still captured the brand we wanted to promote. The logo did, however, have design features like shadowing that was clearly designed for a non-digital world. Our designer was quickly able to modernize the logo, typography and color palette to revamp a legacy brand that communicates excellence and expertise across all mediums.

Our takeaways

Building a genuine brand is an incredibly rewarding process that should be approached deliberately. As dentists and business owners, we are accustomed to being a jack-of-all-trades and taking on roles outside of our formal training. We also recognize that the need to build a brand often comes when time and money are limited resources—following the purchase or startup of a practice. It's tempting to assume the role of brand designer in addition to being a dentist. We're sure there are some readers who have the necessary tools to do so, however, we have found that working with a professional brand designer is essential.

The first step is to be able to concisely define the culture, values and audience of your business—as well as what sets you apart. Then, take your time interviewing brand designers to find someone you vibe well with, and be sure to ask for a portfolio of their previous work. Our brand designer had never worked on a dental project but had an impressive portfolio of designing brands for small and large businesses.

Be deliberate with your decisions but also take your time at every step. Digest the information and gather perspectives from as many brand-aligned people as possible. The result will be a brand that is genuine to you and your business and that will define your career. **DT**

Stevie Ames Roberts, DMD, is a general dentist and owner of Dentiste in Kirkland, Washington, as well as a co-founder of Duo Toothpaste. She is a member of the *Dentaltown* editorial board. She was all but raised in a dental office—her parents are both dentists in Philadelphia and practice out of their family home in Rittenhouse Square.

She completed a Master of Biomedical Science in addition to her Doctorate in Dental Medicine at Tufts University in Boston. She met her husband, Dr. Robert Johnson, while in dental school. He is an oral surgeon practicing in downtown Seattle. When they are not talking about teeth and toothpaste, they enjoy exploring the country in their RV trailer and spending time in the mountains and on the water, as well as back East near Stevie's childhood home. She also enjoys playing the piano and reading. They live on a floating home on Lake Union with their rescue dog, JoJo, and their son.

Robert E. Johnson, DMD, MD, is a third-generation dentist and oral surgeon at Maring & Johnson Oral and Maxillofacial Surgery, and co-founder of Duo Toothpaste. His family has provided compassionate oral surgery care to Seattle for more than 80 years, a tradition he is proud to continue.

Johnson earned his undergraduate degree from the University of Washington before moving to Boston to pursue dental school at Tufts University, where he met his wife, Dr. Stevie Roberts, who practices in Kirkland, Washington. He then returned to the University of Washington where he completed medical school, a general surgery internship and residency training in oral and maxillofacial surgery.

How Do You Run a Practice When Your Patients Can Melt the Equipment?

XbiteDoc77 *Member since: M-Day Recovery Program* Post: 1 of 16

Running a dental office near Westchester is no joke—especially when 90% of your clientele are mutants, Avengers or both. But today, I hit a new low.

A new patient came in, glowing (literally) and complaining of jaw pain. Said she cracked a molar while biting through Vibranium shackles. I didn't ask too many questions, but her gamma-irradiated saliva fried the suction system in my third new chair this month. That's $15,000 down the drain ... again.

Here's where the real chaos started: She hovered six inches off the floor the whole time. Our ceiling panels are still scorched from what I assume was accidental propulsion.

The front desk staff panicked because her aura set off the sprinkler system, flooding the waiting room. Now half my afternoon appointments have rescheduled because "the office smells weird."

Insurance? Forget it. She's apparently covered under the Avengers' "mission-related injury fund," but when I called to verify, Stark Industries' billing department laughed and hung up.

I tried to recommend an Adamantium crown for durability, but when I mentioned the price, she told me "money's not a problem" and pulled out a literal gold ingot from a pocket dimension. Now my staff wants hazard pay for handling interdimensional currency, and the accountant is calling about potential IRS audits.

To top it off, she didn't leave through the door. She phased through the wall and dislodged our new "Mutant-Friendly Practice" sign. Repairs alone are going to wipe out this month's profits.

So, how do you all manage a practice with patients who can destroy half your equipment by accident? ■

Beastly_Bicuspid_Connoisseur *Member since: Founding of the Xavier Institute* Post: 2 of 16

Welcome, my fellow enthusiast of the oral arts, to the delightful chaos of mutant dentistry! Where the biggest hazard isn't root canals—it's mitigating the occasional collateral damage. For your equipment, I'd recommend Stark Industries tech. Yes, the price tag might make even an Omega-level mutant wince, but it's practically indestructible. Also, make sure your insurance policy includes "Acts of Heroism and Villainy" coverage.

On billing? Try asking the Avengers for payment in Vibranium scrap. It's surprisingly lucrative on the black market (allegedly).

My sincerest condolences for your recent plight, but as Ralph Waldo Emerson once brilliantly stated, "Life is a succession of lessons which must be lived to be understood." ■

WeaponXtractEmEH *Member since: The American Civil War* Post: 3 of 16

Listen, Bub, let me give it to you straight: you're never gonna have a peaceful day with these types. They blow up your chair, shred your drywall and "forget" to pay half the time. You gotta adapt. I charge triple for any patient with a danger rating above Beta. Also, install steel-reinforced walls—they can't phase through that.

And ditch the "Mutant-Friendly" sign. You're in Westchester. If they don't already know, they're probably in the wrong neighborhood anyway. ■

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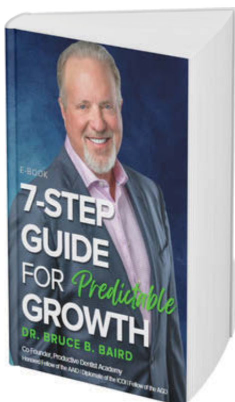

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