ISSN 2372-0808 (Print); ISSN 2372-0816 (Online)

FALL 2022

the Journal

American Academy of Clear Aligners

The Academy for Clear Aligner Therapy

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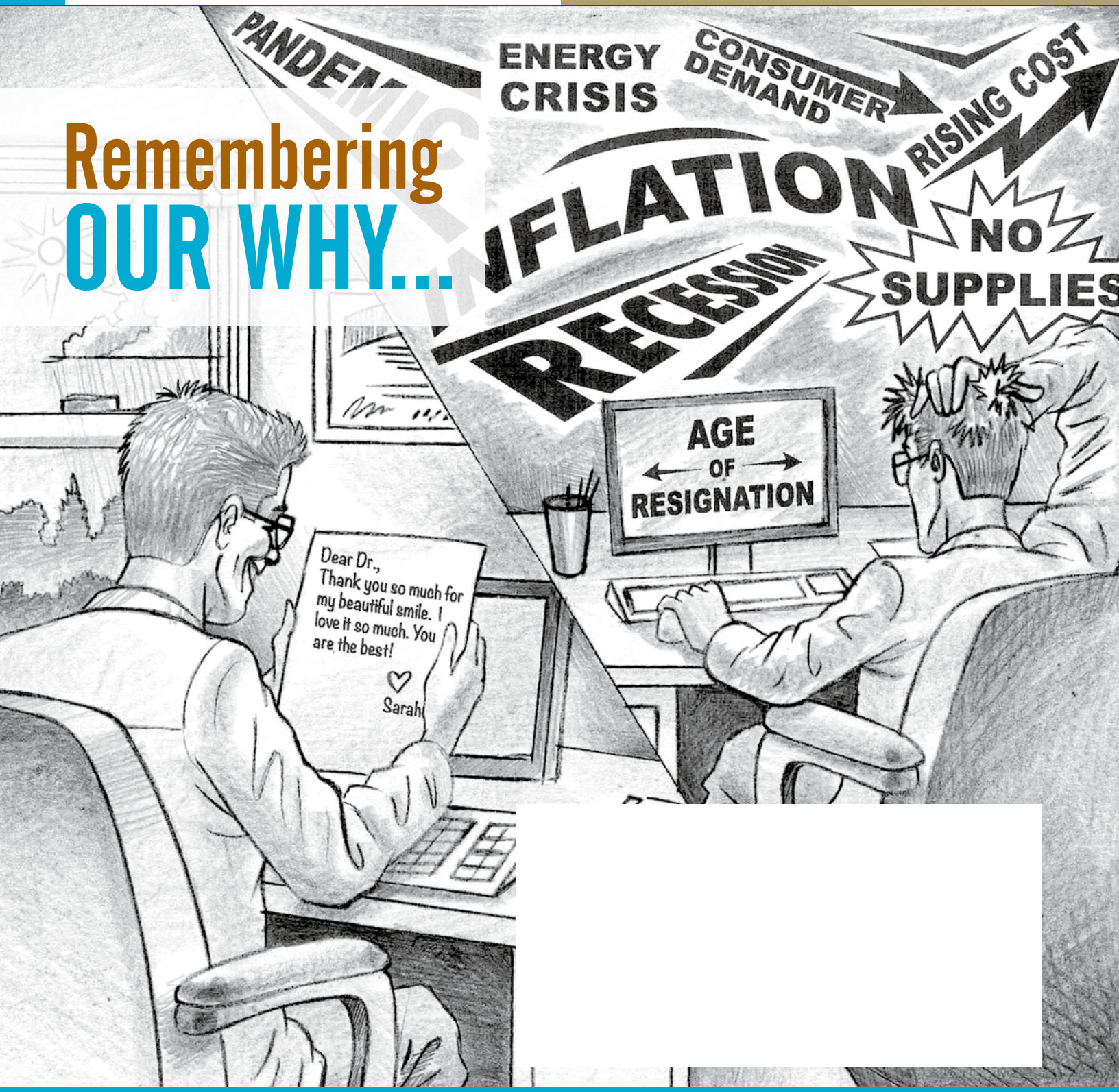

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the Journal
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Dr. Jeffrey Galler
Editor

Editorial

Why Does It Matter?

Decades ago, a typical eighth-grade science test involved naming the 9 planets. And, for extra credit, you could list some of the moons revolving around those planets.

Since that time, our knowledge of the universe has expanded astronomically. That sentence, besides being a bad pun, is an intergalactic understatement.

Today, sophisticated, multisyllabic, and unpronounceable instruments and techniques are able to discern billions of stars in our own Milky Way galaxy, and billions of other galaxies outside of our own.

However, an astounding article in the *Astrophysical Journal* reported: the entire universe consists of matter and energy, and 68% of the universe is dark energy and 27% of the universe consists of dark matter.

The rest of the universe—everything observed with all of our instruments not only on Earth but also throughout the rest of the cosmos—consists of what we call normal matter and energy, and adds up to less than 5% of the universe.

What are dark matter and dark energy? Nobody knows. Brilliant cosmologists suspect that the answer has something to do with subatomic particles. Despite all our increasing knowledge, 95% of the universe remains beyond our understanding.

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Provider ID#350507.

Creative Direction/Design: Cause Creative, LLC
Copyeditor: Marc S. Glasser
Cover Illustration: Tom Lange

Contact

Advertising: drgaller@hotmail.com
Editorial: DrJeffreyGaller@gmail.com

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Case Reports

Dustin's Multidisciplinary Restoration

by Steven Glassman, DDS; co-authored by Ryan Wagner

Dr. Steven Glassman reached the level of Invisalign® Elite Advantage Provider in 2005 and has been treating Invisalign patients since 2003 at the prestigious New York City practice he owns with his wife. In addition to being a successful practitioner, Dr. Glassman has published several articles on Invisalign technology, implants, and restorative and laser dentistry in well-regarded publications, including *Inside Dentistry* and *Contemporary Esthetics Magazine*. He has been invited to lecture about Invisalign Clear Aligner Therapy at hospitals and universities across the country. Dr. Glassman won the Invisalign Case Shoot-out in 2005 at the GP Summit. He is a proud graduate of Brandeis University and the Columbia University School of Dental and Oral Surgery. In 2018 he was named to the Zimmer Biomet faculty, adding to the digital workflow of aligners and implants. In 2020, he received the faculty award for 15 years of service.

Ryan Wagner is a second-year dental student and vice president of the class of 2025 at Indiana University School of Dentistry, where he is pursuing a career in cosmetic dentistry. Ryan has co-published dental case reports, conducted behavioral research, tutored undergraduate students, and volunteered at both local and international health clinics.

Outside dentistry, Ryan spends his time traveling, cooking, and participating in real estate renovation projects. He has honed his technical and interpersonal skills working at Dr. Glassman's New York City dental practice and is eager to join the wonderful profession of dentistry.

Figure 1: Dustin presented with a request for an esthetic improvement. Pre- and post-treatment.

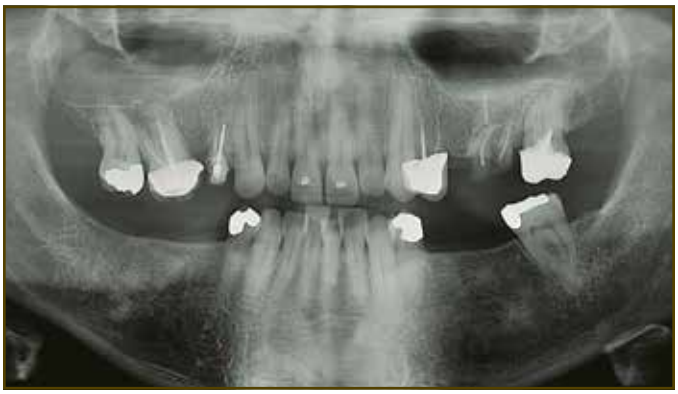

Figure 2: Panorex. Patient was missing 11 posterior teeth.

Abstract

This case will demonstrate the use of clear aligners to:

1. Achieve proper setup for placement of 10 posterior implants and their restorations
2. Correct lower crowding and deep bite
3. Close the maxillary diastema between teeth #8 and #9

This case will also showcase digital planning for final restorations in several steps. Notably, the clinicians will digitally plan the surgical placement of 10 implants by performing 3D and digital scans, and then using a third party to combine the

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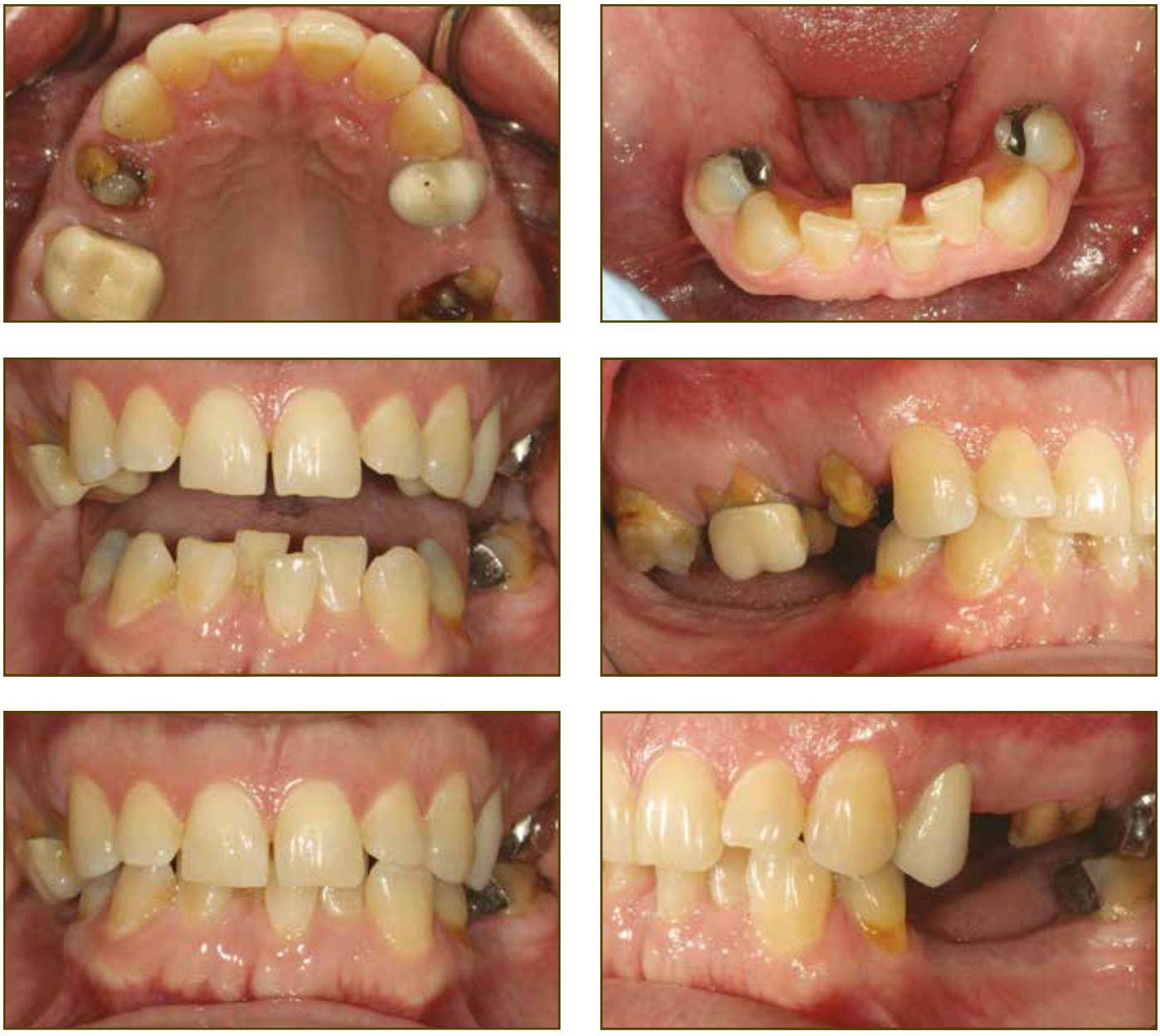


Figure 3: patient had moderately overcrowded lower anteriors, a deep bite, and a diastema between teeth #8 and #9. More importantly, teeth #5, #14, and #15 were fractured and failing, and the upper right molars had supererupted and had drifted mesially.

scans and design a surgical guide for precision implants in multiple planes.

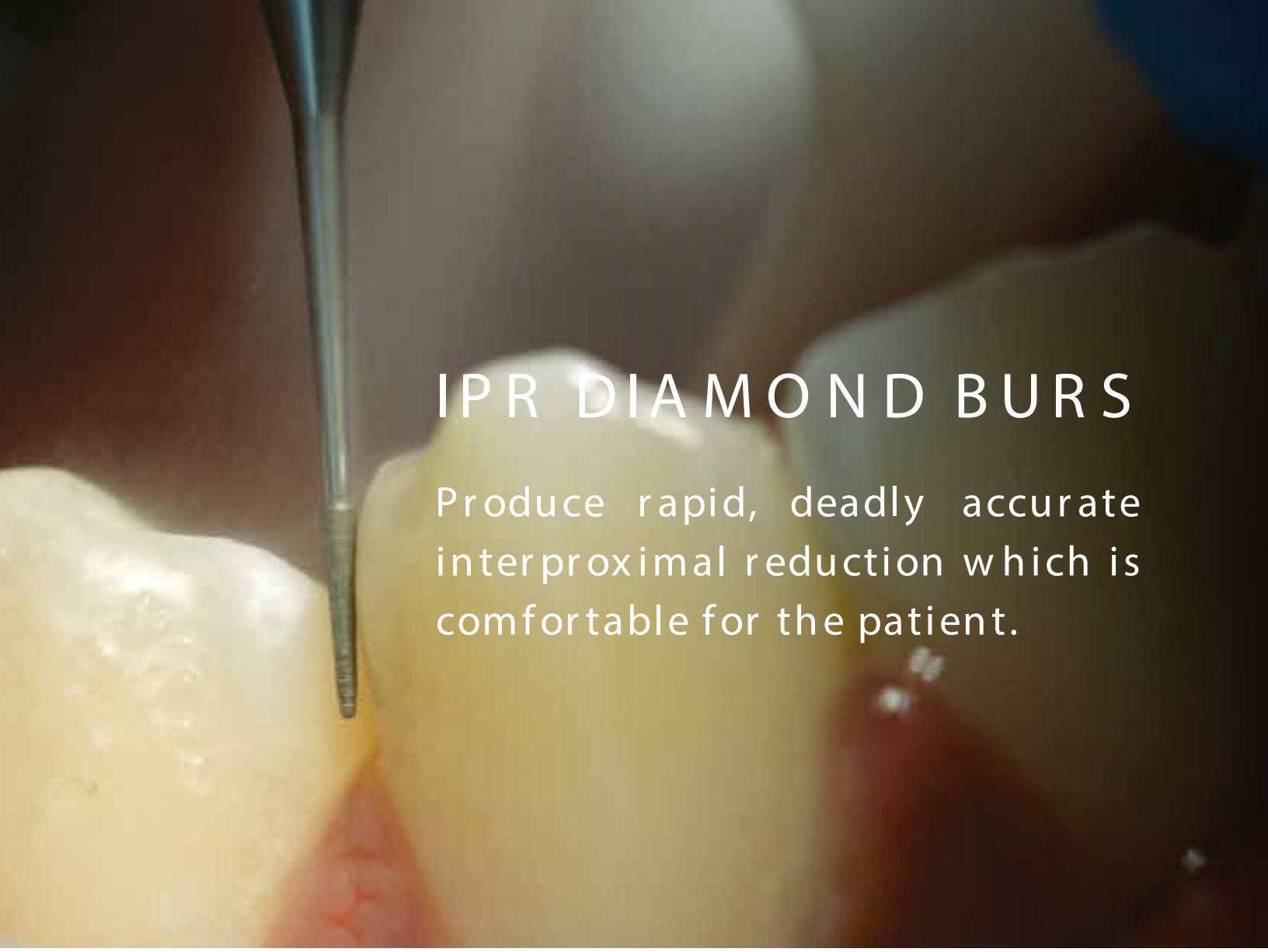
After integration of the implants, the clinician will perform a digital scan using scan bodies, and provide it to the lab for design of screw-retained PMMA provisionals with stock abutments. These provisionals will be used to finalize the occlusion and esthetics and to allow the soft tissue to develop around the abutments to permit proper hygiene maintenance. Once the tissue is matured and the patient has approved the provisionals, the final screw-retained zirconium restorations will be fabricated, and retainers made to prevent ortho relapse.

Patient chief complaint

Dustin, a 44-year-old man, presented with the chief complaint that he wanted an esthetic improvement (**Figure 1**). He works in the healthcare industry and is aware of the correlation of oral health to overall health. He had 11 posterior teeth missing (teeth #1, 4, 13, 16, 17, 19, 20, 29, 30, 31, and 32) (**Figure 2**). His dental history revealed that he was aware of his posterior missing teeth, as well as the failing of some fractured teeth—specifically teeth #5, #14, and #15. This case was complicated because the upper right molars had drifted mesially and had supererupted, making implant placement in positions #4, #5, #30, and #31 very challenging owing to lack of restorative space (**Figure 3**).

Treatment planning

After consultation with the treating oral surgeon about dental implants, we decided to extract teeth #5 and #14 due to nonrestorable caries, place bone grafts, and begin Clear Aligner Therapy (**Figure 4**). The remaining teeth with poor



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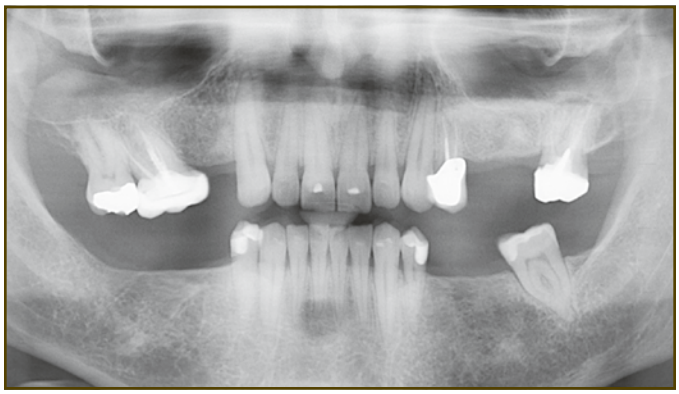

Figure 4: after extraction of nonrestorable teeth #5 and #14 and placement of bone grafts.

prognosis—#2, #3, #12, and #15—were asymptomatic and free of infection. Therefore, they would serve as excellent anchors during the orthodontic phase of treatment. After the Clear Aligner Therapy, any teeth with poor long-term progress that would inhibit proper placement of implants would be extracted. Bone grafts would be placed and allowed to heal before planning the dental implant phase.

Clear aligner phase

We took a digital scan with iTero 6 weeks after Dustin had healed from extraction of teeth #5 and #14 and bone grafts had been placed. The orthodontic diagnosis was Class I, moderate crowding of the lower incisors, deep bite, and diastema between teeth #8 and #9. The final setup would allow ideal placement for the posterior implants, taking into account the mesiodistal, buccolingual, interocclusal, depth and angulation.

ClinCheck review

To treat the lower crowding, the patient needed proclination and expansion in the canine and bicuspid areas. Proclination and intrusion of the lower teeth would treat the deep bite. The diastema between teeth #8 and #9 would be treated by mesializing #8 and #9 by retroclining #7 and #10.

In addition, to help finish the occlusion, we planned the distalization of teeth #12 and #13. The use of teeth #2, #3, and #15 as anchors was key to the success of this step, even though they were treatment-planned to be extracted later. Extrusion of teeth #12, #21, #27, and #28, and distalization of #12, were difficult as planned and had to be monitored. The final position helped set up the proper vertical dimension with an improved overbite, overjet, and arch form (**Figure 5**).

Monitoring treatment

We had to do multiple sets of additional aligners for various reasons. The primary reason was the lockdown during the COVID pandemic. The patient was a healthcare worker who was under significant stress and was not as compliant as he could have been. The more difficult movements, such as distalization, should have been monitored more closely, but under the conditions the patient had to do multiple rescans for additional aligners.

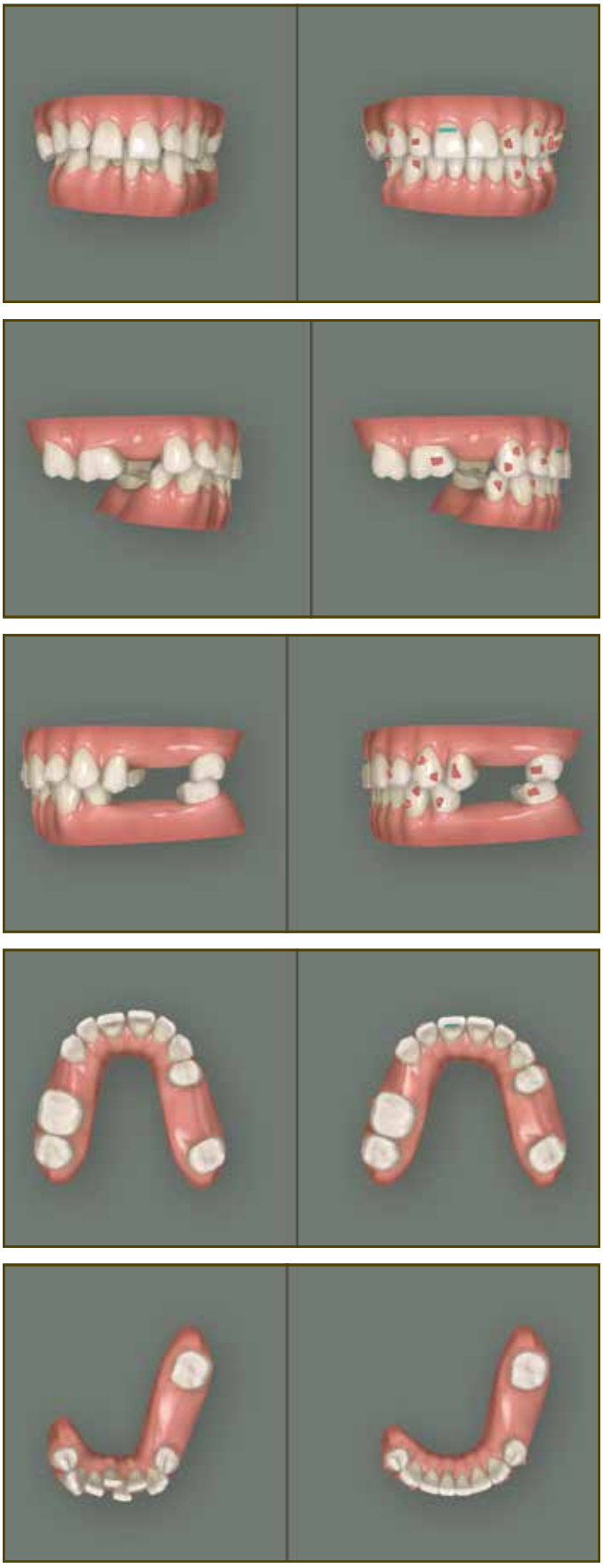

Figure 5: ClinCheck plan: anterior, right, left, maxillary occlusal, mandibular occlusal.

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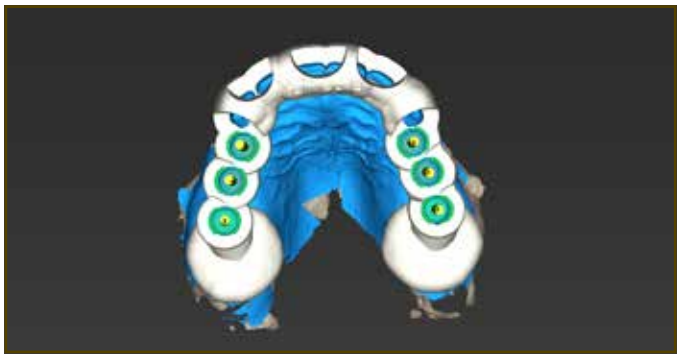
Figure 6: after 100 aligners, before restorative phases.



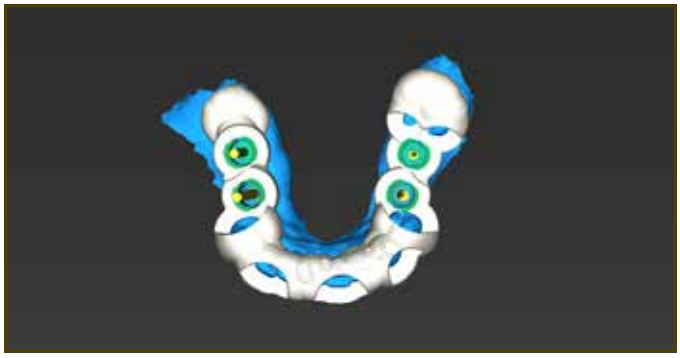


Figure 7: surgical planning.

Dustin wore 43 upper trays between June 2017 and February 2020, with several brief interruptions that together delayed his progress by over a year. He was then unable to continue until January 2021. He wore about 60 more trays during the ensuing 13 months, for a total of over 100 trays (**Figure 6**).

After Clear Aligner Therapy: second phase, oral surgery

The oral surgeon, the restorative dentist, and the dental laboratory now discussed the ideal implant placement in the edentulous regions of Dustin's mouth. We agreed that teeth #2, #3, #12, #15, and #28 would be extracted because of poor long-term prognosis, thus producing an ideal setup for dental implants. When appropriate, teeth with questionable prognosis or poor position are sacrificed for ideal implant placement, which has a success rate (as most studies agree) of over 95 percent.

Figure 8: 10 implants placed at positions #3, #4, #5, #12, #13, #14, #19, #20, #29, and #30.

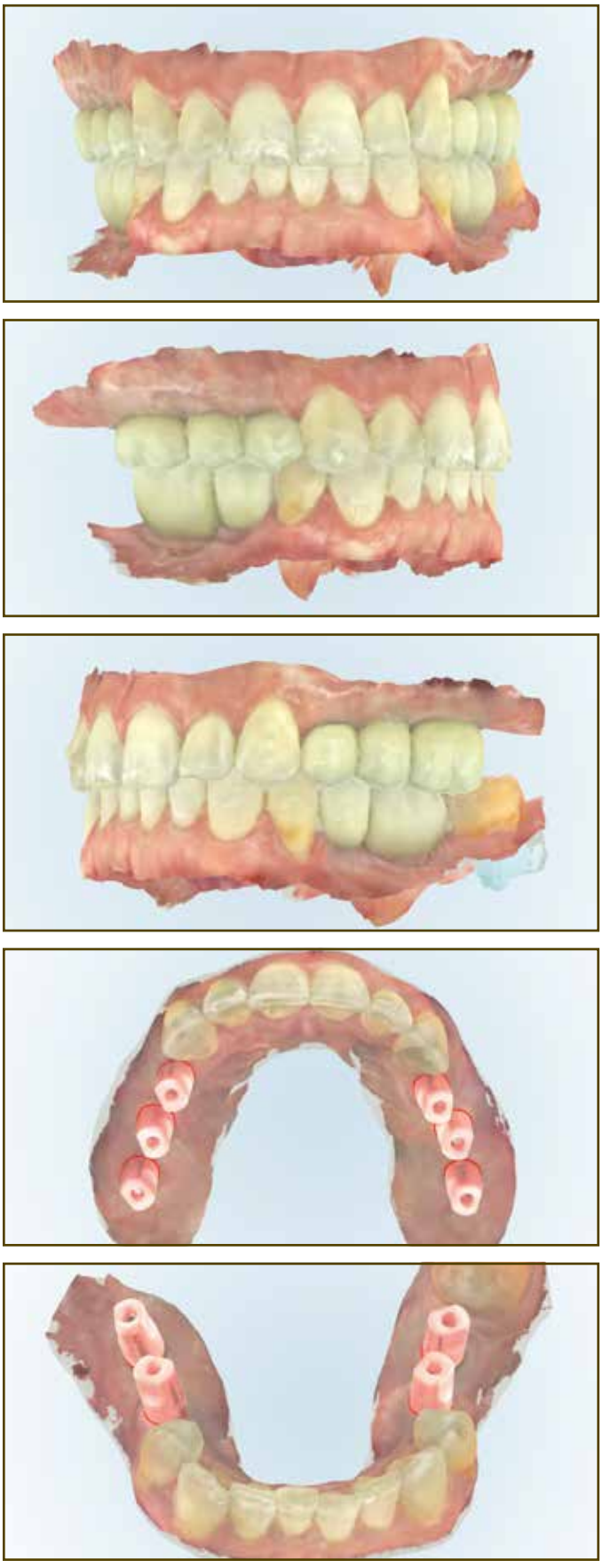


Figure 9: digital scan of scan bodies.

We extracted the teeth and placed bone grafts and membranes. The patient wore clear retainers to prevent relapse before the final restorations were placed.

Implant planning, surgical guides, and implant placement

After 4 months of healing time, we took a new CBCT and digital scan, and uploaded the DICOM and STL files via a portal of a third-party company, Implant Concierge. Implant Concierge and the treating doctors would develop a surgical plan that would not only provide for optimum placement of the implants, but also position the ideal access holes for the planned screw-retained ceramic restorations (**Figure 7**). The author has increased the use of surgical guides in the last few years because of the high level of predictability that they provide. The oral surgeon used these guides to place 10 Straumann Bone Level implants at positions #3, #4, #5, #12, #13, #14, #19, #20, #29, and #30 (**Figure 8**).

Final restorative planning/provisional phase

Four months after the implant fixtures were placed, Dustin returned to the restorative dentist's office. Since the implants had been placed using a digital wax-up of the final restorations, the restorative phase went very smoothly. We removed the healing abutments and placed a third-party (TruAbutment) scan body. After taking a radiograph to verify proper seating, we took a digital scan (**Figure 9**) and sent it to the dental laboratory.

Owing to the number of implants that were used in this case, we implemented an 8-week trial period using provisional abutments of PMMA placed in the implant fixtures. They were splinted in design for easier removal. We torqued them to 35 Nm and covered the access holes with a light cured provisional material. Contacts and occlusion were adjusted, and we sent the patient home to allow the soft tissue to heal and develop the correct emergence profile. We also asked Dustin to evaluate the esthetics, phonetics, and vertical dimension. Any changes or modifications would be made before fabricating the final restorations.

Final restorative phase

Minimal adjustments were needed once the PMMA provisionals were placed, and the fit was accurate and passive. The only change the patient requested was to have each implant restoration be individual rather than splinted. The team felt confident, because of the implant and bone quality, that this added only minimal risk to the final outcome.

Following the trial period, Dustin underwent whitening. Two weeks later, we took the final shade as well as a scan of the provisionals and the scan bodies. The newly developed tissue, as well as the adjusted provisionals, allowed the lab to make final zirconium full-contour individual crowns that had the developed emergence profile, esthetics, and occlusion. The case was seated in less than an hour and required minimal adjustments (**Figure 10**). We closed the access holes with Teflon

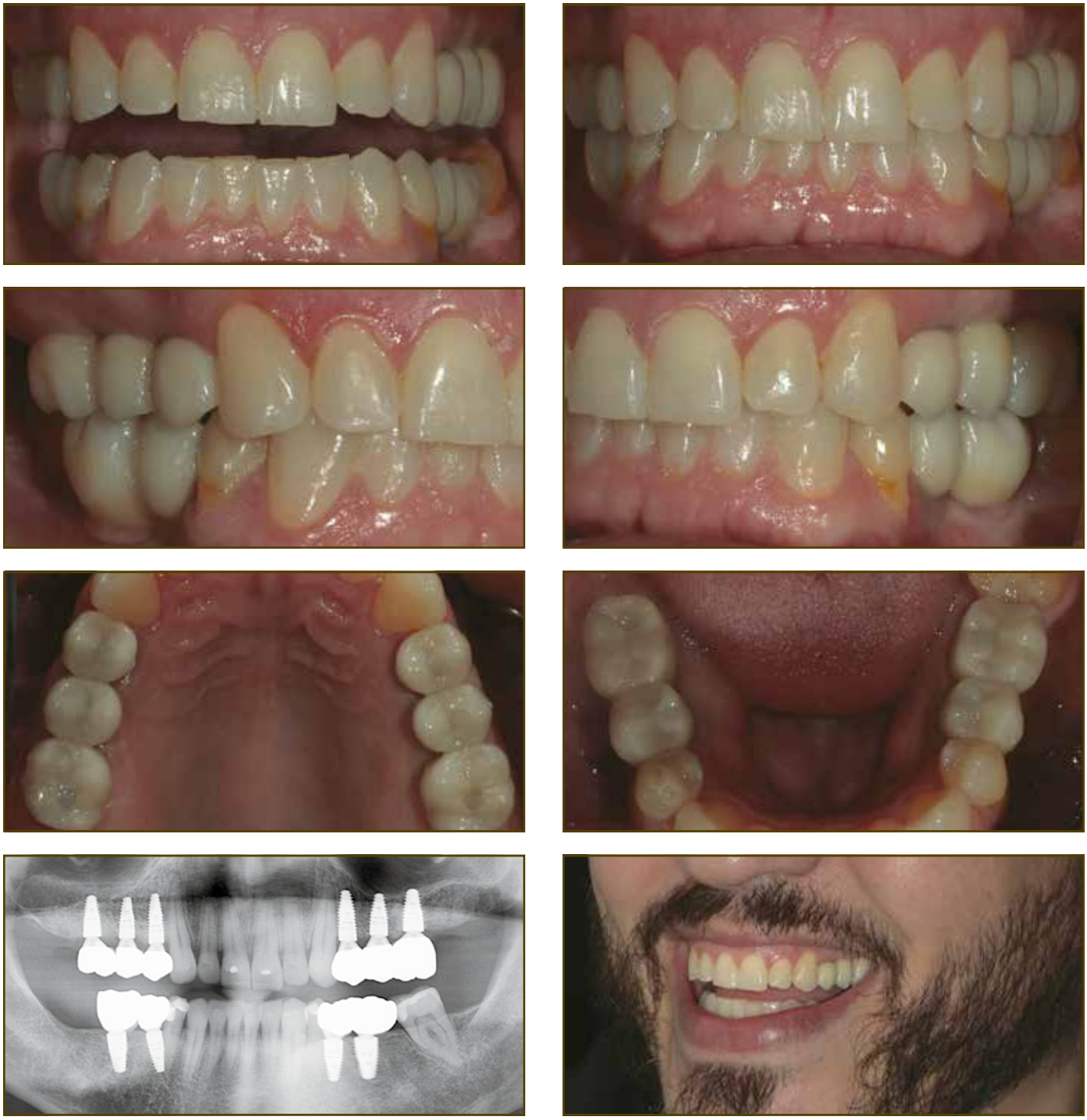


Figure 10: post-treatment.

tape and 3M Filtek Supreme restorative (shade A1, body). We took one digital scan for retainers.

Dustin's treatment began in June 2017 and was not finished until February 2022. We estimate that if not for the time lost due to COVID considerations, the case could have been completed in 2 years.

Conclusions

In the author's opinion, the use of digital planning is quickly becoming the standard of care in comprehensive dentistry. The merging of dental photography, STL files, and DICOM files with the use of software and 3D printing is allowing for a predictable facially generated treatment plan. In turn, this allows for precise plans for orthodontic, implant, and restorative dentistry. This case demonstrates the use of digital dentistry for a predictable, efficient, and esthetic outcome. Before we plan, we must digitally scan.

The authors wish to thank Evan Lenhoff, DDS, for his role in the Invisalign and restorative treatment, and Ben Jacobs, DMD, for his role in the surgical aspect of the treatment. ■

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Clear Aligner Treatment for Overerupted Lower Anteriors

by Richard Schmidt, BSc, DDS

Introduction

A frequent cause of overerupted anteriors is the body's response to a lack of opposing tooth contact. The lack of contact can be skeletal (**Figure 1a**) and/or dental (**Figure 1b**) in origin.

Dr. Peter Dawson discusses dento-alveolar eruption (DAE) in his textbook *Functional Occlusion: From TMJ to Smile Design* with the concept of "balance of eruptive forces." Dr. Frank Spear has also demonstrated this concept of DAE when referring to "compensatory eruption in response to tooth wear" during the SPEAR Education course "Treating the Worn Dentition."

Dr. Richard Schmidt practices general dentistry in Brampton, Ontario. He has been in practice with his wife, Dr. Tamara Sosath, for 33 years. He has always had an interest in orthodontics and recently introduced Clear Aligner Therapy (Invisalign) as a treatment option for his patients to establish a sound occlusion. In addition to treating teens with Invisalign, he is utilizing it to align teeth conservatively for rehabilitative restorative treatment.

Traumatic occlusion and overeruption are often accompanied by bruxism. This wears down the overerupted teeth and leads to even further overeruption (**Figure 2**).

In such cases, the clinician must correct the patient's bite and then restore the overerupted teeth by means of bonding.

The author's treatment method of choice for excessive lower anterior DAE entails dento-alveolar intrusion (DAI) of the incisors to reposition the anteriors' gingival margins into their proper gingival height, eliminate the malocclusion with minimal change in the vertical dimension of occlusion (VDO), and develop interincisal space to permit the lengthening of "clinical crowns" through restorative bonding. The author refers to this as non-surgical clinical crown lengthening.

The benefits of using non-surgical clinical crown lengthening are many:

Soft tissue benefits

- It maintains pre-treatment gingival embrasure, with size and shape of interdental papillae.
- It maintains favourable gingival margin architecture: tapered, scalloped.
- It achieves conservative leveling of gingival margins.

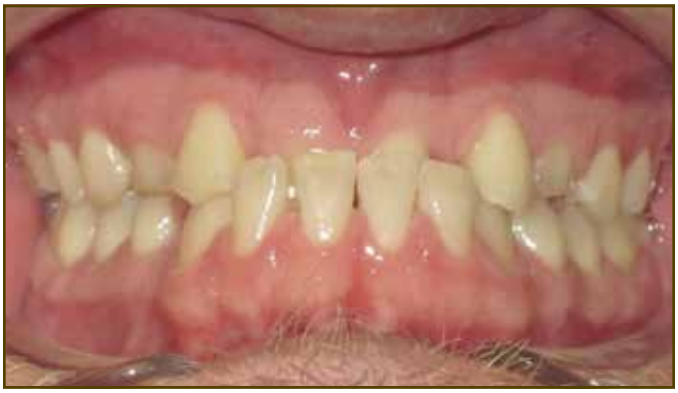


Figure 1a: Class III skeletal relationship, lack of anterior contact.

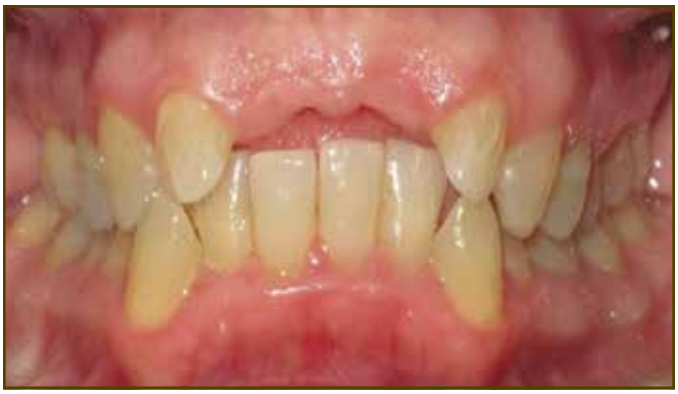


Figure 1b: long-standing (40 years) missing maxillary anterior teeth, without favourable anterior contact; mandibular DAE.

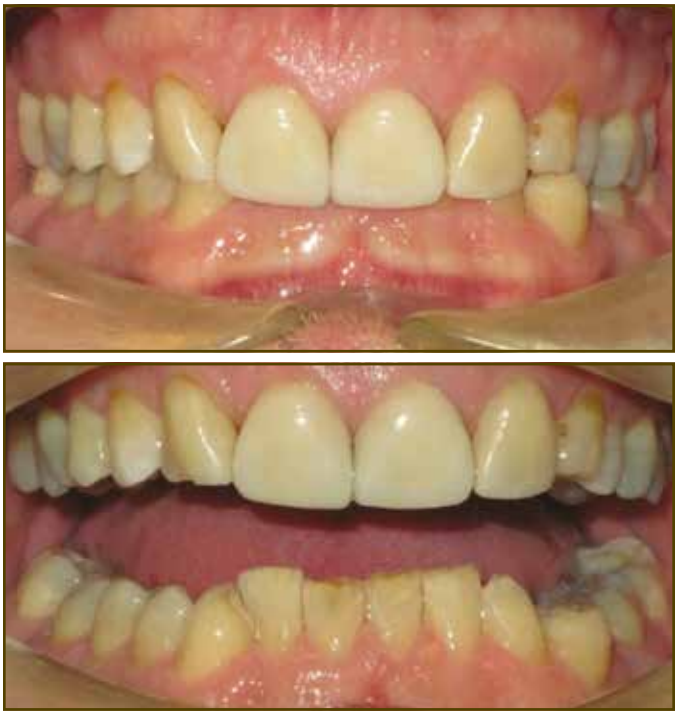


Figure 2: excess overbite, retroclined mandibular incisors, compensatory DAE in response to tooth wear, restricted mandibular movement.

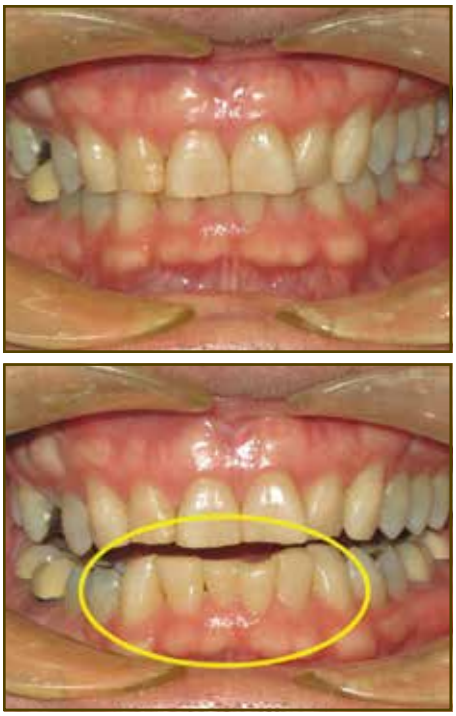


Figure 3a: Case #1. Initial October 16, 2015.

Figure 3b: Case #1. Post-Ortho March 2, 2017.

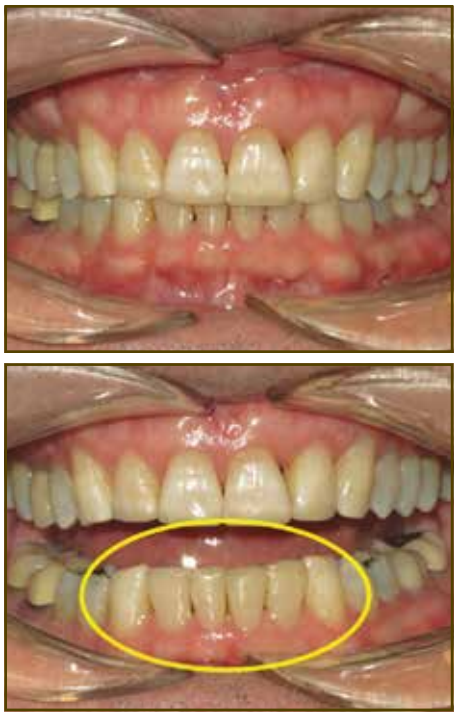


Figure 3c: Case #1. Restored March 22, 2017.

- It produces level gingival margins that will provide the foundation to produce aesthetically pleasing adjacent clinical crowns of equal size (height and width).
- Most importantly: it involves *no* pain, *no* injections, *no* incision, *no* sutures, *no* analgesics, *no* antibiotics, and *no* emergency calls.

Hard tissue benefits

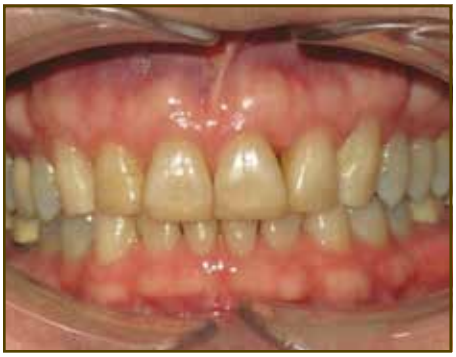
- It permits minimally invasive tooth reduction to create space for restorative material.
- It maximizes the amount of available enamel to bond restoration (avoids cementum exposure).
- It provides opportunity for conservative restoration: resin, veneer vs. crown.
- It minimizes the need for surgical crown lengthening, to increase clinical crown height to provide an aesthetically acceptable height/width ratio (assuming sufficient ferrule is present).
- It maintains root form and width at the gingival margin, avoiding exposure of the narrower root.

By contrast, the chief disadvantages of this method are its time and cost.

The best appliance to perform dento-alveolar intrusion for the adult patient is the Invisalign system. The system offers excellent vertical control, targeted gentle intrusive orthodontic forces, and exceptional access to oral hygiene during treatment. These advantages enable the clinician to rehabilitate the anterior worn dentition in a minimally invasive manner. This approach will provide the patient with many years of an aesthetically pleasing smile and optimal function. All the following cases were treated using the Invisalign system followed by conservative, minimally invasive restorative treatments.

Case #1

The patient initially presented with level incisal edges with uneven gingival margins. With orthodontic DAI, these became uneven incisal edges with level gingival margins. This new arrangement allowed the patient to receive four equally sized lower incisors (**Figures 3a-c**).



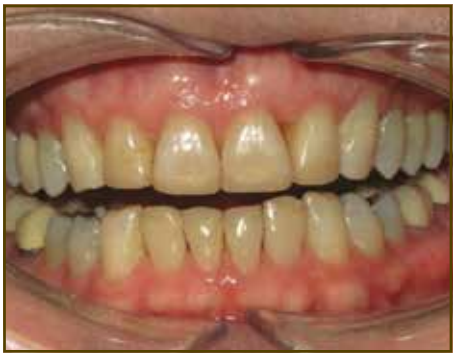


Figure 4: Case #1. Five-year follow-up shows very stable outcome.

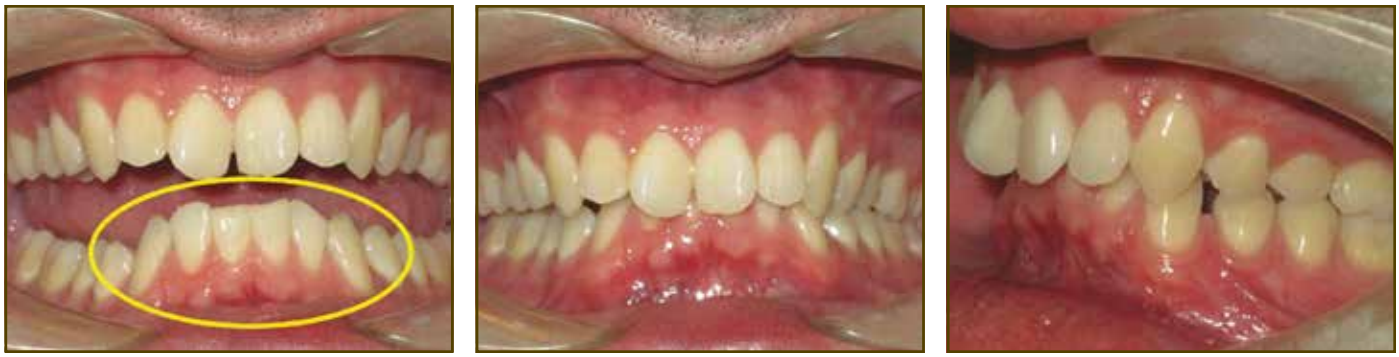


Figure 5: Case #2 before treatment. Lack of anterior contact due to excess overjet, Class II skeletal imbalance, severe DAE, stepped incisal plane, moderate incisal tooth wear.

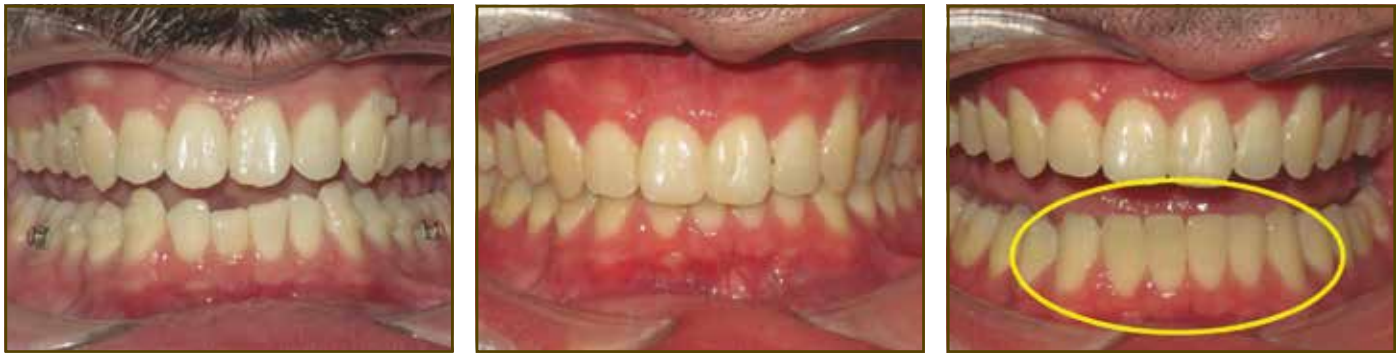


Figure 6: Case #2, after treatment. 5.0 mm of dento-alveolar intrusion, levelled gingival margins, no significant change in VDO, followed by conservative resin restorations.

The patient's bruxism had led to loss of incisal tooth structure, followed by compensatory DAE. Improved anterior guidance with favourable overjet/overbite, as a result of treatment, has reduced the risk of catastrophic destruction of tooth structure.

As of 5-year follow-up with minimal natural tooth/restoration maintenance, the outcome has proven to be very stable (**Figure 4**).

Case #2

The patient's dentition showed the results of a lack of anterior contact due to excess overjet and a Class II skeletal imbalance: severe DAE, a stepped incisal plane, and moderate incisal tooth wear (**Figure 5**).

The patient demonstrated a skeletal deficient mandible, and ordinarily a clinician would recommend a surgical approach to provide an "ideal" jaw relationship. However, the patient opted to take a non-surgical, dental compensation approach instead.

With Invisalign we were able to effect 5.0 mm of dento-alveolar intrusion, with levelled gingival margins and no significant change in VDO. We then applied conservative resin restorations to the lower incisors (**Figure 6**).

In the absence of orthodontic DAI, we would have been forced to take an extraction-and-implant approach. We avoided this necessity, and the patient was very pleased with the outcome.

Conclusion

The clinical management of anterior tooth wear is very challenging. It requires a thorough diagnosis and the implementation of a realistic and predictable treatment plan to provide the patient with the best possible outcome dentistry can deliver. When one uses an "Ortho First" approach, these outcomes can be realized in a minimally invasive manner, both non-surgically and restoratively.

For an adult patient, one of the best appliances to move the teeth into their optimal position is the Invisalign system. The Invisalign system is a patient-friendly and socially acceptable alternative to conventional brackets and wires. The combination of the Invisalign system and subsequent restorative treatment can provide patients with outcomes they have always been wishing for. ■

Do you have an idea, treatment, or review that you feel your peers would benefit from? Contact DrJeffreyGaller@gmail.com to find out how to author articles in future issues of the Journal.

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Practice Management

How to Hire and Develop a World-Class Dental Team

by Wendy Briggs, RDH

Wendy Briggs is a practicing hygienist, strategic advisor, speaker, trainer, consultant, coach, product developer, and author. She is the president and founder of Hygiene Diamonds as well as the president and co-founder of The Team Training Institute.

Wendy's excellence as a hygienist and patient care advocate has directly influenced more than 3,718 dental practices in 12 countries. She has a proven track record of supporting dentists, hygienists, and their teams (many of which are among the biggest and fastest-growing practices in the United States and Australia) in increasing patient care and doubling hygiene production.

The dental industry is experiencing unprecedented labor market challenges, and it's come at a time when other business challenges are stacking up. We've reached a pivotal moment when it's time to adapt.

The business of dentistry is much more complex than it was just 10 years ago. The margins are slimmer, the debt required is expanding, and the risk is higher. The entire financial model of dentistry has been turned upside down. The dental industry has become highly fragmented, which has allowed predatory pricing and reimbursement to overwhelm it. Payor sources, suppliers, lenders, and other vendors enjoy massive profit margins many times those of dental practices, and this will likely only worsen over time.

In addition to all of this, the current labor market is creating challenges in hiring enough team members. Many dental professionals have left the industry, creating incredible stress for dentists and team leaders tasked with hiring and training. Many practices are currently feeling forced to hire those they know aren't a good fit, compounding the stress.

So, how do practices navigate these challenges, create a strong team, and thrive? What do effective teams do differently than the masses? And, how do you find a great office manager, assistant, or hygiene provider?

Three nonnegotiables

As a practicing hygienist who has consulted with more than 1,800 dental practices in recent years, I'm often asked these questions. Gino Wickman's book, *Traction: Get a Grip on Your Business*, has absolutely brilliant team management advice for small businesses. In the book, Wickman argues that teams should possess these three qualities:

1. **Get It: They understand what you're trying to accomplish.** It's important that all team members understand critical concepts. For instance, if a team member doesn't understand great customer service or teamwork, the whole practice feels the effects.
2. **Want It: They want success badly enough to do what has to be done.** Disengaged employees often carry around attitudes similar to this: "Well, I'm here 8 to 5. I'll clock in and I'll clock out, but I'm not going to put any extra effort into this. It's not worth my time. I just don't want it that badly." Negative attitudes in a dental office tend to be contagious, so a great attitude should be nonnegotiable for team members.
3. **Can Do It: They are capable of doing the job well.** Employees that simply don't have the essential skill sets are very difficult to deal with. Even if someone understands what you're trying to accomplish and wants to do it, he or she needs to be able to execute the required tasks to be a good fit for the practice.

To succeed in building a great business, dentists need to build a team of people that get it, want it, and can do it.

The cost of a bad hire

Lately we've heard from dentists and team leaders around the country that they've never had a more difficult time getting potential hires to apply. They're increasingly frustrated with

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applicants who don't show up for interviews, and we've even seen applicants accept positions only to back out later. Some of these offices have been working without a hygienist for months. These providers often feel that they are up against a wall and must hire anyone who shows up and is willing to work. How can dental practices create an ideal team if it's difficult to hire anyone at all?

While it's tempting to disregard Gino Wickman's 3 requirements and hire anybody, it's important to consider the true cost of a bad hire. The true cost often includes:

- Wasted salary: 1 to 6 months, 8.5%–50% (as a percentage of annual salary)
- Recruitment costs and time, 5%–40%
- Training costs (and time), 5%–20%
- Impact on rest of team, 5%–50%
- Missed/delayed business deliverables

At a minimum, the total cost of a bad hire is around 25% of the salary, but the cost is often over 1.5 times the salary. This means that if you're hiring someone at $80K, the range of potential losses could be from $20K to over $120K. Simply put, hiring mistakes are far more costly than most dentists realize.

Tony Hsieh, the CEO of Zappos, once said, "We've actually passed on a lot of really smart, talented people that we know can make an immediate impact on our top or bottom line, but if they're not good for the company culture, we won't hire them for that reason alone."

It's so important to have truly excellent team members. I've seen countless struggling practices thrive once the right team members are found. This is particularly true in hygiene. So, if the pool of providers isn't as deep as you'd like, how do you grow and develop the hygiene department into a dream team?

Step #1: Hire for personality

Building a world-class team requires a willingness to do things differently. In a recent post on LinkedIn, Richard Branson said that the single most important attribute he uses when considering whether to hire someone is personality. "People who are fun, friendly, caring and love helping others are winners, and the rest of the job can be taught." During the hiring process, pay close attention to personality and attitude. Skills are important, of course, but skills can be taught and attitude is typically permanent.

His words ring true especially when hiring team members to work in the front office. Helping patients with appointments, ensuring things run smoothly throughout the office, and dealing with insurance and financial matters require the right demeanor. People who are fun and love helping others will excel in these roles. Often when it comes to assisting and hygiene, the clinical skills are already there. You can teach the rest of the necessary skills they'll need to excel in your practice. The first step is finding those people who "get it."

It's important to seek out those with an ideal personality and those who align with the practice's core values from the first moment of contact. The words you're using in your employment advertisements can help weed out many potential applicants who may not fit what you're looking for. Using words in your ads such as "highly motivated," "patient-focused," and "team player" will often weed out those who just want an easy 9-to-5 paycheck.

Personality is hard to detect just by looking at work history or education background. It can even be difficult to observe over the phone, during an interview, or in brief contact. One great way to improve your chances of hiring a good fit is to share your vision and mission with the potential hire during the interview. This is also a great way to stand out among employers and let candidates know that at your practice they'll be a part of something bigger than themselves. Ask your candidate a few questions related to one of the values you live by in your office and see if your values align.

For example, if teamwork is one of your values, here's what that might look like: "One of our core values is teamwork. We love to hire team members who share these values. Can you think of an experience in your past work history where you had team members that weren't interested in working as a team? How did that affect you in your role? What could you have done to improve that situation?"

Step #2: Onboard for top performance

Bad hires destroy value, break apart teams, and cause stress. But the truth is that most bad hires don't start off as bad hires. Most new hires only become bad hires because of a failed job transition. The process of onboarding is an essential step to creating a team of people who "want it" and "can do it." Many dental practices don't have a system for onboarding and developing their teams, and new hires are often thrust into the job with very little training and guidance. This can cause the standard of patient care to slip, creating a lower-quality, inconsistent patient experience. So once you hire a great candidate, then it is time to help build him or her up into the team member you're looking for.

Onboarding is also a prime opportunity to make a great first impression on new team members. Often in practices, new hires are trained by the employee who is leaving, which may not be the ideal introduction to the practice. It's important to present your practice in the best light possible. For instance, team members in dentistry are often not challenged enough. This can lead to lack of engagement and burnout. So, what opportunities are you providing your team to grow? Are you communicating those opportunities clearly and regularly? This should be laid out on Day One in the onboarding process to make sure new hires are informed and excited about their future with your company.

Dr. Galler asked me to come and speak to his beta group of office managers a few months ago. During this Mastermind

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session, I shared with them my 3-3-3 system for onboarding. I helped these practices create their ideal checklist for everything a new hire should know after 3 days, 3 weeks, and 3 months with the practice. This is a simple, powerful way to ensure smoother transitions for new team members while making expectations clear. This system also takes the pressure off team leaders and the doctor and places the responsibility on the team members themselves. They are the ones responsible for making sure they complete the items on their 3-3-3 checklist. Imagine how much better things would be in your practice if all your team members and providers (including the dentists) performed at the highest level. Having a process for developing providers helps them understand their role, create more value for patients, and drive productivity higher.

Zig Ziglar once said, "The only thing worse than training employees and losing them is to not train them and keep them."

Our mission at The Team Training Institute is to make training team members easier and more effective. We partner with dentists and bring real-world solutions that address these very common frustrations. If your team needs some help reaching their full potential, we'd love to help. Our programs help teams in a variety of areas from clinical skills to leadership to communication to creating an exceptional patient experience. Our goal is to build teams that have a greater positive impact on the health of the patient, the performance of the business, and the community as a whole. All team member performance can be elevated, and when that happens, everybody thrives.

To learn more about how we work with practices, go to **www.TheTeamTrainingInstitute.com**. For immediate hiring resources, get a copy of our book, *The Insider's Guide to Hiring a World-Class Dental Team*. You can grab a free copy at **www.dentalhiringresource.com**. ■

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Office Management

The Life Happens Committee

by Ashley McGowan

Ashley McGowan manages Ironwood Dental in Tucson, Arizona, for Dr. Karley Schneider. While relatively new in dentistry, Ashley has management experience with a number of multinational companies and grew up watching her family manage dental practices in Austin, Texas. Ashley attended the University of Arizona, where she studied journalism and Spanish. She was previously published in *El Independiente*, a bilingual magazine in South Tucson.

In her first year working with Ironwood Dental, the practice expanded from 7 employees to 14 and moved into a new, cutting-edge office. Ashley is focused on facilitating the rapid growth of the practice, as it prepares to expand into a brand-new space in 2023. She is also thrilled to step into her new role, publishing an office management column for the AACA.

Ashley has lived in Tucson with her husband for 10 years. In her free time, Ashley loves to play Dungeons and Dragons with her friends and to catch Texas Longhorns football games on TV.

Where dentistry leaves off and life begins, the AACA is still there to support its members. Amid a sea of cold, bureaucratic, and impersonal dental organizations, the AACA is proud to acknowledge the milestones of its members outside the dental chair and offer love and encouragement to members in need.

The Life Happens Committee, headed by Dr. Kristen Ritzau, has been working quietly and anonymously since 2018 to send messages and gifts of celebration and support. Working through the many AACA WhatsApp groups, the committee is dedicated to keeping the ever-important family quality of the AACA alive. Dr. Ritzau and her small team of 5 board members stay in touch with AACA members through the group chats and keep their eyes open for any mention of noteworthy events or need for comfort.

The opportunity to celebrate new babies, marriages, and achievements brings so much joy to the committee members. They love to see the many photos of precious newborns donning their personalized AACA gifts posted on the WhatsApp groups. It's about more than the gifts for the Life Happens Committee; "the gifts are a representation of the heart of the AACA," says Dr. Ritzau.

For AACA members experiencing a difficult time, Dr. Ritzau says, "We know, we care, and we want to be there for more than just dentistry." Her most memorable moment with the Life Happens Committee occurred when they sent messages of love and uplifting gifts to an AACA member and his family as one of their sons was hospitalized. The member was so grateful for the support and said that "the biggest blessing is that it brought a smile to his son's face," Dr. Ritzau recalls.

As the AACA continues to grow, and new members are added to the group chats every day, it is becoming more difficult to keep up with all the Life Happens news. Also, in the larger chat groups, members may be less likely to share about personal achievements or strife. The Life Happens Committee needs more members to speak up and share news about their colleagues, to keep this warm-hearted project alive.

Dr. Ritzau encourages members to reach out to their local study club leaders, get loud in the group chats, or email Dr. David Galler directly with any news about other members that needs to be acknowledged. The Life Happens Committee and all of its efforts help create the close-knit atmosphere that sets the AACA apart. Together, we can continue to ensure that our members are treated like family. ■

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AACA Spotlight

National Align Your Teeth Day: Peak Performers

August 11, 2022—TOTAL CASES STARTED: 2,349

Last year, the AACA brought about the creation of a new holiday. Now and forever, August 11 will be known as National Align Your Teeth Day. You can find it on the National Day Archives calendar at **www.nationaldayarchives.com**.

Why have we done this? Because "A healthy, perfect smile enables a person to reach their maximum potential in life." That is our credo and our mission statement. A healthy smile is a magical gift to each of our patients.

We are few, but with our dedication, we can and do change the world. We do it quietly every day, and on this one day we declare it out loud for all to hear.

During the first annual Align Your Teeth Day in 2021, AACA members started 1,754 Invisalign cases. This year we exceeded that accomplishment by more than a third, with a stunning 2,349 case starts—testimony to the power of a small group with a commitment to its goal.

***CS = Case Starts**

PLATINUM PERFORMERS

Name	CS*	Name	CS*	Name	CS*	Name	CS*
Sigrid Mojica	59	Danny Lawen	51	Mithila Sharma	38	Lindsey Zeboski	36
Sarah Ash	56	David Gutwirth	48	Beth Rosenberg	36		
Smilesal	53	Andrea Dernisky	41	Hamasat Gheddaf Dam	36		

GOLD PERFORMERS

Name	CS*	Name	CS*	Name	CS*	Name	CS*
Rahul G. Kode	33	Don Shimizu	24	Richard Short	21	Kasha Ujda	17
Tony Thomas & Assoc.	31	Carlos Beltran	24	Sarah Pless	21	Carl J. Metz	17
Rob Gill	31	Chelsea Mortell Petisme	24	Andrea Ho-Fatt Wang	20	Deirdre Denis	16
Joseph DiSano	30	Michael Huguet	23	Tracy Petry	20	Whitney Wolff	16
Deepthy Thomas	28	Chip Lewis & Kenly Dine	23	Mary Ann Garcia	20	John Michael Garcia	16
Sama Salim	26	Lindsey Papac	22	Adriann Hooks	20	Jessica Tendero	16
Mark Edington	26	Leanne Ball	21	Adriana Leone	19		
Katie Beach	25	Alison Scott	21	Kyle Low	18		
Kristen Ritzau	25	Carissa Sherwood	21	Paul Raines	18		

SILVER PERFORMERS

Name	CS*	Name	CS*	Name	CS*	Name	CS*
S. Gopal Sirivolu	15	Bari Posner	14	Jeanine Sasek	13	Ingrid Puig	11
Sheena Sood	15	Keith Schwartz	13	Christopher Hart	12	Bryan Tuttle	11
Michael W. Jones	14	Sunny Gill	13	Kashfia Vohra	12	Marta M. Rivera	11
Mardily Gonzalez	14	Lenny Arias	13	Ryan Galligan	12	Diana Loperena	11
Angelie Zamora	14	Ashley Ayuso	13	Ben Omrani	12	Andrew Dela Rama	11
April Kern	14	Uttma Dham	13	Sanaz Rouhani	12	Diana Torres	11
Richard Dickinson	14	Andrea Giraldo	13	Kenneth J. Bevan	12	Michael Danial	11
Kristin Horman	14	Steven Liao	13	Young Kim	12	Jose Abadin	11

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Name	CS*	Name	CS*	Name	CS*	Name	CS*
Jon Reagan	11	Luis Camacho	11	Janna Spahr	10	Anu Sood	10
Sandhya Anantuni	11	Giselle Serrano	11	Frank Neves	10	Isam Estwani	10
Christopher Anton	11	Jimmy Loo	11	Misty/Aman Bhullar & Josh Kriegstein	10	Ashley Keen	10
Ashley Humlicek	11	Ben Yaghmai	10	Shumaker	10	Amanda Canto	10

BRONZE PERFORMERS

Name	CS*	Name	CS*	Name	CS*	Name	CS*
Marcia Martinez	9	Mana Badipour	6	Adrian Cummins	3	Kenia Cuevas	1
Ashkan Haeri	9	Sukhman Chauhan	6	Laura Justice	3	Ghanem Ghannam	1
Frances Yankie	9	Nishant Goswami	5	Sulochana Gurung	3	Rivka Goldenhersh	1
Michael Cimino	9	Ali Modiri	5	Gina Johnson-Higgins	3	Gladys Maldonado	1
Corey Wilson	9	Reem Salam	5	Shradha Sharma	3	Daniel Stockburger	1
Nandini Murthy	9	Dave Cantwell	5	Kiran Khemani	3	Cynthia Mikula	1
Nadia Saad	9	Katie Meister	5	Kristin Wade	3	CP	1
Mark Anderson	8	Katelyn Niu	5	Ana Santana Guerrero	3	Andrea Guess	1
Susan Ellison	8	Joanna Hong	5	Thuy Le	3	Jaspinder Bhattal	1
Koppikar	8	Sheila Farahani	5	Anthony Vondra	3	Marry Hong	1
Karen Lee	8	Erick Hosaka	5	Tyler Francis	3	Israa Fakhri	1
Alan Chang	8	Caylin Frye	5	Marlene Shaw	3	Meenal Patel	1
Sergio Rauchwerger	8	Meredith Hughes	5	Gina Marcus	3	Shila Ghasemi Moridani	1
Michael Folck	8	Jason Elliott	5	Juan F. Quintero	3	Robert Christ	1
Mai Ly	8	Riaz Rayek	5	Keith Hollinger	3	Eduardo Ubieta	1
Meghan Toland	8	Andres	5	Beth Caunitz	3	Heidi Finkelstein	1
Cameron Turner	8	Ron DiRezze	5	Andrea Ball	3	Nerissa Aquino	1
Aladino Valiente	7	Eric Dendinger	5	Thao Bui-Nguyen	3	Joita Ghosh	1
Rob Herron	7	Sun Park	5	Wendy Steger	3	Reddy	1
Lior Neuman	7	Karleen Boparai	4	Marlene Rivera	2	Lee Falkenheiner	1
Palmi Testa	7	Aramesh Darvishian	4	Alonzo Bell	2	Kimberly Zizic	1
Bhawna Gupta	7	Prachi Deore	4	Rajab Zaza	2	Basem Ghadban	1
Angela Anton	7	Jason Schermer	4	Jennifer Mackey	2	Mina Armanious	1
Rashmi Bhatnagar	7	Un Chong (Maxine) Tam	4	Jeff Davies	2	Michael Rotter	1
Sophie Polymeneas	7	Michael Perona	4	Cassie Allison	2	Michael Gertsen	1
Josh Summers	7	Viviana Waich	4	Cristian Lofvall	2	Meysam	1
Navneet K. Chahal	6	Zareena Banu	4	Arvind J. Petrie	2	Madhu Mahadevan	1
Lamiaa Elghandour	6	Charles Poblenz	4	Joseph Giangrasso	2	Maryz Estedrak	1
Rachel Tambunan	6	Maxwell Johnson	4	Sonya Reddy	2	Kelli Brady	1
Janette Larsen	6	Swagatha	4	Brian Brodersen	2	Lindsey Price	1
Yulia Paterson	6	Tony	4	Vivianne de la Camara	2	Jimmy K. Bhatt	1
Zahra Omar	6	Donny Viggiani	4	Elaine Gonzales	2	Shwetha Silver	1
Alexandra Gherbali	6	Sumbul Naqvi	4	Vanja Cosic	2	Angela Abernathy	1
Julie Storm	6	Isabel Cancino	4	Ilona Furman	1		
Lauren Lee	6	Saba Rizvi	4	Alma Lombardo	1		
Marianna Rexan	6	Maria Burmaster	4	Neelima Ravi	1		
Robin Lucas	6	Gohar Grigorian	4	Monika Mahajan	1		

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Jack's Corner

by Jack Von Bulow, DDS

Hollywood Confidential

So, now that I've hung up the gown, the shield, both masks, the loupes, the laser filter, and the cap, I'm embracing some added freedom to share stuff.

And you might have heard my Invisalign story (yada, yada, yada) more than once. But there are parts of the story that I've never divulged. And my stinginess with the story doesn't serve anything all that noble, like protecting the innocent or guarding my sources. Mostly, I've refrained from sharing what would tend to make y'all judge me for my immaturity, silliness, or just plain ole stupidity. But at the same time, I believe the trinity of flaws I've just confessed is exactly what it takes to keep you young (and I left out vanity).

I've always been vain, wanted to stay young, and looked and listened for any form of humor and (on the sly) attention.

The sunglasses I wear while whale watching, ordering a Havana Cappuccino, or posing with patients who've completed Invisalign care (in front of a poster displaying a short woman with a big head) are indeed part of my SoCal brand. But the shades also cover my optic bagginess and eyebrow scarcity. The poster makes my oversized melon seem smaller, and in my own delusional mind I look much taller than a more likely shrinking 5'9".

What really turned me into a total clear aligner true believer might surprise you: it was my attending the Invisalign Summit for the first time. The biennial meeting included an event called the Shootout. The competitors presented their Invisalign cases on stage in front of all those attending (around 1,000 GPs and teams); the winner was determined by texted vote. What I saw on stage encouraged me to take on more challenging cases; I thought it would be crazy awesome to be up there one day. And at the super-amazing Summit party and after moderate libation, I karaoked for the first time…in front of a band and backup singers. I can't say the attention bothered me.

Two transformational moments arrived in 2015. My Align territory manager nominated me for Reingage, "The (Invisalign) course that changed everything." My new mentor was a little different: he performed full-out comedy while teaching. In fact, Dr. David Galler now works stand-up in Las Vegas, his present educational home base. And then, within days, I learned that the only case I'd ever submitted for the Shootout had made it to the Final Four.

Galler had so much energy and was so funny, it was almost impossible not to learn everything you didn't know you didn't know about Invisalign. So, even though I'd been a dentist for almost 40 years, I was still as impressionable as I was at my first glimpse of the Matterhorn…in Anaheim. And I saw something that touched, moved, and inspired me: my first Galler video, "Invisalign Man." Initially, I wanted to share the video with all my clueless non-Invisalign colleagues just to make them jealous. But then, being in one of 'em became a goal; make that an obsession.

Okay, and the Shootout result was a joke, the final vote processed by a text accounting firm straight outta year-2000 Florida. I lost to a French-Canadian wearing sausage pants, an accent, and the willingness to use traditional braces as part of clear aligner orthodontics. Ugh.

But I freakin' loved the experience! I walked on to Eminem and "Lose Yourself" wearing a Cardinal & Gold (USC Trojans colors) hooded silk robe. My first slide showed the Trojans emerging from the tunnel at the Los Angeles Memorial Coliseum on a Saturday night. Galler and Pete Carroll occupied two of my five Mt. Rushmore positions. I dropped the mike as my beautiful patient sang "Smile" from a ginormous screen. I was no longer a closet attention hound; everything had changed.

Over the past 7 years, my Los Aligners team has won the Galler Cup, I've become a board member for the American Academy of Clear Aligners, I even get to write this column every quarter, and I've had a chance to travel to the Bahamas, Jamaica, and New Orleans for winter meetings; we've made a major difference in the lives of patients we see as family. I've met the coolest colleagues on the planet. And I've weaseled my way into every Galler video project, gained greater speaking parts, and provided Invisalign care for patients who just might get me more screen time.

When *Access Hollywood*'s Mario Lopez requested Invisalign for boyhood best friend, make-up artist, and future Orson Welles all-purpose actor/filmmaker Rodney (in return for being the

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SCAN ME

Gallerite Reunion Convention spokesperson), I stepped up. Did it for nuthin' and (taking one for the team) even took a smiling photo with Lopez.

When Galler's multi-talented filmmaker Tara sought me out for Invisalign care, following another impressive video performance, I was honored; almost composed an acceptance speech. And…it's amazing how persuasive you can be while providing care for the casting director. I think Tara may have been kidding when she promised me a 10-film contract and a trailer at the next shoot. My hearing can sometimes be selective and/or creative.

Tara also won a competition involving 1,000 filmmakers. I received an invitation to see Tara's *Before Dawn, Kabul Time*, a riveting 15-minute ultra-dramatic short, shown with Jordan Peele's *Nope* during its opening weekend. Tara addressed me as her "star" right in front of my spin class date when we arrived. And I know sweetness when I hear and see it, so I'll take my new title because (just like Shakespeare) I'm considering the source.

And it's just one more thing to love about Invisalign: hanging out with colleagues who can stay out all night and building better lives. Being on the screen, acting silly and immature, and enjoying the attention may sound a little unprofessional. But if you're anything like me and you've been part of the "Wolf of Invisalign" video and you're a dentist, that's show business! ■

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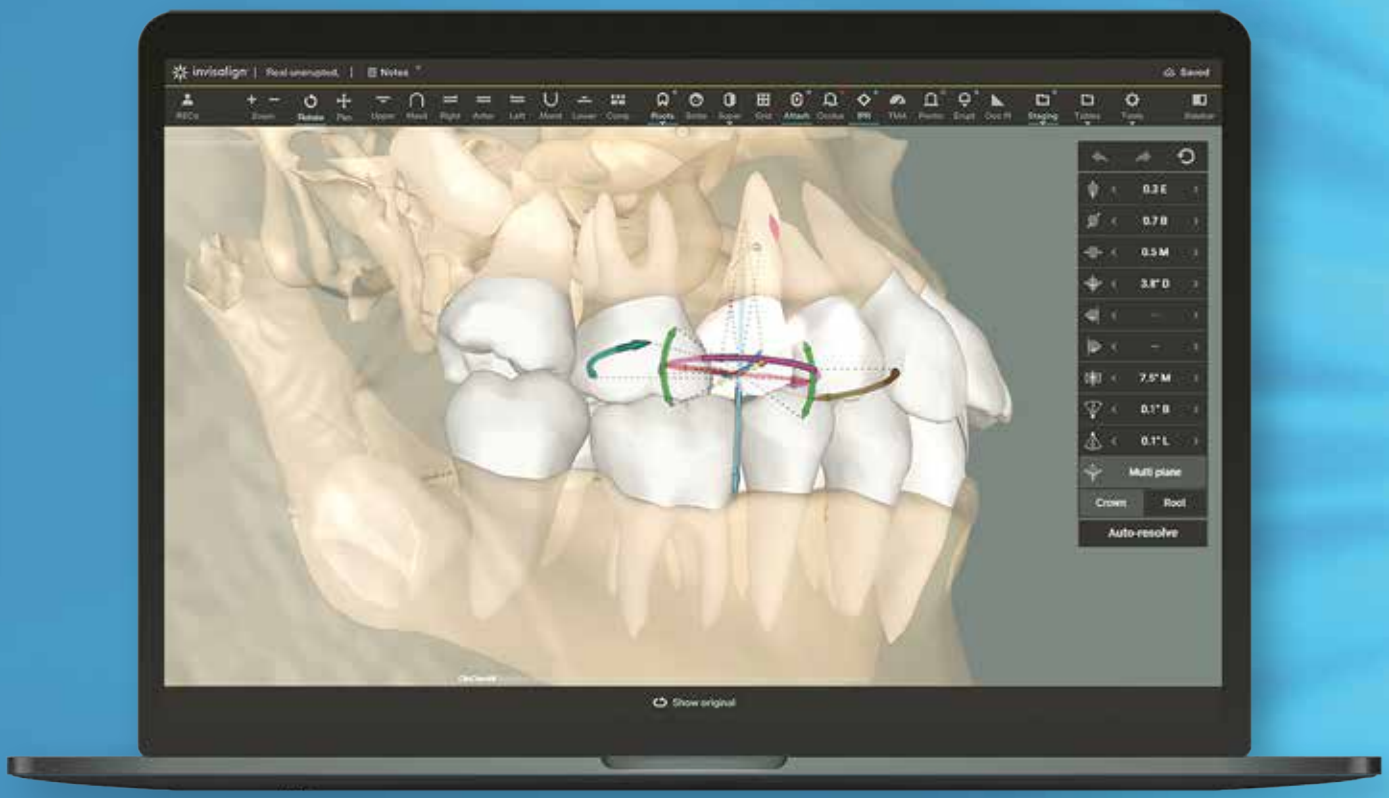

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