

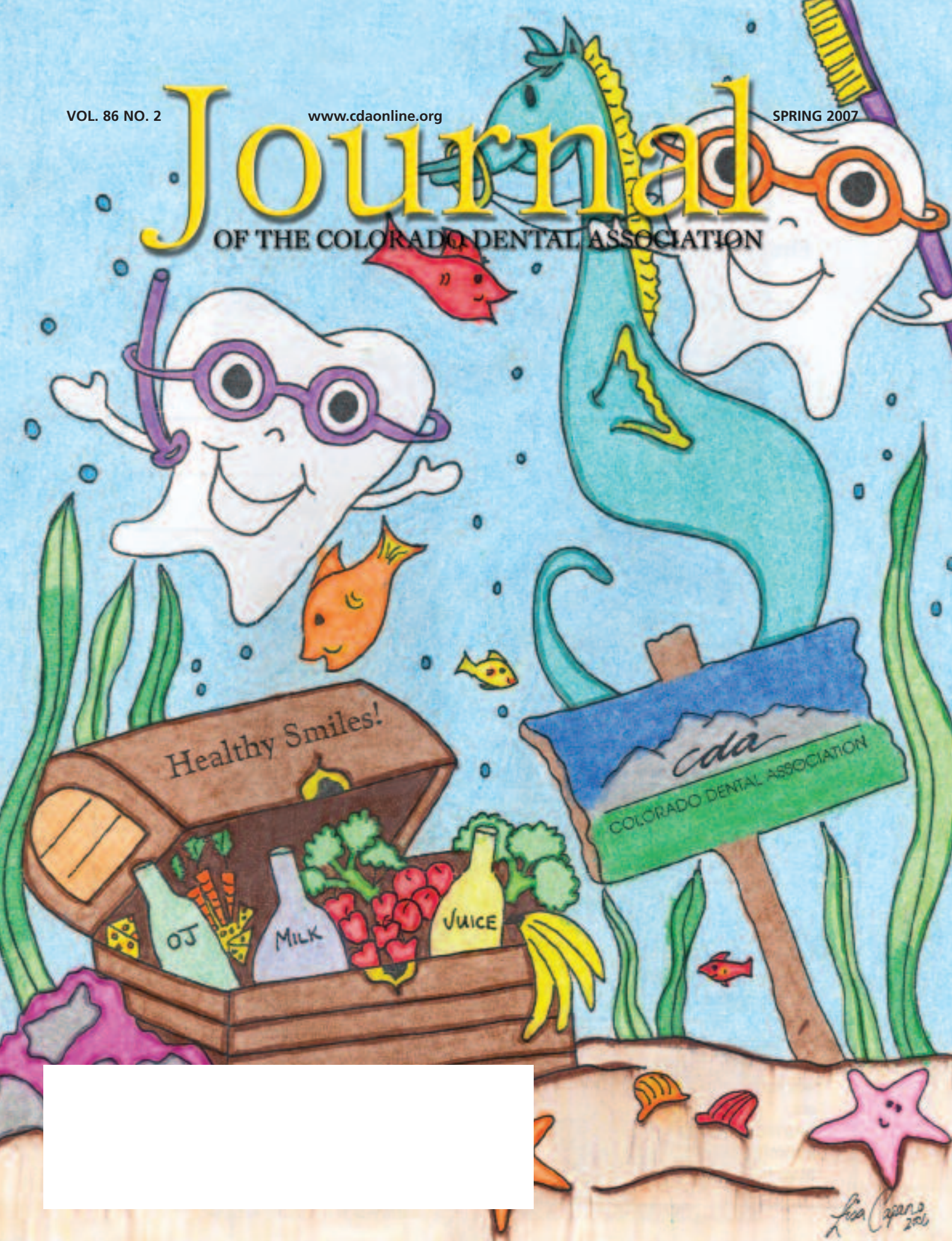
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Lisa Capano
2006

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Spring 2007

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Amanda Moore, from Maranatha Christian Center in Arvada, Colo., won the 2007 CDA Coloring Contest. 3,715 entries were submitted this year, setting a record for the annual contest. Please see the May issue of the *Colorado Dentistry* newsletter for the full story and other winners.



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“If You Have a Good Idea, Share it With Your Colleagues.”

(Quote by Dr. Gordon Christensen, ADA Annual Session in Orlando, Fla.)

By Joseph Tomlinson, D.M.D.



Dr. Joseph Tomlinson is a General Practitioner in Fort Collins, Colo.

a program to the Larimer County Dental Society about a concept and technique I had developed following a discovery I made over 25 years earlier while trying to solve an unusual occlusal and orthognathic problem for a patient who was very dear to me, my own mother. In addition, I had nearly completed a paper on the concept, which had been accepted for publication pending a few revisions.

When I heard the words spoken by Dr. Christensen as his opening comments before an all-day seminar at the 2004 ADA Annual Session in Orlando, I knew he was speaking to me. In fact, I was already scheduled to present

“You should write a paper on this and have it published.”

—Dr. Irwin Becker, CDA Annual Session in Telluride, Colo.

Prior to Dr. Christensen's statement, I had attended a lecture by Dr. Irwin Becker, of the Pankey Institute, at the 2003 CDA Annual Session in Telluride. One of his sub-topics dealt with increasing Vertical Dimension of Occlusion (VDO). During a question and comments period at the conclusion of his presentation, I explained to him that I had been using the technique described in my accompanying paper for years, and I wondered what he thought of the technique. He told me “it was a great idea,” and added that he and others were experimenting with such a concept at the Pankey Institute for the previous two years. They were using it as a means to temporarily establish an appropriate vertical dimension for patients before completing more permanent treatment.

My next question to him was “had he ever seen anything published on this concept?” It was important to me that something be published on this topic as another **one of my patients insisted that I teach this concept to other dentists as it had made such a dramatic improvement in her condition and her life.** What I had accomplished for this patient was to create the right amount of interocclusal space to allow me to properly restore her badly chipped and worn anterior teeth, enhancing her smile. Her upper and lower incisors had been in an edge-to-edge position for years and there was simply no room to add restorative material until after this “bite opening” technique was performed. In addition to enhancing her smile, an unexpected benefit occurred very soon after I altered her vertical dimension of occlusion (even before I had a chance to restore the incisors) – her jaw muscle spasm dysfunction, which had been troubling her for years, had a complete spontaneous resolution.

In order for me to accept this patient's charge to teach this concept, I believe it is essential that it be supported by published papers including a discussion of the technique, results, findings and any untoward outcomes. Dr. Becker's answer to my question in the preceding paragraph was, “no, nothing has ever been published on my concept, but it should be.” He then added, “you should write a paper on this and have it published.” Through e-mail correspondence, Dr. Becker provided me with suggestions on completing the paper

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for publication. Thanks to his charge, and after waiting a reasonable amount of time for untoward outcomes to surface, if there should be any, I am now ready to publish my paper in this *Journal*.

The article that accompanies this column, "A Simple Technique for Opening the Vertical Dimension of Occlusion as an Aid in Solving Challenging Restorative Problems," is one that I feel passionate about. I used Power Point to present this concept to a group of about 50 dentists at the Larimer County Dental Society in October 2004. The response has been overwhelmingly positive. A few general practitioners have indicated to me that they have used the technique a few times since learning about it. They have reported that it allowed them to better solve some challenging problems that could not have been so easily solved without the aid of this technique. Two orthodontist friends,

Dr. Bill Iversen of Fort Collins and Dr. Mark Stasi of Denver, have expressed support for the fundamentals of this technique and an interest in utilizing it to simplify some of the issues they face in their everyday orthodontic practices. Both have recommended I publish a paper on this concept and technique.

Please read the accompanying article and, if you would like to know more about the concept and its applications, contact me. I would be happy to spend an hour with any group or study club, teaching and discussing this concept by way of the same Power Point presentation shown to members of the Larimer County Dental Society. I also plan to follow the paper published in this issue of the *Journal* with subsequent papers showing examples of patients already treated with this technique, and to discuss various other conditions that could reasonably be corrected or improved with this concept. ■

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There is Nothing That the Dentist Can Do, Which the Patient Cannot Undo

By James C. Grant, D.D.S.



Dr. James Grant is a General Practitioner in Colorado Springs, Colo.

This statement has never rang truer than today. For the past 31 years, I have practiced clinical dentistry. I am now observing some very disturbing trends and habits related to society that are here to stay. Patients who have been in my practice for years and have exhibited consistently good oral hygiene habits, regular prophylaxis and exams, are now presenting with gross recurrent decay on multiple teeth, and decay on previously non-restored teeth. It is not an isolated case or some anomaly, rather a disturbing frequency and commonality. I have had long conversations filled with probing questions regarding the habits and nutrition of these intelligent, long-term patients to see if I could discern a diagnosis. The following are my clinical observations and conclusions from the answers that these patients informed me as to the etiology. The answer comes in at least five parts and has developed as a social trend or blight that I feel is here to stay, and dentists will need to deal with this trend from now on.

Within walking distance from my office are seven (no kidding) coffee shops – some the trendy specialty cafés, others the quick stop type, but all still serving the new definition of coffee. The extensive menu of sugared, creamed, foamed, flavored, syrupy, whipped creamed,

caramelized, hot, cold, ordered to your temperature, oversized to today's Super Size mega drink is readily available. The calories with accompanying weight and medical problems are an issue unto itself; however, my concern is the way it is ingested. My experience is this: in the morning, on the way to work, people purchase one of these enormous and expensive drinks — say a 16 oz. caramel latte with whipped cream — and plan on sitting at their desks and sipping it from morning to lunch. It costs too much to not drink it all, and they need the caffeine and sugar buzz. So for hours they are bathing their teeth, root surfaces and restoration margins in sugar. The outcome is obvious. What isn't so obvious is the patient's perspective as to this daily ritual being a source of tooth decay. Will these trendy coffee shops go away as some fad? Will people go back to plain black coffee and sugar substitute? Or at least if they drink the flavored, syrupy coffee over say a 15 minute period, will they then rush to the bathroom to brush and floss the sugary residue off their teeth? I'm not too optimistic.

I do see patients who don't drink coffee at all, perhaps substituting a healthier alternative, and some of them have the same problem with recurrent decay and periodontal lesions not previously seen. Another possible contributing factor are the latest hip sport drinks, which replace electrolytes and hydration lost during exercise. Again, we have a pleasant drink that is "good for us," and is to be consumed over a long period of time: before, during and after exercise. The patient

perception is, "at least I'm exercising and helping my body, so now I need to replace the lost fluids." Unfortunately, we have the same problem with exposure to sugar for extended periods of time, except now we add in acids. One bottle (almost 17 oz.) of fitness water has only 25 calories, which doesn't seem too bad, but along with the sucrose syrup and high fructose corn syrup, we now have citric acid, ascorbic acid and phosphoric acid (a lesser percentage of the blue gel we etch teeth with). Even some bottled water with 0 calories has at least two of the mentioned acids added to them. Again, it's the patient's perception of these exercise-related drinks that worries me, not to mention the effects they have on their teeth.

Which brings us to diet drinks: One of my patients likes to argue with me (ok, he's a lawyer and likes to argue with anybody) because he drinks (as he is willing to testify to) diet soda, and only diet soda. He finally admitted, thanks to his wife, that this means multiple sodas daily, but nevertheless only diet. The amount of erosion around margins of restorations, class V areas, and the general destruction of his teeth, was remarkable. So, here is an intelligent man who thinks he is causing no harm to his teeth by drinking a diet soda, when in fact he is doing everything possible to erode all the organic tooth structures, and cause irreversible damage to restorations, necessitating early replacement.

One of the more recent drinks to come out is the "energy drink." I see this in the younger patient. The chemistry of these is pretty simple – they are loaded with

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caffeine and sugar. These patients are sometimes already a challenge nutritionally, and with so many of these products available, coupled with pressures from peers and high demands on performance, I think we'll continue to see more of this deleterious affect in the future.

The last trend I have identified is without a doubt the worst, and unfortunately, I have seen some cases this past year. The diagnosis of "meth mouth" is a hard one, as it is shocking for me to think one of my patients who has never shown signs in the past, can now be diagnosed with all the symptoms. The ingredients in methamphetamine that are so damaging are muriatic acid, sulfuric acid, red phosphorous and lye, to name a few. Along with xerostomia, tooth decay, poor oral health, cracked teeth and gum disease, it is shocking to think anyone would voluntarily do something to his/her body such as this, but lately it seems that

no person or class status is immune from this blight on society.


At times I am discouraged with defeat of how we, as dentists, can combat this relentless attack on our tight margins and well-placed, contoured restorations, by patients who knowingly or unknowingly inflict this abuse on themselves and their teeth. These are the patients who trust us, but put an unrealistic expectation on the longevity of the outcome. It has to be a renewed partnership, a symbiotic relationship where we both do our part and help counteract the slick advertising with information and truth. We can do the diagnosis and inform the patient of the side effects of these hidden habits and actions, resulting in dire consequences if not altered or eliminated entirely. As a dentist, I will continue to do my best in treating and combating the new trends, but frankly I am not hopeful for most of these patterns to be altered. ■



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Mission of Mercy – My Experience

By John Hanck, D.D.S.

You have no doubt heard a buzz recently about COMOM – the Colorado Mission of Mercy – a large-scale, multi-chair dental clinic that will travel around the state annually to underserved areas. As part of the CDA team that scouted out whether a Mission of Mercy (MOM) event would be a good fit for Colorado, I can tell you that without a doubt you will not know what you're missing until you participate in a MOM. It is an opportunity that provides an enormous amount of oral health care to people who don't have access to dental treatment but desperately need help. It has been an opportunity that has warmed my heart and has made me proud to be a dentist.

I first learned about MOM when Dr. Bob Morrow of Walsh, Colo. informed the CDA Board of Trustees of the event in 2002. He had participated in the Kansas Mission of Mercy (KMOM) and was eager to establish a MOM event in Colorado. The Board asked Dr. Morrow to invite Dr. Jeff Stasch, of Kansas, to attend a Board meeting to tell the trustees more about MOM. I remember being very impressed by the amount of dental care that was delivered and the amount of need that existed in the small area of Kansas where the MOM events had been held.

In 2004, CDA staff members Lu Anne Garvin and Molly Osberg, as well as Dr. Pasco Scarpella, Dr. Bob Morrow and I went to the KMOM in Pittsburg, Kan. to volunteer at and observe a MOM in action. We saw the transformation of a college gymnasium into a working dental care center, complete with triage, anesthesia, central supply, sterilization,



COMOM registration is open online at www.cdaonline.org. Please sign-up to be a part of this inaugural event in Colorado. Dental and non-dental volunteers are welcome!

operative dentistry, oral surgery, pediatric dentistry, hygiene, radiology, endodontics, pharmacy and a prosthetic lab. There was food provided for the patients and staff, and traffic and crowd control by the National Guard. There was a health history station run by nurses, entertainment for children, post-treatment interviews for patients, and paramedics available in case of emergency. Just watching the set-up of this grandiose event generated excitement to start treating patients the next day.

Patients started coming to the parking lot at 3 a.m. – they knew it was a first come, first served event. As the crowd grew, the National Guard directed cars to the proper parking lots and maintained order while patients waited in line for the doors to open. We started seeing patients in triage at 6 a.m. Once screened, the patients would go to the anesthesia station and then to operative, where I was assigned, or to another treatment area. We treated patients using portable dental stations, complete with sterile water and suction.

The amount of dental care that was needed, primarily by adults, was shocking.

Due to the nature of the event, and to alleviate the pain that many of the patients were suffering from, the motto of the day was, "If in doubt, take it out." Almost all necessary treatment was completed at the event – we didn't want to leave the local area dentists with large numbers of problem teeth needing follow-up care.

During the evenings, KMOM provided us with dinner, music, dancing and camaraderie, as well as an enthusiastically announced report of the day's donated services and the treatment goals for the next day. The two and a half day KMOM in Pittsburgh treated 2,761 patients, delivering \$981,500 worth of dental care.

It was a wonderful feeling to be part of a "bigger than life" event. The expressions of gratitude from the patients were heart felt and continuous throughout the weekend. The hug quotient was also very high with many tears of appreciation. It was a life-changing event for me and many others.

The pride I felt in my profession was indescribable. To have the opportunity to be part of a large philanthropic event that is open to the entire dental team was beyond gratifying.

I hope that all of you will join the COMOM in Alamosa, Colo. on Oct. 19-20, 2007. The first COMOM will take place at Adams State College. The CDA is also seeking monetary donations. If every CDA member donated just \$100, we could cover the cost of this COMOM and purchase equipment for COMOMs in the future (checks should be made payable to the CDA Charity and Educational Fund, Inc.). ■

Relationship Questions: The Glue to Create Powerful Doctor-Patient Bonds

By Janet Steward and Lawrence Steward, M.B.A.

QUESTION: I feel very comfortable with my clinical skills but my staff keeps hinting that they think I could do better relating with patients. How can I improve?

ANSWER: Your current approach to patient relationships is common among dentists, but it may be placing too much emphasis on increasing patients' dental IQ while underestimating the power of treating patients as unique individuals. The "problem" with the common approach is it assumes that patients are coming to your practice because they just want their teeth fixed. Naturally, some

patients do, but most want more. They want relationships with professionals they know and trust.

Many corporations and business researchers have spent hundreds of thousands of dollars, and years of their time, studying the question of how their businesses can improve relationships with their customers.

The simple response, in spite of all that research, time, money, and volumes of reports and articles, can be condensed into two concepts: (1) ask questions that engage and (2) listen to the answers.

are questions typically asked of new patients, such as "are your teeth sensitive to hot or cold?" Most dental practices do a very respectable job asking transactional questions. While essential, be aware that they do not create patient bonds.

While transactional questions don't build patient relationships, the second category of questions are the powerful tools that spark patient-doctor bonds. Relationship questions are patient centered and designed to get to know the patient as a person. Good relationship questions can't be answered with a simple yes or no because they're designed to engage the patient in conversations about themselves.

Unless you ask, it's unlikely you'll learn the fact a patient has just received a new promotion at work, has written a book, has a new baby, or is a new grandparent. Sure, patients want a great dentist, but to them that means a dentist who is good clinically AND who understands and cares about them.

Successful dentists want to know more about their patients, but very often, while doing so, amazing things happen that benefit their practices as well. For example, by asking an older patient about his life, the dentist may learn this patient has a huge extended family and their current family dentist is retiring at the end of the month. The time it took to get to know the patriarch of the family may benefit the dentist with three-dozen new patients in the future (without a cent spent on external marketing)!

In fact, the art of asking questions is clearly the most powerful tool in creating personal and professional relationships. Of course, it does little good to ask questions if you don't listen to the answers, so it's obvious the two go hand in hand.

There are two types of questions that are important in dentistry: transactional and relationship builders. The transactional question is used to gain basic but important clinical information. These seek specific responses and often can be answered with yes, no, or a single word/phrase. These

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GLUE *continued from page 11*

Once the dentist has established a personal relationship, it's appropriate to move on to such issues as clinical history and experience, goals for dental health, and any current financial concerns they might have. (Remember, nearly everyone feels broke today, but most feel optimistic about their ability to afford important purchases at some time in the future.) Even when patients have huge financial obstacles for treatment acceptance today, establishing a bond with them ensures that, when they're ready, they'll come to you.

So what questions seem to get the best results? The best approaches are well rehearsed but very conversational and natural. For example, one doctor might start the conversation with a new patient by saying something similar to this after introductions: "One of the things I like to

do in my practice is spend a little time with you as a patient just so I can get to know you better. So what's happening in your life?" Further questions then seem natural and are based on patients' responses.

When these questions are skillfully used and the doctor uses active listening skills, a transformation is taking place within patients. Suddenly, instead of being asked for passive information, they are being engaged. Somewhere inside the patient's brain, the message is sinking in: "this doctor really cares enough about me to find out about my life and what's important to me, my family and friends."

There is a time tested and true analogy that patients won't care about what you have to say until they know you care about them. Through the use of active listening skills, doctors are not using

manipulation or other tricks just to sell something: they are genuinely interested. Despite their simplicity, relationship questions provide dramatic returns by creating lasting bonds with patients as real people who like to create relationships. ■

Janet and Lawrence Steward are speakers, consultants and authors. Their book, What Do Dentists Really Want? is available through www.Amazon.com or www.theManageDentPros.Com. Janet Steward, president of Quantum Leap Dental Consulting, can be reached at 970/207-0776.

Do you have a practice management question you'd like answered in this quarterly column? Submit your questions to molly@cdaonline.org or 3690 S. Yosemite St., #100, Denver, CO 80237.

The Importance of Documentation and Use of Progressive Discipline

By Stacy Jensen

QUESTION: One of my hygienists is constantly late, uses foul language on the job, and has a terrible attitude in general. When I called my HR company to tell them that I wanted to fire her, they told me that I should give her a written warning instead.

I thought that Colorado was an at-will state. Why can't I just terminate her?

ANSWER: Colorado is an employment-at-will state, as are most other states in the nation. Although you can terminate any employee who does not have a written contract with your practice, in many instances it is not always advisable.

There are several reasons why employers are advised against terminating an employee when there is an absence of documentation or progressive discipline. The threat of complaints such as wrongful discharge, discrimination, and a host of other legal battles are reason enough to make sure that your practice adheres to a strict and uniform discipline policy. Used properly, progressive discipline gives managers the tools they need to make fair, consistent, and legally defensible disciplinary decisions. Because it's based on communication and collaboration, true progressive discipline also helps employees improve, which is the ultimate goal of any disciplinary system.

The first step is to ensure that your company policies are legal and up-to-date. Every employee should receive and acknowledge receipt of your employee handbook prior to commencing their first day of employment. Keep a copy of the acknowledgement of receipt in their employee file. This makes it more difficult

for an employee to allege that they "didn't know the policy."

If there is a breach or a suspected breach of company policy, a thorough investigation should be conducted. Employers need to be relatively certain about what's really going on in order to address the situation. If the problem is clear-cut (i.e. tardiness) the situation requires little investigation. If an employee is being accused of some type of negative behavior by another co-worker, however, it is important to seek both sides of the story.

When you are certain that a breach in company policy has occurred, the next step is to determine the severity of the offense. A first-time offense should call for less of a formal intervention than a repeat offense. If the employee has committed an illegal act you will most certainly impose more serious discipline.

Written documentation officially recognizes that a problem exists and should be prepared after meeting with the staff member (if there is any uncertainty about the alleged offense). When a manager presents the disciplinary action form to the employee, it is important that it is signed by both the manager and the employee. The form should indicate the details of the occurrence as well as the required employee action. Maintaining clear and accurate documentation at every step of the disciplinary process is crucial in the final stages of progressive discipline when termination of the staff member is probable.

When appropriate, establish a timeline for the corrective employee action. If you give an employee a certain time frame to

improve their performance, it is important that you revisit the issue when the time has elapsed. If the behavior or offenses continue, and you have appropriately documented the lack of improvement, your grounds for terminating the employee are more likely to be substantiated, helping you to potentially avoid an unemployment claim or discrimination suit.

It is critical to maintain equitable treatment in your disciplinary process. If you treat all employees equally, each employee's personnel file will reflect your disciplinary action consistency. Though each disciplinary problem is unique, civil rights investigators and plaintiffs' attorneys will not just accept your "word" that you do not discriminate. Despite a state's "at-will" policy, adhering to a consistent disciplinary procedure will protect you in the unfortunate event that employment must be terminated.

Stacy Jensen is a Communication Strategist for Terra Firma, a locally owned and operated Professional Employer Organization (PEO) in Denver, Colo. Terra Firma is a CDA Medallion Plan Partner and provides small to mid-sized employers with a full scope of human resources services, safety and risk management, employee benefits administration, and regulatory compliance consulting. Contact sjensen@hrvp.com for information.

Do you have a human resources question to be answered in this quarterly column? Submit your questions to molly@cdaonline.org or 3690 S. Yosemite St., #100, Denver, CO 80237.

A Simple Technique for Opening the Vertical Dimension of Occlusion as an Aid in Solving Challenging Restorative Problems

By Joseph C. Tomlinson, D.M.D.

A Dental Technique Paper

Abstract: The technique presented in this paper allows general dentists and specialists to more effectively treat a wide variety of conditions in a simpler and far more affordable manner, bringing better dentistry to more patients than ever before. The technique itself is very simple. It consists of applying a composite build-up to the occlusal surfaces and cusps of two or more teeth on each side of the mouth. The teeth I recommend selecting for this procedure are the four lower premolars. However, variations of the technique are acceptable, and are discussed later in this paper.

Introduction: Many times during the course of a typical week in the dental office, we are faced with a situation where the patient's teeth are heavily worn, either in the molars and premolars, or the upper and lower anteriors, or both. If the teeth have not passively erupted to compensate for that wear, we may be faced with a difficult challenge in restoring any one of the teeth, especially if the patient needs crowns but can't afford full-mouth reconstruction, or can't afford more than one or two crowns at a time over the course of a year. In such cases, gaining an extra two to three millimeters of inter-occlusal space can make a huge difference in allowing us to accomplish something that will be durable over time and acceptable in function and appearance. In these situations of excessive

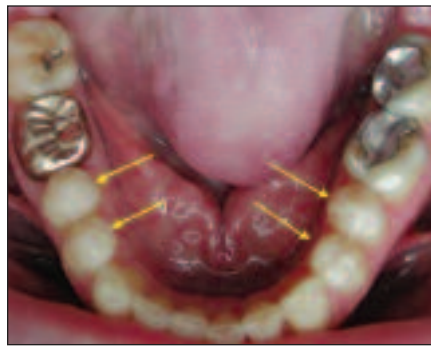


Figure 1: Four lower premolars have been built up two to three millimeters with composite. Photo was taken more than two years after procedure was initially performed.

wear, utilizing the technique presented in this paper can facilitate achieving a positive solution for both the patient and the dentist.

Technique: This can be performed with any type of durable, tooth-colored composite material. I prefer to use a three-step (etch, prime, bond and composite) technique using Kerr Opti-bond. More specifically, I etch the enamel, rinse and dry, prime and dry, bond and cure, reapply bonding, and then apply a composite buildup to the cusps and occlusal surfaces of at least two teeth on each side of the mouth to a height of two to three millimeters. I overbuild the teeth slightly so that, as the bite is checked and adjusted for balance, and polished for smoothness and comfort, the end result is a total height increase of two to three millimeters. This can be reduced if less

space is needed, or if the patient doesn't tolerate this amount of opening. While I haven't tried using a two-step or one-step product for this procedure, manufacturers of those products indicate that they bond as well as a three-step technique.

For many patients, the four lower premolars are selected for this procedure (Figure 1). For others, the four upper premolars are selected; and for some, the buildup is divided between upper and lower premolars. In some cases the procedure may involve using one or two molars, especially if the cusps are heavily worn or cupped out, or show signs of excessive wear and would benefit from being restored to their original unworn shape and contour. This is particularly helpful when some of the premolars are crowned or otherwise unavailable for this purpose. Regardless of whether the teeth selected are in the lower arch, the upper arch, or a mix of upper and lower arches, **what matters most is that there are at least two teeth on each side of the mouth, resulting in occlusal contact on at least four teeth in each arch.** This is to prevent overloading any one tooth with an excess of occlusal stress and possibly damaging it.

Another important factor in deciding which teeth to bond is the effect created on the esthetic transitions from the anterior teeth to the built-up premolars and/or molars. In other words, this procedure should be planned to provide



Figure 2: Side view of build-up on teeth #20 and #21 reveals harmony in appearance with nearby teeth.

the best esthetic enhancement (Figure 2), rather than creating a cosmetic problem.

Obviously, it is important to avoid creating any new problems, such as abnormal lateral shifting of the bite, which could lead to stress or strain on one or both TM joints, or an uneven function of the muscles of mastication, resulting in fatigue and muscle spasm, or to cause a hypersensitive tooth. To minimize problems with the bite, the modified teeth on both sides of the mouth must contact at the same instant when the teeth are closed together. In addition, the patient must be able to move the lower jaw and teeth freely from side to side and forward and back. If new occlusal contacts turn out to be heavier on one side than on the other, or if a "slide" is created, or if muscle tightness occurs, or if any soreness develops in the joints or in the teeth, appropriate adjustments must be made until those problems are corrected. Urge the patient to call the office for minor reshaping (or major reshaping if necessary) if contact problems are noticed, and for relief of any soreness that may have developed in the teeth, muscles or joints. It has been my experience that most patients undergoing this procedure have reported being able to relax more, breaking up their patterns or habits of chronic clenching or grinding. This is borne out by the fact that they rarely wear down or chip off the composite material.

Educating the patient is a big part of this technique. This should always precede performing the procedure. The

patient must be educated as to why their condition causes concern, and how utilizing this technique could help solve these difficult and challenging problems. In addition, the patient should be shown how the treatment will help to improve the long-term prognosis for the subsequent restorative treatment. This will make the patient's investment in his or her teeth more predictable, both initially and in the long-term.

The patient must also understand that this procedure will not harm the teeth by applying this material, nor will it cause them to need crowns or other treatment they didn't already need. The molars, which are initially left out of contact after the composite is applied to the premolars, tend to passively erupt into contact over a period of four to six months. For some patients, passive eruption of the molars does not occur. In those cases, the molars will need to be restored with onlays, crowns or composite build-ups, or repositioned orthodontically to establish normal occlusal function. This potential need for crowns, even on otherwise healthy molars, should be discussed in advance with the patient.

Patients must be informed that the *bite will feel strange* for the first week or two, possibly as long as a few months, and they will have difficulty eating some foods. In addition, they may find their speech affected slightly, at least initially, until the anterior teeth are restored, or realigned, if orthodontic treatment was planned.

In addition to educating the patient, a **trust level** must be established with the patient before this procedure is performed. It is best to offer this service only to patients you have known awhile, people who already trust your skills and clinical judgment.

Discussion and Application: This technique allows the opening of the Vertical Dimension of Occlusion (VDO) in a simple, straightforward manner. It has a variety of applications across several disciplines. One such application is the

restoration of difficult and challenging conditions such as an edge-to-edge anterior bite, which has resulted in excessive wear and chipping of the upper and/or lower anterior teeth (Figure 3). It is impossible to restore teeth in this condition to a normal incisal-gingival length without opening the VDO, or undertaking a major treatment alternative.

Common treatment alternatives to create inter-incisal space, to permit teeth in this condition to be restored, are orthodontic realignment, surgical repositioning of the lower jaw, or surgical repositioning of the upper anterior segment of teeth and the alveolar process. All three alternatives are costly and constitute a major undertaking, something that many patients will refuse to consider.

Traditionally, opening of the VDO usually means placing crowns on most of the teeth (full mouth reconstruction), an area generally reserved for prosthodontists, or others with special advanced training. In addition, such treatment is limited to a select few patients who have substantial financial resources.



Figure 3: Black lines across the upper and lower incisors depict the pre-treatment level of wear of these teeth. Upper and lower incisors were edge-to-edge prior to opening VDO, leaving no space to add restorative material to develop a normal shape and contour. Photo was taken more than one year after procedure was performed.

TECHNIQUE continued on page 16

TECHNIQUE *continued from page 15*

Another application of this technique for opening the vertical dimension is to create inter-occlusal space in the posterior regions, making it easier to place crowns on teeth with short clinical height, or on teeth with heavily worn chewing surfaces. Teeth in that condition have inadequate inter-occlusal space available for a normal thickness of material. In addition, the risk of pulpal exposure is high and retention can be a problem due to the shortness of the walls retaining the crown. By opening the vertical dimension of occlusion, it is possible to restore the molars with minimal to no occlusal reduction during crown preparation. The space gained from opening the vertical dimension allows us to achieve an adequate thickness of material on the occlusal aspect of the crown and avoid exposure of pulp horns lying close beneath the heavily worn surface. In addition, the retentive walls will be shortened much less than they otherwise would be, resulting in far better retention of the crown.

More importantly, some of the molars and premolars may not be as heavily worn, and will not require crowns at all, especially if passive eruption is allowed to occur, as it often does in these cases. For those teeth that need to be crowned, this can be staged over time so that patients who need assistance from their dental insurance plans, or who simply need to pay for the treatment over time, can end up with an outstanding result. For those patients in need of full mouth reconstruction, and who have committed to paying for it, this technique can serve to test the patient's tolerance for the new position of the mandible before commencing with the major reconstruction procedures. This testing of the opening of vertical dimension may uncover previously unknown sub-clinical TMJ issues.



Figure 4: Blue marks on occlusal surfaces of this patient's molars confirm they have passively erupted into occlusal contact over time. The gold crown was made prior to opening of the VDO. The two molars on the right have been crowned since this photo was taken.

I have been reluctant to recommend this procedure for patients with known TMJ signs or symptoms. However, I did recommend it to one of my TMJ patients for several reasons. First, I thought it might actually help reduce her muscle spasm problems. Secondly, we agreed that if, at minimum, it didn't make her TMJ muscle problems worse, her other malocclusion conditions would greatly benefit from this procedure. To the delight and amazement of both of us, it actually provided almost immediate, profound, and permanent relief from chronic muscle symptoms and spasms thought to be TMJ related.

Benefits: The greatest benefit of this technique is to gain space inter-occlusally and inter-incisally for obvious reasons already discussed. Another benefit of this technique is to be able to test a patient's tolerance and adaptability to an increased vertical dimension of occlusion before commencing with more involved restorative treatment. A reasonable time period for most patients to decide if they are going to find this new position agreeable and either comfortable or at least tolerable, is three to five weeks after the composite buildups are completed.

No tooth preparation is required for this technique, making it *completely reversible*. This is important in case the patient

should decide that he/she doesn't find this change to be acceptable or tolerable. For many patients, after a period of four to six weeks, passive eruptive movement by the molars will have begun to occur, making it less possible to fully reverse this procedure. Since passive tooth eruption is a desired result for many of the patients, this should be viewed as a positive effect (benefit). However, if it is desired to utilize the inter-occlusal space for achieving an adequate thickness of material for new crowns that are planned, it is best not to wait much longer than six weeks to commence with the crown treatment, or the space created may be lost due to the passive molar eruption (Figure 4). If it is desired to prevent passive molar eruption, this can be accomplished by applying composite to the occlusal surfaces of those teeth within a few days or weeks of initiating treatment, if it hasn't been done in the beginning.

Of all the patients I have treated with this technique, which includes about 25 during the past 10 years, a few in the five years prior to that, and the very first one over 25 years ago, none have requested reversing this procedure. None have wanted to end the quest to achieve the goal that was established. None have ever expressed dissatisfaction with the overall outcome. In fact, all have been pleased that it has corrected a long-standing problem.

History: The genesis of this concept came about while evaluating and treating an unusual anterior cross-bite condition that my mother had developed early in my dental career. I determined that this patient needed to see an orthodontist to correct this, or else have her lower incisors extracted and replaced with a removable partial denture. Neither option was acceptable to her, and she challenged me to think of a better solution. The only idea I could think of was one based on certain principles I had learned during orthodontic classes taught by Dr. William Proffit, professor of orthodontics and

department chair, when I was a student at the University of Kentucky. I decided that a temporary bite opening procedure using a composite material fixed to the lower premolar teeth might be a solution. It was at least worth a try. What started out as a temporary bite opening for my mother, to help in the correction of her late onset anterior cross-bite, evolved into a permanent and stable new Class I bite relationship for her, without the help of orthodontic treatment. The results were so astounding and unexpected, that it took me awhile to comprehend just what we had accomplished so serendipitously. Gradually, I gained confidence that I could incorporate this concept into my treatment protocol for other patients with worn dentition problems without causing them harm. I began to offer it to more and more of my patients with heavily worn dentitions, especially those with heavily worn incisors. It has also been used for other conditions, such as flared upper incisors, and even for sagging faces that I determined were the result of a loss of vertical dimension of occlusion.

Untoward outcomes or results: So far as I know, there have been no untoward

outcomes. Most of the patients treated with this technique continue to see me for regular cleaning and check-up visits. If there is any dissatisfaction, and this is rare, it is that the composite material is wearing down, and they need a little supplemental treatment to re-establish the vertical dimension again. Most patients, however, do not lose the vertical dimension gained as it becomes stabilized by the molars that have passively erupted into occlusion, or have been restored with crowns.

Summary: The chief advantage of this technique is to create an adequate amount of space between the upper and lower anterior and posterior teeth so those that are most in need of restoration may be properly restored, achieving more ideal proportions for cosmetic and functional results, as well as greater durability. In many cases, only a few teeth will need to be crowned, rather than all the teeth in the mouth. While full mouth reconstruction will still be necessary for some patients, this technique will greatly assist in the transition, both functionally and financially.

The second major advantage is that, for patients with otherwise healthy posterior teeth (not otherwise in need of crowns), the potential for passive molar eruption is high. When it occurs, it eliminates the need to restore them while correcting problems in the anterior part of the mouth, greatly reducing the costs for these patients compared to the cost of full mouth reconstruction. ■

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Dr. Eric VanZytveld sneaks a toothbrush to a happy GKAS patient.



CU School of Dentistry Dean Dr. Denise Kassebaum (left), CU student Kristin Jones, Dr. Randy Kluender and Dr. Rodger Miller take a break to pose for a photo.



In the waiting room, patients take turns working at their brushing skills.



Husband, wife team Dr. Richard Sathre and Janette Sathre treat a patient at CU.



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Dr. Troy Fox (right) and CU student Sung Cho work together at GKAS.



Just a few of the CU staff members who make GKAS such a success: Nancy Jamehgar, Sonia Perez, Fabian Walker, Theda Goodgain Williams, Debbie Norwood and Ruth Wilson.



Dr. Tom Pixley gives instructions to his patient and her dad.



Dr. Cynthia Sheeks (left) and her dental assistant at the CU School of Dentistry.

Despite Gloomy Weather, Colorado Dentists Shine

By Molly Osberg, Associate Executive Director



This February marked the fifth year of Colorado's Give Kids a Smile program. In just five short years, Give Kids a Smile has established a huge following of dental teams willing to donate their time to serve children from low-income families in desperate need of care.

Feb. 2 was not only this year's Give Kids a Smile day, but also one of the coldest days of the season for Colorado as temperatures dipped 18 degrees below zero in some parts of the state. The frigid temperatures and icy roads had an impact on patient flow and transportation, but it didn't affect the generosity of over 800 dentists and dental team members who were determined to honor the nationwide movement to help kids. In fact, despite the conditions and several "no-show" patients, Colorado dental professionals treated more children and donated more dental treatment than ever before.

This year, 258 dentists registered, setting a record for Colorado. Dental volunteers in Colorado treated patients in their private offices, volunteered in clinics,

gave school presentations and conducted community center screenings.

In Colorado:

- 1,480 children were given free dental treatment.
- 3,500 students were educated about the importance of good oral health.
- \$441,298 was donated in dental services.
- 34 statewide media stories were broadcast and published, bringing awareness to Colorado's access-to-care issues and how dental professionals are trying to help.

Impressive numbers weren't the only marks of success from Give Kids a Smile Day. In fact, the *ADA News* sent a reporter to cover the Give Kids a Smile event at the CU School of Dentistry this year. Colorado was highlighted in the Feb. 19 issue of *ADA News* on page 21.

Thank you to those of you who volunteered for Give Kids a Smile Day. You are responsible for a great success story in Colorado and for improving the lives of the children you helped. Your dedication and continued support of this program truly makes a difference and the Colorado Dental Association is proud to have so many members committed to Colorado's communities and the oral health of children. We also appreciate the completed surveys that have been sent back to the CDA. This information will be put to good use to enhance Give Kids a Smile in the future. Thank you for sharing your thoughts with us.

In addition to the dental volunteers, this day was not possible without the Metro-

Save the Date: Give Kids a Smile Day, Feb. 1, 2008

politan Denver Dental Society staff, Colorado Springs Dental Society staff and key organizers across the state. Thank you Dr. **Randy Kluender**, Dr. **Bob Murphy**, **Fabian Walker**, **Michelle Cunningham**, **Sharyn Markus** and **Marcie Feinglas**. Additional appreciation goes out to the Region II Migrant Education Program for closing their office to provide translating services in private offices and clinics. Thank you to **Leslie Bennett**, **Karina Bonilla**, **Joy Castillo**, **Joe Archuleta** and **Marie Guinet**.

As in past years, **Doug and Pat James**, with the Broomfield Photography Studio, Inc., generously donated their time and talent to taking professional photos of the Give Kids a Smile event. Their dedication to this cause is again greatly appreciated.

Give Kids a Smile Day was fortunate to have follow-up care provided by the **Colorado Foundation of Dentistry for the Handicapped** Disadvantaged Youth Program. Over 100 children were referred to the Foundation for additional treatment.

Lastly, Give Kids a Smile Day owes a great deal of appreciation to national sponsors: Colgate, Sullivan-Schein Dental and Dexis Digital X-ray Systems.

For information about the 2008 event or if you would like to share your feedback from the 2007 event, please call the CDA at 303/740-6900 or 800/343-3010. We'd love to hear from you! ■

Thank You Volunteers!

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Media Spotlight

***Give Kids a Smile Day drew media attention from around the state.
At least 34 media stories were published and broadcast in Colorado cities.***

Jan. 9: **Glenwood Springs Post Independent**, Give Kids a Smile Day

Jan. 18: **The Colorado Springs Gazette**, Free Dental Care for Kids

Jan. 18: **Craig Daily Press**, Give Kids a Smile Event Coming

Jan. 24: **Moffat County Morning Press**, Free Dentistry for Kids

Jan. 25: **The Business Times of Western Colorado**, Marillac Clinic to Offer Free Dental Care for Kids

Jan. 25: **KTVD-TV Channel 20**, Denver, 7AM

Jan. 25: **KUSA-TV Channel 9**, Denver, 5AM, 6AM, 4PM, 5PM, 6PM

Jan. 28: **The Grand Junction Daily Sentinel**, Give Kids a Smile Day

Jan. 28: **Moffat County Morning Press**, Free Dentistry for Kids

Jan. 29: **Summit Daily News**, Dentists to Participate in Give Kids a Smile Day

Jan. 30: **Glenwood Springs Post Independent**, Give Kids a Smile Day

Jan. 30: **KOAA-TV Channel 5 and 30**, Colorado Springs/Pueblo, 5 PM and 10PM

Jan. 30: **Rocky Mountain News**, Give Kids a Smile Day

Jan. 31: **Commerce City Beacon**, Children Free Dental Care



Jan. 31: **Fort Morgan Times**, Fort Morgan Dentists Giving Free Services

Jan. 31: **Fountain Valley News**, Fountain Dentists Give Free Services to Youth on Give Kids a Smile Day

Jan. 31: **Glenwood Springs Post Independent**, Give Kids a Smile Day

Jan. 31: **KOAA-TV Channel 5 and 30**, Colorado Springs/Pueblo, 5AM

Jan. 31: **The Wray Gazette**, Wray Dental Office to Give Kids Free Care Friday

Feb. 1: **Fruita Times**, Fruita Dentists Provide Dental Education to Kids in February

Feb. 1: **The Grand Junction Daily Sentinel**, Give Kids a Smile Day

Feb. 2: **Glenwood Springs Post Independent**, Give Kids a Smile Day

Feb. 2: **The Grand Junction Daily Sentinel**, Give Kids a Smile Day

Feb. 2: **KJCT-TV News 8**, Grand Junction, 10PM

Feb. 2: **Moffat County Morning Press**, Free Dentistry For Kids

Feb. 3: **Fort Collins Coloradoan**, Filling Gaps in Care

Feb. 3: **Glenwood Springs Post Independent**, Where Did All the Food Go?

Feb. 6: **Craig Daily Press**, A Smile A Day

Feb. 7: **Craig Daily Press**, Give Kids a Smile (follow-up coverage)

Feb. 8: **Durango Herald**, Give Kids a Smile Day Makes a Difference for Local Children

Feb. 8: **The Aurora Sentinel**, Chomper Charity

Feb. 19: **ADA News**, Warm Smiles Beat the Cold in Colorado

Feb. 25: **KYGO 98.5, KJCD 104.3, KQKS 107.5, KKFN 950AM, KEPN 1600 AM**, Public Affairs Program Spotlighting Oral Health

Mar. 4: **KYGO 98.5, KJCD 104.3, KQKS 107.5, KKFN 950AM, KEPN 1600 AM**, Public Affairs Program Spotlighting Oral Health

Mar. 11: **KYGO 98.5, KJCD 104.3, KQKS 107.5, KKFN 950AM, KEPN 1600 AM**, Public Affairs Program Spotlighting Oral Health

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Some Bite, Some Benefit – A Look at Recent Tax Law Changes

By Mimi N. Hackley, C.F.P.

The year 2006 brought a flurry of tax law changes that will impact nearly every taxpayer. Some of these changes will save you money, while others are just another bite out of your wallet. Here are some changes to consider:

Donations of used clothing or household goods to charity are only deductible if they are in "good condition." Many accountants are suggesting having a garage sale instead or documenting an article's condition by taking photographs and submitting them along with your tax return. Another suggestion is to have a representative from the charity sign a statement that the items donated were all in good condition.

Donations of cash to charity must have proof or won't be deductible. Proof is a bank statement, cancelled check or receipt from the charity indicating its name, date and gift amount. Merely saying that you gave to the collection basket at church is no longer sufficient, regardless of the amount given. All amounts must be documented.

Gift of IRA required minimum distribution to charity applies only for tax years 2006 and 2007, and only if you're age 70½ or older. Up to \$100,000 of your required minimum distribution can be taken *directly* from your IRA and be

given to a tax-exempt organization (excluding private foundations and donor advised funds). By doing this, you can avoid paying income taxes on this distribution and meet most, if not all, of your charitable giving goals.

Long-term capital gains and qualifying dividends (generally assets owned for more than one year) will be taxed at a maximum 15% rate for anyone in the 25% tax bracket or higher. Taxpayers in the lowest two tax brackets will have a maximum tax rate of 5% (which will drop to 0% in 2008). Although these capital gains rates were scheduled to expire and revert back to 20% after 2008, they have been extended for two years until 2010. A good strategy is to make gifts of appreciated assets – within the \$12,000 annual per recipient gift-tax exclusion – to low tax-bracket children or parents so that the recipient can sell the property in 2008, 2009 and 2010, and take advantage of the 0% tax. (Beware of the new Kiddie Tax rules addressed below!)

The Kiddie Tax maximum age has increased from 14 to 18. This means that any child under age 18 who has more than \$1,700 (effective in 2007) in unearned income will be taxed at the parents top-marginal tax rate. The child will receive an \$850 standard deduction, which offsets some taxable income, and will have the next \$850 taxed at his/her

own rate, but ordinary or capital gains income above \$1,700 will be taxed at their parent's ordinary or capital gains rate, respectively. This makes it unlikely that children under age 18 will benefit from the 0% capital gains rate despite their low incomes. In light of these changes, alternative college savings ideas are available, which may be more practical.

Beginning in 2010, conversions of traditional IRAs to Roth IRAs will be allowed for those with modified adjusted gross income (MAGI) above \$100,000 (even for married filing separately). Until 2010, Roth conversions are limited to only those taxpayers with MAGI below \$100,000. Additionally, taxpayers who convert in 2010 have the option of spreading the reportable income over the following two years. Remember, distributions from a Roth IRA are tax-free after age 59½ and after the account has been open five years. Furthermore, there are no required minimum distributions while the original Roth IRA owner is still living. A conversion might appeal to someone whose IRAs have a large amount of non-deductible (after-tax) contributions. ■

Mimi N. Hackley, is a Certified Financial Planner™ at Sharkey, Howes & Javer, Inc., a Denver based, fee-only, financial planning and investment management firm that has worked with many dentists over the years. Visit www.SHWJ.com or call 303/639-5100 for more information.

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Spring Cleaning for Your Practice

Collecting Unpaid Balances

By Lori Lepar, Quantum Healthcare Services

Every dental practice faces challenges when attempting to collect unpaid balances from patients in a timely manner. Statistically, you will have a higher collection success rate if you aggressively seek collection by waiting no longer than 90 days after services have been rendered. However, you must also give consideration to the fact that an aggressive policy may make some of your patients leave your practice if sent to collections.

Some dentists, especially specialists, seek payment at the time of service. They often pay processing fees of 2-5% or more for credit card transactions, patient financing plans or check guarantee services. This can be expensive!

Quantum Healthcare Services is a newly endorsed company of the Colorado Dental Association. Quantum offers some very unique "hassle free and cost free" methods that can be effective in collecting patient payment in a timely manner:

No charge to access a national reporting agency for check verification. If the patient's check declines after verification, you might then ask for another form of payment such as cash or credit card.

No charge for collection of non-sufficient funds (NSF) or account closed checks. Your practice is paid 100% of the face value of the check plus a rebate of either \$7.50 or \$10 per check to help offset bank charges. The patient is charged a fee of either \$20 or \$40.

No charge to send a 10-day pre-collect letter on Quantum Healthcare Services letterhead. If the patient pays the full amount in 10 days or less, your practice will receive the full amount of the debt with no collection fee.

Quantum offers CDA members a special discounted rate for account receivable collections (see the boxed fee structure).

Quantum Healthcare Services also recently enhanced its Client Web Access. This program allows authorized users at your practice to access your collection accounts to view patient status, upload new accounts and customize reports. ■

Quantum was established in 1998 and is headquartered in Lakewood, Colo. For more information, please call 303/984-8300 or 877/984-8300.

Quantum Healthcare Services Fee Structure

The Following Fees are Contingency Based

"No Collection – No Fee"

Amount Sent To Collections	Non-Member Collection/Legal Fee	CDA Member Collection/Legal Fee
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\$1,000 to \$2,499	25%	18%
\$2,500 to \$4,999	20%	15%
\$5,000 to \$7,499	17.5%	13%
\$7,500 to \$9,999	15%	11%
\$10,000 to \$24,999	12%	9%
\$25,000 & over	10%	7%



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Classified Ads:

Journal of the Colorado Dental Association, Vol. 86, No. 2, Spring 2007 issue.

POSITIONS AVAILABLE

Director: The CU School of Dentistry is seeking full-time or part-time faculty member(s) at the assistant or associate professor level in the Department of Applied Dentistry to direct its new mobile dental program providing care to underserved rural children in Colorado.

Candidates must have extensive experience treating pediatric patients with advanced training in pediatric and/or public health dentistry, demonstrated experience in education and administration and ability to speak Spanish. The position is available immediately. Required D.D.S./D.M.D. degree from an accredited U.S. dental school. Salary and academic rank commensurate with candidate's credentials and experience. The University of Colorado is committed to diversity and equality in education and employment. The University of Colorado at Denver and Health Sciences Center requires background investigations for employment. <http://www.jobsatcu.com>.

Opportunity: Dental partnership available in emergency dental clinic in Denver. Limited number of partners accepted. You do not need to work there. The value of partner doctors' expertise and management skills advantageous. LLC with benefits of partnership without the risks. All inquiries confidential, drstarkey@hutel.net, 402/740-9235.

Opportunity: If you're not sure about re-upping with your current lease or want to expand, build or start-up in the Littleton area, look me up before you commit to something else. I have 2,600 sq. ft. of well-designed, already built-out space with great street visibility, and I want to keep my practice active and growing. Write me at iowagraddds@yahoo.com and see if there's a deal that's right for both of us!

Associate/Partner: Colorado Springs, Colo. This beautifully designed, well-established fee-for-service general dental practice is an excellent opportunity for a general dentist seeking an associate/partnership opportunity in a unique patient-centered practice. This premier practice has an excellent reputation in providing comprehensive quality dentistry with an emphasis on cosmetic, laser and implant dentistry. Wonderful patients and growth opportunity with an exceptional dental team that will welcome you to the community. Please reply in confidence with your objectives, Curriculum Vitae, and written goals to: The Sletten Group, Inc., c/o Terri Ness, 7882 S. Argonne St., Centennial, CO 80016. Contact 303/699-0990, fax 303/699-4863 or e-mail terri@lifetransitions.com.

Associate/Partner: High-quality group practice in Aurora is seeking a FT associate/partner. Must have a minimum of two years dental experience. Potential for partnership within 12 months. Please e-mail your resume to familydentist4you@yahoo.com.

Associate/Partner: Littleton/Denver, Colo. New, freestanding, state-of-the-art practice on busy street. 12 ops., 5,200 sq. ft. X-rays, PentaMix, RotoMix, Cavitron, Digital IOC, Dentrix, Panorex, CAESY, Diagnodent. Fee-for-service. Seek associate to integrate as future partner. Visit www.transdent.com or call Mercer Transitions, 800/588-0098.

Associate/Owner: Retirement age doctors wanting to transition in Denver metro and surrounding areas (Colorado Springs, Durango and other areas). Fee-for-service. High-net income with lots of potential. E-mail fourboysforus@msn.com or call 877/680-3973.

Associate: Positions leading to buy-in. CO: Colorado Springs, Littleton, Longmont, Denver (Spanish speaking), Parker. Temporary Dentist Available: 20+ years experienced practitioner will work anywhere in Colorado. WY: Casper, state-of-the-art facility, \$1.2M collections, buy-in. Buffalo: Gross \$816,000, net \$474,000 w/buy-in. Oral Surgery Assoc.: Denver. Precise Consultants: Peter Mirabito, D.D.S., Jed Esposito, M.B.A., www.dentalsales.com, 303/759-8425.

Associate: Colorado Springs, Colo. Unique practice seeking an associate. Possible buy-in potential. Four general dentistry operatories, and three prosthetics operatories. Modern office equipped with latest technology. On-site laboratory. 2006 gross production: \$1.3M. Fax resume to 719/213-2249. Include references, experience and education.

Considering Bringing in an Associate? I have wonderful candidates waiting! Call Susan Spear, practice transition specialist/licensed broker, Medical Practice Brokers, Inc., 303/973-2147 or susan@sastransitions.com.

Associate Buy-In: Cheyenne, Wyo. Three operatory practice grossing \$820,000, with 45 percent overhead. Call Larry Chatterley 303/795-8800.

Associate: Associate needed for our established practice located Wheat Ridge/Denver, Colo. Great money for a production oriented dentist. This is a full-time position. We see adults and children. Please call Todd at 303/940-9755.

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CLASSIFIEDS continued on page 28

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CLASSIFIEDS *continued from page 27*

Dentists: Attention soon-to-be-graduates! We have space for two additional dentists in our Community Health Center in Casper, Wyo. New graduates often incur debt for setting up their first office: buying equipment, software and operatory fixtures, and then also having to be concerned with hiring staff. All this while trying to pay off student loans! There is no overhead involved; we already have an open office with trained staff to assist you. Plus, you would qualify for our entire benefit package! Please send your CV/resume and letter of interest to: Beth Eveland, CEO, 1522 E. A St., Casper, WY, 82601, or fax 307/235-6202.

Dentists: Dental One is opening new offices in the upscale suburbs of Denver. Dental One is unique in that each office has an individual name. Our latest office to open is Cherokee Trail Dental Care in Aurora. All our offices have top of the line equipment, digital X-rays and intra-oral cameras. We are 100% FFS with some PPO plans. We offer competitive salaries, benefits and equity buy-in opportunities. To learn more about working for Dental One, please call Rich Nicely at 972/755-0836.

Full-Time/Part-Time Dentists: Dentists needed for unique, fee-for-service, for-profit, dental clinic in northern Colorado Springs. Since we are open seven days per week, including holidays, we have openings for a full-time "anchor" dentist, as well as part-time. Applicants must be comfortable with molar endo and oral surgery. Excellent compensation

for hard-working professionals in a laid-back environment. Please forward your resume to 866/839-8849.

Full-Time/Part-Time Dentist: Aurora, Colo. Large, busy established bilingual practice seeking full/part-time dentist starting in June. Lots of endo, crown and bridge, and general dentistry. Speaking Spanish a plus but not necessary. Opportunity for buy-in. Please fax resume to 303/367-2776 or e-mail esandoval@apolloniandds.net. Cell: 303/908-5155 (after 6 p.m.).

Part-time Endodontist: Busy SE Denver practice seeks endodontist part-time. Please contact Dr. John Pfalzgraf at Cherry Hills Dental Associates, 303/757-8446.

Front Desk: Aurora, Colo. Need experienced front desk team member. Must be bilingual, possess basic computer skills, and be able to handle appointments and patient issues in Spanish and English. Please fax resume to 303/367-2776 or e-mail esandoval@apolloniandds.net. Cell: 303/908 5155 (after 6 p.m.).

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Practice: Lakewood, Colo. \$341,000. Producing \$40,000-\$45,000 per month part-time! Newly remodeled, five high-tech ops. Susan Spear at 303/973-2147 or susan@practicebrokers.com.

Practice: Ouray County, Colo. \$244,000. Producing \$390,000 part-time. Beautiful resort town. Susan Spear at 303/973-2147 or susan@practicebrokers.com.

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Practice: Pueblo, Colo. Well-run family practice in a professional building. Four plumbed ops. 1,566 sq. ft. Normal operative, surgical, implant equipment. No capitation or PPO insurance. Looking to transition ownership over to the new dentist. Visit www.TransDent.com or call Mercer Transitions at 800/588-0098.

Practice: Southern Colorado pediatric dental practice for sale or looking for associate/ buy-in. Excellent opportunity with competitive salary. Southern Colorado has numerous outdoor activities. Very busy practice with dentistry limited to children and young adults. Hospital based dentistry is also practiced. General dentistry with an emphasis in treating children also considered. We are seeking caring, motivated individuals with excellent skills including sensitivity of the diverse socioeconomic and ethnic backgrounds of our patients. Please fax or e-mail resume to mpurcell1215@msn.com or 719/253-7761.

Practice: Boulder, Colo. Practice at the foot of the Rockies in the beautiful, exciting city of Boulder – where recreational, educational and lifestyle opportunities abound. Well-established, highly successful, high-income oral surgery office offering a partnership leading to a progressive buy-out and complete ownership. Owner will assist in the transition. Modern, highly computerized, no managed care. Emphasis on dentoalveolar, implants, bone grafting, pathology, some orthognathics and trauma with full scope opportunities. Ideal candidate will be honest, caring, and have excellent people and surgical skills. Please send objectives and CV to: The Sletten Group, Inc., 7882 S. Argonne St., Centennial, CO, 80016. Contact 303/699-0990, fax 303/699-4863 or e-mail terri@lifetransitions.com.

Practice: Fort Morgan, Colo. Enjoy fishing and boating in the Colorado Eastern Plains. General practice. \$200,000 gross with great potential. Practice and stand alone building for sale, \$300,000. Contact Dr. Robert B. Deloian at Professional Transition Strategies, 303/814-9541.

Practice: Greeley/Loveland, Colo. Must see two office, modern growing orthodontic practice. \$650,000 gross. Seller can stay to introduce. \$458,000. Contact Dr. Robert B. Deloian at Professional Transition Strategies, 303/814-9541.

Practice: Westcliffe, Colo. Beautiful small town community, 75 miles south of Colorado Springs. Three operatories, \$160,000 collections for 2006, two days a month. For inquiries, call Tom Abood, 303/793-3200.

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Practice: Longmont, Colo. Grossing over \$700,000 and netting \$350,000, fee-for-service patient base. Call Larry Chatterley at 303/795-8800.

Practice: Centennial, Colo. Grossing over \$600,000 with four ops. Priced at \$225,000. For details, please call Larry Chatterley at 303/795-8800.

Practice: SE Denver, Colo. Grossing \$272,000 with two ops. (can expand to three). Call Larry Chatterley at 303/795-8800.

Practice: Cherry Creek area, Colo. Grossing \$590,000 with three ops. 61 percent overhead. Please call Larry Chatterley at 303/795-8800.

Practice: South Colorado Springs, Colo. Five ops., new equipment with digital X-rays and grossing \$477,000. Call Larry Chatterley at 303/795-8800.

Practice: Fort Collins, Colo. Grossing \$240,000 with three ops. Call Larry Chatterley at 303/795-8800.

Practice: Small town southern Colorado. Grossing \$343,000, 51 percent overhead, busy practice, facility and equipment look great. Call Larry Chatterley at 303/795-8800.

Practice: Delta, Colo. Acquire the building and the practice for \$220,000. Call Larry Chatterley at 303/795-8800.

Practice: Evergreen, Colo. Grossing \$423,000 and netting \$195,000. Call Larry Chatterley at 303/795-8800.

Practice: Southwestern CO in Durango/Cortez area. Grossing \$240,000. Call Larry Chatterley at 303/795-8800.

Seller/Buyer Services: If you would like more information on how to buy, sell or associate in a practice, please check our Web site, www.ctc-associates.com or call CTC Associates at 303/795-8800.

Practices: 1. Lakewood, Colo. Great west-side location with three ops. Collecting \$650,000 a year. Profit of approximately \$300,000. Motivated seller. 2. Centennial, Colo. Four ops. of new equipment. Collecting \$35,000 per month, owner financing. For more information on these and other listings, call Professional Marketing and Appraisal, 800/632-7155.

Practices: CO: Aurora, Boulder, Colorado Springs, Crested Butte, Denver, Cherry Creek, Downtown Denver, Dillon, Fort Collins, Denver Tech Center, Dillon/Silverthorne, Glenwood Springs, Eagle, Littleton, Lakewood, Loveland, Western Mountain Resort, Central CO, Southern CO, Steamboat Springs, Pueblo, Rifle, South-west CO, Edwards, Winter Park. AZ: Arrowhead, Bullhead City, Prescott, Mesa, Phoenix, Flagstaff, Yuma. NE: Scottsbluff. SD: Sturgis-Spearfish. WY: Casper (state-of-the-art facility, \$1.2M collections, buy-in), Buffalo (gross \$816,000, net \$474,000). Specialties: oral surgery in Denver; pediatric in Colorado Springs and Arvada. Precise Consultants: Peter Mirabito, D.D.S., Jed Esposito, M.B.A., www.dentalsales.com, 303/759-8425.

Office Space: Boulder: 2,000 sq. ft. space share dental office for lease. Ken Caryl: 1,550 sq. ft., four ops., newly finished dental office for lease. Southeast Denver: 1,490 sq. ft., three ops., partially equipped dental office with some charts for sale \$60,000. Littleton: 1,542 sq. ft., four ops., dental office for lease. Castle Rock: Five op. dental office for lease. Precise Consultants: Peter Mirabito, D.D.S., Jed Esposito, M.B.A., www.dentalsales.com, 303/759-8425.

Space Sharing: Denver, Colo. Share expenses - why pay for everything yourself? Seeking general dentist/specialist wanting to share practice costs without the burden of going solo on expenses. Office totally re-equipped three years ago. Four operatories, each with computer, intra-oral camera, DVD, CD, satellite radio and TV. Digital x-ray, Pan-X, Caesy, Luma bleaching, portable Diagnodent, Harvey, Statim, & Hydrim washer. Software schedules, bills, processes insurance for multiple providers. Private office, consult room, and reception room with large flat screen educational program. Contact Dr. Pavlik, 719/592-0878 or pjp@trackerenterprises.com.

Office Space: Boulder general practice offering cosmetic services, high-tech equipment. Great location with high visibility. Open to share space with dentist or specialist. Please call 303/449-1119 or fax 303/449-1914.

Office Space: Loveland, Colo. New construction, class "A" space; L.E.E.D. Certified: 1,500-8,000 sq. ft. Available May 2007, Call Dr. Ted Mioduski, 960/663-1000.

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CLASSIFIEDS continued from page 29

Office Space: SW Colorado Springs, Colo. Excellent location near Broadmoor-Skyway area. Open concept with dental chairs, Panorex and cabinets that can be purchased. Beautiful view of mountains. Professionally designed. Great for GP or specialist. 2,500 sq. ft. Call Dr. Gary Stiehl, 719/636-3015.

Office Space: Space is available for lease with option to buy in fast growing Conifer/Aspen park area. Owner converting approximately 2,000 sq. ft. of building into dental facilities. Construction estimated completion date is May 15, 2007. If purchase is preferred, an additional \$2,700 per month income available in addition to the dental space utilized. For details, call Paul Tillotson, 303/526-1277.

Office Space: Erie, Colo. New construction dental arts building in the heart of the new Erie Commons. Generous tenant improvement allowance. Seeking pediatric practice, general practice or other specialists to join the building group. Contact Dr. Steven Markowitz at DrJaws@qwest.net or 303/444-6680.

Office Space: Fort Collins, Colo. Commercial land: Very desirable Harmony Corridor location near South College Avenue. Highly visible across from busy mall. Initial work-up/layout and architecture is city approved for dental office. 4,400 sq. ft. Building plans with eight operatory office can also be included. Private financing possible. Contact coloradodentist@yahoo.com or 970/988-6655.

Office Space: Build/Relocate/Remodel: Call us or visit www.fcbsdenver.com for free office locator assistance. Foothills Commercial Builders, the future is now! 303/755-5711 x306.

Office Space: Fountain, Colo. Close to Colorado Springs. One of the fastest growing areas in Colorado. 25-year dental office location, available in October. Dr. Stephen Seiler, 719/576-4247.

Office Spaces: Plug and Play #1: Finished dental suite, south DTC. Three-to-five ops., two offices, lab, reception, admin. #2: Finished dental or oral surgery space, County Line Road and south Holly Street. Four ops., office, reception, two restrooms, recovery room, two labs. Great location, excellent value. Contact Bob, 303/713-1588.

Office Space: Two months free rent! 2,500 sq. ft. dental space, already plumbed and ready to go. Building totally renovated in 2005. By new streets of Southglenn redevelopment. Average HH income, \$98,000. 303/726-2093.

Office Space: First floor office with five operatory suites located in central Greeley. All plumbing, nitrous lines, computer lines and cabinetry are in place, along with sterilization room and lab space. Call 970/356-5151.

Office Space: Operatories to rent. One to two fully equipped operatories in lovely tech center office. Call Dr. Kevin Evans, 303/796-8668.

Office Space: Dental office condo for sale near University and County Line in Centennial. 2,028 sq. ft. Leaseholds in place. Great location! 303/881-1263.

Office Space: Lakewood, Colo. Dental office space for lease at 2290 Kipling St. Building has eight other dental practices. 1,000 sq. ft., three ops. plus office, lab and x-ray. Owner will assist with cost of tenant finish. Call Jack Maxfield, 303/919-0813.

Office Space: Office for lease or lease/purchase. Up to 4,800 sq. ft. ready to build-out in brand new building with dramatic views of the Front Range. Access growing patient populations in northeastern Colorado Springs and expand your practice from this ideal location adjacent to Endodontic Specialists. Competitive lease rates with generous tenant finish allowance or lease-purchase as condo. Call Jane Peck, 719/599-3210 or Tom Binnings, 719/471-0000.

Office Space: Aurora, Colo. Professional dental office space consisting of 1,234 sq. ft. will be available for lease on July 1, 2007. It is currently partitioned, plumbed and wired for three dental operatories. The dental suite is in excellent condition, and in a wonderful location and beautiful building. Great visibility and easy access near a highly residential area. Ideal location for a general dentist, orthodontist, pedodontist, prosthodontist, periodontist or endodontist. Call Dr. James Trompeter at 303/688-3838.

SERVICES/ANNOUNCEMENTS/MISC.

For Sale: Dental Art Collectables by Charles Fazziano, world-renowned 3-D artist. Three matched-number DX three-layer editions w/all Warner Brothers cartoon characters. Beautiful, entertaining art for your office. Seller retired – will sell below market value as package. 303/425-0114.

For Sale: Belmont X-ray, doctors stool, Rinn chairside developer, Sterident sterilizer, lead aprons, Whaledent Biosonic cavitron, assorted stainless impression trays, assorted hand and surgical instruments, intraligamental and regular injection syringes, amalgam, X-ray viewer, laboratory high-speed lathe, Leeson model trimmer, buffalo vibrator, Hanau articulator and pink boxing wax. Most items are less than three years old, reasonably priced. Please call Dr. Richard Collar at 970/921-6474 or 505/536-3641.

For Sale: Three Pelton-Crane Chairman chairs and 1 ADEC chair, several matched and mismatched stools, all good condition. VISICOM inter-office messaging system; Mada Jet XL "painless" injector; Jelenco burn out furnace; Ellman 90 FFP electro surgery unit; electro surgery manual and video film (new, never opened); lab pans; computer CPUs with XL Professional; Alginator; NewImage Intraoral camera, printer, monitor, mobile cabinet; Dr./Asst. carts and more! Needs? Contact coloradodentist@yahoo.com, 970-988-6655.

For Sale: Antique oak dental cabinet, excellent condition, 39"x44"x19", 24 drawers, glass pulls. Contact 303/601-4750.

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Temporary Dentist Available: Why close your office for lack of vacation, pregnancy, or disability coverage? I am semi-retired, quality oriented, GP dentist that owned a successful, fee-only, solo practice. Willing to cover your office on short-term basis anywhere in Colorado. Terms negotiable. 970/547-1440.

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Service: Concerned Colorado Dentists (CCD) is a subcommittee of the Colorado Dental Association. We are in existence to help colleagues, staff and/or families who think they may have a problem with substance abuse. If you think you or someone you know may have a problem, please call Dr. Brett Kessler at 720/989-7960 (day or night). All inquiries are kept confidential.

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