DENTAL TRIBUNE

The World's Dental Newspaper · U.S. Edition

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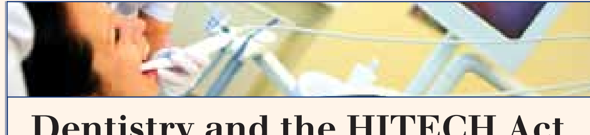

Dentistry and the HITECH Act
So just how much of that $22 billion is earmarked for dentistry? ▶ page 5A

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Learn exactly what you need to know before making your choice. ▶ page 7A

HYGIENE TRIBUNE
The World's Dental Hygiene Newspaper · U.S. Edition

Hygiene and ortho
What are the connections you should be aware of before, during and after ortho? ▶ page 1B

Teeth can be saved for future stem cell harvesting

By Fred Michmershuizen, Online Editor

The Save-A-Tooth system can be used to transport teeth destined for cryopreservation and stem cell treatment of disease.

Recent research has shown that normally shedding baby teeth and extracted wisdom teeth can be a source of stem cells that are the equivalent of umbilical cord blood stem cells.

The use of umbilical cord blood as a source of stem cells has been routine for several years. However, this method has many problems.

The window of time for the retrieval of the cord blood is very short, the hospital staff needs to be well trained in the technique and it is expensive.

Every child loses 20 baby teeth over a period of six to eight years, and 1.4 million wisdom teeth are extracted each year. Each of these is a rich source of stem cells.

In the past, these teeth were thrown in the trash, but now they can be saved and shipped to a cryopreservation facility and the stem cells stored until needed for the many possible future clinical applications.

"This potential source of stem cells from teeth is a tremendous breakthrough," said Dr. Paul Krasner, professor of endodontics at Temple University School of Dentistry.

"Four million baby teeth a year normally fall out, and for a small cost and virtually no effort, each can have

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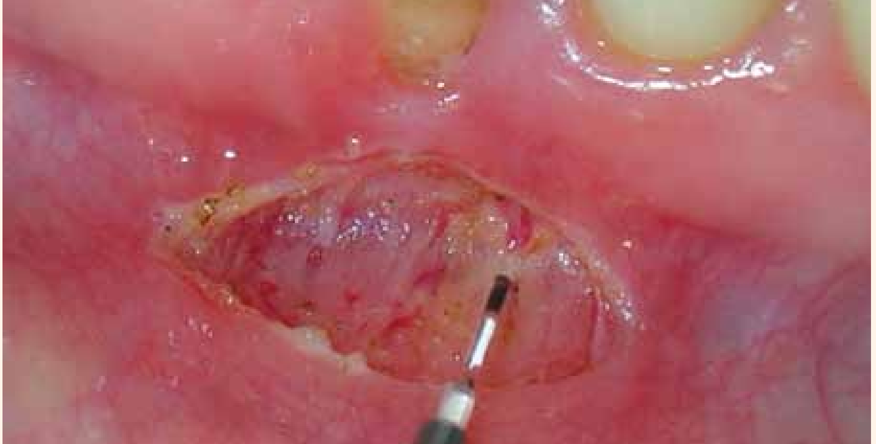
The Save-A-Tooth system can be used to transport teeth destined for cryopreservation and stem cell treatment of disease.

Deliberating about a diode laser?



If you think you cannot afford a diode laser or it's just too complicated to use, think again. Read what a dentist who is not a 'high-tech' junkie has to say about incorporating this technology into her practice.

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Olympians screened for oral cancer

By Fred Michmershuizen, Online Editor

Many of the world's top athletes were competing for medals during the 2010 Winter Olympic Games, held in Vancouver, British Columbia. When they weren't skiing down slopes, skating around ovals or whooshing down tracks, several hundred of the athletes were undergoing screening for oral cancer.

That's because the International Olympic Committee (IOC) mandated that 20 percent of athletes competing in the games receive a comprehensive examination that

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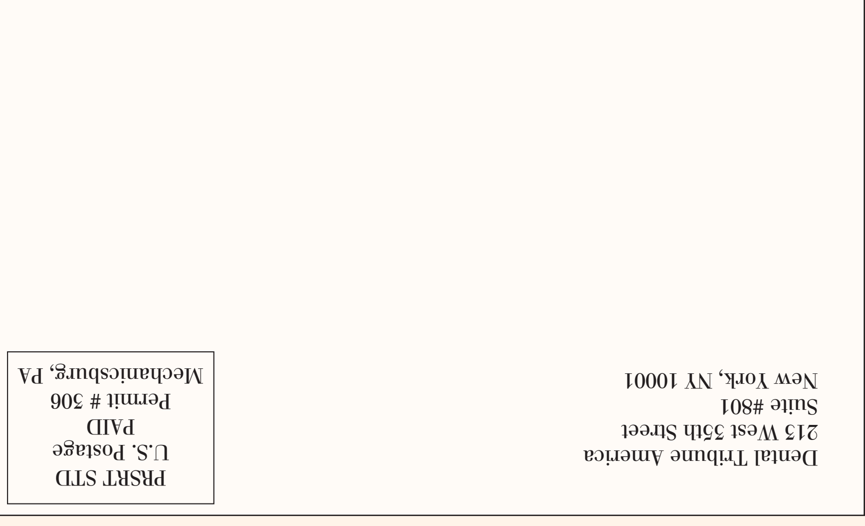

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At the Winter Olympics in Vancouver, British Columbia, the VELscope System was used to screen athletes for oral cancer. The device was developed in British Columbia.

included screening for oral cancer. The device used to conduct the screenings was the VELscope system, which happened to have been developed right in British Columbia by LED Dental, in collaboration with the British Columbia Cancer Agency.

During the games, a team of 72 dentists and their volunteer assistants were offering about 800 athletes everything from routine dental care to trauma surgery. All who were being treated received the oral cancer screenings.

"Year-round, the alpine athletes follow winter around the world to train, and they are at higher risk of lip and mouth cancers because of the altitude and sun exposure," said Dr. Jack Taunton, co-chief medical officer of the games. "The skin on the lips is thin and poorly protected. The damage is cumulative, and you have to consider they are exposed to these intense ultraviolet rays for up to 30 years, through their training and post-competitive coaching years in many cases."

Moreover, Taunton said, some athletes in Nordic events chew tobacco, which contains numerous carcinogens that can cause oral cancers.

The VELscope, a device that emits a special blue light inside the mouth to help detect suspect tissue that needs further investigation, was used to screen for cancerous and precancerous lesions in the athletes. According to LED Dental, the VELscope is the No. 1 oral cancer screening device in the world, having been used to conduct an estimated 3 million screenings in the past year.

"It's a terrific adjunctive visual tool being integrated more and more into general dentistry practices," said Dr. Chris Zed, associate dean of dentistry at the University of British Columbia and co-head of dental services for the 2010 Olympic Games.

The athletes were also receiving education about the importance of wearing sunscreen to prevent oral cancers. Alpine sports athletes who train year-round at high elevations are especially prone to damaging ultraviolet rays, raising the risk of developing skin and lip cancers. The problem is compounded by the additional reflection of ultraviolet radiation off the snow and ice.

Zed cited a German study that showed outdoor athletes seem unaware of the elevated cancer risks associated with their training. DT

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Unless it is placed in a preservation solution, a knocked-out tooth dies within one hour.

their stem cells stored for future medical use."

The Save-A-Tooth System from Phoenix-Lazerus — one method for storage of knocked out teeth — can be used to transport teeth that can be used as a source of stem cells.

Provia Laboratories, the provider of the Store-A-Tooth service and a company that preserves the valuable stem cells found in extracted wisdom teeth and baby teeth, is now using the Save-A-Tooth system to transport these teeth.

"We get the best results banking these stem cells if the teeth that contain them are not damaged during the transport," said Dr. Peter Verlander, chief scientific officer of Provia.

"The Save-A-Tooth system has a patented suspension and retrieval net that protects the teeth during transport, and none of the other methods of transporting teeth have this safety factor."

There are stem cells present on the roots of extracted wisdom teeth that are especially delicate and subject to crushing damage. The Save-A-Tooth method protects these delicate cells.

These stem cells are found at the root end of the wisdom teeth and could be damaged by banging against container walls or crushing during removal from the container.

The Save-A-Tooth system has the American Dental Association Seal of Acceptance for transporting knocked out teeth and is used by dentists, schools, hospitals, ambulances and the U.S. Olympic teams.

Because knocked out teeth will die within one hour of their being knocked out, the Save-A-Tooth should be purchased ahead of time and kept in first aid kits just like bandages, burn cream and gauze.

If the Save-A-Tooth is used within 60 minutes of the accident, over 90 percent of knocked out teeth can be saved by reimplantation.

The Save-A-Tooth system has been used to store, preserve and transport knocked out teeth for over 20 years.

Its preservation fluid, Hank's Balanced Salt Solution, has been shown to be an effective preservation solution for knocked out teeth.

The value of a complete system for the storage of knocked out teeth is outlined in the dental trauma blog, *Dental911.org.* DT

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An iconic icon

Recognizing today's dentists who have devoted time outside their practice to help others

By David L. Hoexter, DMD,FACD,FICD, Editor in Chief

Each generation has a different concept or image of an icon of contemporary culture. D. Walter Cohen is such an icon of dentistry. He is a pinnacle of energy and accomplishment with a glitter of idealism. Even today, in his 80s, he will play tennis early in the morning before he practices periodontics at his office.

He understands the "gestalt" of life. For example, he talks about Dr. Harry Sicher, author of *Bone on Bones: Fundamental of bone biology*, as not only being a great orthopedist but someone who loves music and catching butterflies as well.

Cohen makes the time and effort to enhance the lives of others and to encourage peace through education and understanding. Sharing his vision through unselfish seeds of giving, Cohen fertilizes the seeds with education and an interchange of knowledge.

With his nurturing, the seedlings grow into trees with strong roots and wide branches with spreading leaves. It is underneath the shade of these leaves that people learn and share knowledge.

He even manages to open eyes and ears that have been waxed shut through years of prejudice and ignorance.

In 1997, Cohen established the D. Walter Cohen Middle East Center for Dental Education in Israel at Jerusalem's Hebrew University. Today, it continues to set the tone of learning for citizens all over the world.

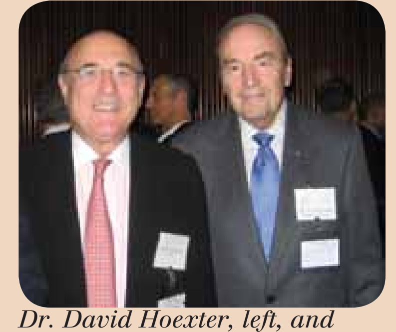
It also allows for the exchange of dental students at Hebrew University with the students at the Al-Quds School of Dentistry in Jerusalem. This exchange illustrates true sharing between Israeli and Palestinians in Jerusalem by stressing knowledge, human compassion and understanding.

Cohen is a passionate man who has given the world a real opportunity to enhance peace efforts and change humanity through education and understanding.

Cohen is also helping to make strides in lowering the number of preterm, low birth weight babies. He is guiding the treatment and cure of periodontal disease during pregnancy, especially among pregnant teenagers.

This may be a major step in order to lower the number of preterm, low birth weight babies. A favorite phrase of his is that "we have to keep trying so we can break through the glass ceiling."

Cohen helped establish the University of Pennsylvania's first department of periodontics and served as its first chair. Growing from professor to dean, Cohen advanced new concepts and raised educational standards.



Dr. David Hoexter, left, and Dr D. Walter Cohen at a recent charity function.

'Dr. D. Walter Cohen makes the time to enhance the lives of others and to encourage peace through education and understanding.'

During his career he has found the time to write and publish 22 books and hundreds of articles. Despite his busy schedule, he always finds the time to participate as dean emeritus of the University of Pennsylvania's School of Dental Medicine.

Among his many honors, he has received the Legion of Merit from France, was named president of the Medical College of Pennsylvania, chair of the Pennsylvania Diabetes Academy, president of the National Museum of American Jewish History and chancellor emeritus of Drexel University College of Medicine.

These are just a few examples of the awards and leadership recognition that he has received.

When I asked Cohen what he considered his greatest achievement to date, he unhesitatingly replied "my family." His daughters would probably agree.

Proudly, he related the wonderful family home in which he was raised, and that his father was the first periodontist in Philadelphia. As he related it, the encouragement and love that his family gave to him made it easy for him to give so much back.

If the question were posed to me as to who and what is an icon in dentistry, I would swiftly reply, "D. Walter Cohen." DT

Limit staff access to drugs

Dental offices and the pharmaceuticals used there present the risk for drug abuse, but dentists can put policies in place that help reduce the chance of illegal use of controlled substances, according to an article in an issue of Anesthesia Progress (2009 edition, 56:112–113).

Joel M. Weaver, DDS, PhD, writes that dentists who place too much trust in their employees make themselves and their practices vulnerable to people who abuse controlled substances.

Dentists who regulate drug access and distribution are protecting more than their practice — they're also protecting their patients, employees and reputation.

While it's often easier to stick with the way things have traditionally been done, making a few changes to drug access policies makes good business sense, Weaver says.

"Although change is difficult and usually meets with resistance, the thoughtful practitioner who can step back and observe his or her practice for potentially fatal weaknesses will be much less likely to succumb to a disaster," Weaver writes.

"Accredited hospitals already have strict rules to help prevent drug theft, but private unaccredited offices without mandatory controls are highly vulnerable to drug theft and deception."

By taking sole responsibility for storing, filling and handling syringes with controlled substances, dentists reduce the chance for illegal drug use and mistaken dosages.

It's important to rely only on those licensed to handle medications, Weaver says, such as physicians, dentists, nurses and pharmacists. Other employees who receive on-the-job training also may be more likely to make mistakes with drug dosages and concentrations.

"Who should have access to controlled substances in the dental office? The answer is simple: only licensed professionals and as few of them as is reasonable," he says.

For more information on limiting prescription drug access, read the entire article, "Who Should Have Access to the Controlled Substances in Your Office?" at: *www2.allenpress.com/pdf/anpr-56-4fnl.pdf.* DT

(Source: Anesthesia Progress)

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CHANGING DENTISTRY. CHANGING LIVES.

$22b for health information technology, but not quite so much for dentistry

By Thankam Thyvalikakath, BDS, MDS, MS and Titus Schleyer, DMD, PhD

When the Health Information Technology for Economic and Clinical Health Act (HITECH) was signed into law in 2009, $22 billion was set aside to improve patient outcomes through increased use of electronic health records (EHR) by clinicians during the next five years (2011–2015).

The proportion expected to go to dentistry: negligible. Prorating dentistry's share of the health-care market (approximately 5 percent) would yield over $1 billion of the allocated amount, but we will be lucky if we receive a fraction of that.

You may ask why. After all, dentistry, with its more than 150,000 practitioners in the United States, is an important primary care discipline that cares for almost 200 million Americans in any given year.

The main reason we are pretty much left out is because the legislation was written with the interests of physicians and hospitals, not with those of other health-care providers, in mind. The consequence is a huge missed opportunity for dentistry.

The federal government requires providers to fulfill three criteria to become eligible for Health Information Technology (HIT) stimulus funds from the HITECH Act. They must use certified EHRs, demonstrate the capability to measure meaningful use of EHRs based on a pre-defined framework and have a patient population that includes at least 30 percent Medicaid or Medicare beneficiaries for oral health care procedures.

Unfortunately, these criteria make it very difficult for any dentist to qualify. At this time, not one dental EHR has been certified by the Certification Commission for Health Information Technology (CCHIT).

Meaningful use criteria have been developed mainly based on general, not dental, health needs. In addition, few dentists have patient pools that include a large share of Medicaid/Medicare beneficiaries.

Electronic health records, the use of which can be supported by the HITECH Act, are certified by CCHIT. CCHIT is an independent, 501(c)3 nonprofit organization that has been recognized by the U.S. Department of Health and Human Services (HHS) as the official certification body for EHRs since 2006.

CCHIT conducts the certification process by following industry standards for EHRs and checking how suitable EHR are in achieving the meaningful use requirements specified by the HHS. As of today, no dental EHR has undergone this certification process.

Another stumbling block is the way meaningful use has been defined by the Office of National Coordinator for Health Information Technology (ONC).

The idea of meaningful use is to define a set of process measures that reflect good health care practices, for instance, periodically checking the blood pressure for hypertensive patients and monitoring glucose levels of diabetics.

While some meaningful use measures, such as generating problem lists for oral health conditions, maintaining lists of active medications and allergies, and recording primary language, insurance type, gender, vital signs and other patient-specific variables are certainly appropriate for dentistry, many measures only apply to physician or hospital settings.

Unfortunately, the meaningful use measures, as currently defined, include very few criteria that are relevant to oral health. Dentists are unlikely to demonstrate the capability to enter orders through an EHR, perform medication reconciliation, submit information to immunization registries and electronically submit lab reports to public health agencies.

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Thus, in general, meaningful use does not work for dentistry.

Dentists and dental schools also need to have at least 30 percent of their patient population qualify for Medicaid reimbursement or Medicare services.

Very few dentists will qualify based on this criterion. Most likely, it will be those who provide dental care in federally qualified health centers or some dental schools.

So, why would all this matter to us? As our studies have shown, more and more practitioners are adopting electronic patient records for a variety of reasons. Some see them as a more efficient way to manage patient information and their practice.

Others use them to keep track of individual, group and population health outcomes. (What is the average survival time of a veneer for all your patients? A difficult question to answer without an electronic patient record.)

Down the road, more widespread adoption of EHRs in dentistry will enable us to track incidence and prevalence of various dental diseases; identify patients at risk for developing disease; systematically follow up on patients with certain conditions; and expand research through practice-based research networks. This is indeed a missed opportunity.

The HITECH Act clearly shows that oral-health outcomes were not on the radar screen when the legislation was drafted.

The HITECH Act clearly shows that oral-health outcomes were not on the radar screen when the legislation was drafted.

As health-care professionals who have played a major role in improving the oral health of Americans, it is important that we as a community make our voices heard on behalf of our dental care and our patients.

We encourage you to write to the American Dental Association and the Office of the National Coordinator for Health Information Technology (see box at right for complete address and fax information) and your local representatives to ask that dentistry be included in support from the HITECH Act. DT

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Do you need 8-, 10- or 15-megapixels? How to choose a digital camera

By Lorne Lavine, DMD

As a technology consultant, I work with many dentists who have a variety of questions regarding the addition of technology to their dental practices.

Many of the questions are related to topics that I have previously written about in Dental Tribune: an overview of how to decide which technologies to purchase, how to choose dental software, digital radiography, etc.

The topic that seems to receive the most attention, and the most confusion, is digital photography and digital images in general. The sheer number of choices perplexes most dentists.

This two-part article will examine a number of issues that need to be answered when adding digital imaging to the dental practice.

We'll explore:

- the pros and cons of both intraoral and extraoral cameras;
- examine the criteria that dentists should use in picking a digital camera for their office;
- look at the software choices that exist for storing and manipulating these images (part two);
- delve into the myriad of options for digitizing existing non-digital images (in part two);
- choices for storing these images;
- printing images;
- and other options for sharing these images with other people (such as the patient, insurance companies and other dental colleagues).

Intraoral cameras

Intraoral cameras have been used for dental applications since the early 1990s. One of the first products was the AcuCam, made by New Image Industries. At one point, New Image held over 40 percent of the market share for these systems.

For many years, intraoral cameras were the cameras of choice. Although there was a bit of a learning curve, they were relatively easy to master and still have widespread acceptance today. Recent surveys have shown that intraoral cameras are found in about 50 percent of all dental offices, which seems to indicate that they may have reached their peak in this regard.

Anyone that has used an intraoral camera is aware of the advantages that these systems offer.

Most cameras are capable of magnifying images at 40–52x. This can be an invaluable tool in allowing the dentist to see pathology, such as open margins, fractures and caries, which wouldn't easily be seen without this level of magnification.

The ability to have images on a computer monitor screen that is visible to the patient is of great benefit. Most experts agree that one of the keys to improving patient acceptance to our treatment plans is the concept of "co-diagnosis."

In other words, allowing the patient to see the problems that we see will allow them to participate in the diagnosis of their dental problems, and they will then be more inclined to accept our recommendations for treating problems that they may have been previously unaware that they had.

The cameras allow us to have a permanent record of a patient's condition before we begin treatment. This can be quite beneficial for cosmetic cases where we can show patients before and after photos of their teeth.

In addition, for legal reasons, it will often be valuable to have a record of a patient's condition before treatment began, just in case the patient is unhappy with the results and is considering legal action.

The cameras can be used to take photos of X-rays, which frees us from having to send in our original radiographs to the insurance companies. Moreover, adding photo documentation to an insurance claim will often speed up the approval of that claim.

How to evaluate intraoral cameras

When evaluating intraoral cameras, there are a number of factors to consider.

I would highly recommend that anyone considering the purchase of an intraoral camera attend a dental meeting where many of the different vendors will be on hand so that you can evaluate the different aspects of the cameras.

- *Ability to handle multiple views.* According to many experts, there are six standard intraoral camera views that should be evaluated when choosing a camera.

These are divided into intraoral and extraoral views. The intraoral views are the distal of the upper last molar, the buccal of the upper last molar and the lingual surfaces of the lower anterior teeth.

As far as the extraoral shots are concerned, test the camera's ability to take a full lower arch, a full-face photo and a photo of a bitewing radiograph that is being lit by an X-ray view box.

Test all of these shots to see which camera can handle the majority of them with ease.

- *Portability.* Many dentists have large offices and, to save costs, they will consider using a camera that can easily be moved from one operatory to another.

Do not fool yourself into believing that if a camera system is on a large cart that you will be willing to wheel the cart from room to room — I tried it myself years ago and it just doesn't work!

Some of the more popular models that allow for this are manufactured by Digital Doc (Iris.), AcuCam Concept IV (DENTSPLY-GENDEX) and the Claris i310D from Sota Optics.

- *Ease of focus.* Does the camera require manual focus or is it autofocus? Most cameras have an adjustable focus, so you should evaluate how easy it is to change the focus.

The focus should be well labeled, and should have a range of motion that is less than 100 degrees so that you can easily change the focus setting with one hand.

- *Built-in freeze-frame.* Many of the older models do not have this feature, and most people prefer this element to be included with the system.
- *Capture button location.* Some units use a foot pedal to capture individual images, but other models have the capture button right on the handpieces.

For many dentists, this is simply a matter of personal preference, so you should try both types of systems to see which feels most comfortable for you.

- *Single lens system.* Many earlier systems contained two wands, one for true intraoral photos (90 degree lens) and one for extraoral photos (0 degree lens). Many of the newer systems now use one wand for both types of photos.

Because you may want to use the camera to take photos of X-rays on a view box, the key factor is the ability of the camera's built-in light to be turned off when taking these types of photos.

- *Unique features.* Most camera manufacturers will add special features to their systems to differentiate themselves from their competitors.

Some of the features that you will see include flexible cords, extraoral light adjustments, printing from a portable unit, light and color adjustments and image

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AD

Practice transition planning

This is part 2 of a two-part series on this topic

By Eugene Heller, DDS

For most dentists, ownership of their dental practice is the major focus of their energy expenditures, financial situation and professional lives.

Years of blood, sweat and tears, coupled with the relationships formed with both staff and patients, have caused dentists to form a deep-seated emotional attachment to their practice. For many, the dollar value of that practice represents a significant portion of their financial assets.

For the new dentist, there is a definite value in acquiring the patient base that has taken the transitioning dentist years to develop and will provide an immediate and substantial cash flow.

Patients' evaluation of the new dentist

Most senior dentists know and understand that the senior dentist's own patients judge their clinical competence by non-clinical factors, such as personality, gentleness, office appearance, etc. It is generally not possible to assess clinical competence until a year or more of actual clinical procedures performed by the new dentist are reviewed.

Unless the transition is preceded by a period of employment prior to the actual ownership change, senior dentists must understand they will not be able to address the clinical competence issue.

Senior dentists must accept the fact that the only control they have over this subject is the fact that the new dentist has been tested and licensed.

Determining the transition plan

The first step in formulating a transition plan involves an appraisal of the practice. The information gathered and evaluated during the appraisal process will aid in determining available transition options.

These options may include: (1) an outright sale, (2) role reversal sale, (3) partnership, (4) merger or (5) production acquisition transaction.

In addition, the appraisal will typically provide a comparison with other practices involved in transitions, thereby allowing an understanding as to how salable this particular opportunity might be.

Finally, the appraisal should also provide ideas regarding enhancing the value of the practice and its desirability as a transition candidate.

Locating a competent transition consultant

The next step is locating a competent transition consultant. A transition consultant is one who understands the entire transaction, the various types of transitions, contractual matters, the operational issues of running a dental practice and the need to have the relationships of the buyer, seller, staff and patients intact after the deal is done.

The best source for these individuals is word of mouth referrals and/or a recognized reputation. He or she may be a national or regional "transition guru;" the dentist's personal accountant or another accountant who restricts his or her practice to health care providers and is familiar with the health care transition field; or an experienced local dental practice broker.

Some of the dental supply companies also have knowledgeable consultants who have been assisting in transitions for years.

The transition consultant will help the dentist identify various aspects of his or her transition. Questions that need answers include the dentist's financial ability to retire and his or her personal transition goals.

For example, how long does the dentist wish to stay on as an associate and/or remain available to aid in the transition process? What is

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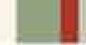

HENRY SCHEIN®
PROFESSIONAL PRACTICE TRANSITIONS

When It's Time to Buy, Sell, or Merge Your Practice

You Need A Partner On Your Side

ALABAMA
Birmingham- 4 Ops, 2 Hygiene Rms, GR $675K #10108
Birmingham Suburb- 3 Ops, 3 Hygiene Rooms #10106
Florence- Beautiful Modern Office, room to expand, GR$656K #10110
CONTACT: Dr. Jim Cole @ 404-513-1573

ARIZONA
Arizona- Doctor seeking to purchase general dental practice. #12110
Shaw Low- 2 Ops, 2 Hygiene Rms, GR in 2007 $645,995
Phoenix- Gen Dentist seeking Practice Purchase Opportunity #12108
Phoenix- 4 Ops - 3 Equipped, GR $515K+, 3 Working Days #12113
North Scottsdale - General Dentist Seeking Practice Purchase Opportunity #12109
Urban Tucson- 6 Ops - 4 Equipped, 1 Hygiene, GR $900K 12112
Tuscon- 1,800 active patients, GR $850K, Asking $650K #12116
CONTACT: Tom Kimbel @ 602-516-3219

CALIFORNIA
Alturas- 3 Ops, GR $611K, 3 1/2 day work week #14279
Atwater- 2 Ops, 1,080 sq ft, GR #177K #14307
El Sorbrante- 5 Ops - 3 Equipped, 1,300 sq ft, GR $350K #14302
Fresno- 5 Ops, 1,500 sq ft, GR $$1,064,500 #14250
Greater Auburn Area- 4 Ops, 1,800 sq ft, GR $763K #14304
Madera- 7 Ops, GR $1,921,467 #14283
Modesto- 12 Ops, GR $1,097,000, Same loc for 10 years #14289
Modesto - 5 Ops, GR 884K w/adj. net income of $346K #14308
N California Wine Country- 4 Ops, 1,500 sq ft, GR $958K #14296
Pine Grove- Nice 3 Op fully equipped office/practice $111,500 #14309
Porterville- 6 Ops, 2,000 sq ft, GR $2.3M #14291
Red Bluff- 8 ops, 2008 GR $1M Hygiene 10 days a wk. #14252
CONTACT: Dr. Dennis Hoover @ 800-519-3458

Dixon- 4 Ops, 1,100 sq ft, GR $122K #14265
Grass Valley- 3 Ops, 1,500 sq ft, GR $714K #14272
Redding- 5 Ops, 2,200 sq ft, GR $1M 14293
Yuba City- 5 ops, 4 days hyg, 1,800 sq ft. #14273
CONTACT: Dr. Thomas Wagner @ 916-812-3255

Rancho Margarita- 4 Ops, 1,200 sq ft, Take over lease #14301
CONTACT: Thinh Tran @ 949-533-8308

CONNECTICUT
Fairfield Area- General practice doing $800K #16106
Southburg- 2 Ops, GR $254K #16111
Wallingford- 2 Ops, GR $600K. #16113
CONTACT: Dr. Peter Goldberg @ 617-680-2930

FLORIDA
Miami- 5 Ops, Full Lab, GR $835K #18117
CONTACT: Jim Puckett @ 863-287-8300

Jacksonville- GR $1.3M 3000 sq.ft., 7 op's, 8 days hygiene #18118
CONTACT: Deanna Wright @ 800-730-8883

GEORGIA
Atlanta Suburb- 3 Ops, 2 Hygiene Rms, GR $863K #19125
Atlanta Suburb- 2 Ops, 2 Hygiene Rms, GR $633K #19128
Atlanta Suburb- 3 Ops, 1,270 sq ft, GR $438,563 #19131
Atlanta Suburb- Pediatric Office, 1 Op, GR $426K #19134
Dublin- GR $1M+, Asking $825K #19107
Macon- 3 Ops, 1,625K sq ft, State of the art equipment #19103
North Atlanta- 3 Ops, 3 Hygiene, GR $678K+ #19132
Northeast Atlanta- 4 Ops, 1 Hygiene, GR $607K #19129
Northern Georgia- 4 Ops, 1 Hygiene, Est. for 43 years #19110
South Georgia- 2 Ops, 3 Hygiene Rms, GR $722K+ #1913
CONTACT: Dr. Jim Cole @ 404-513-1573

ILLINOIS
Chicago- 4 Ops, GR $709K, Sale Price $461K #22126
1 Hr SW of Chicago- 5 Ops, 2007 GR $440K, 28 years old #22123
Chicago- 3 Ops, GR $600K, 3 day work week #22119
Galena- GR180K, located in Historic Bed & Breakfast Community #22129
Western Suburbs- 5 Ops, 2-2,000 sq ft, GR Approx $1.5M #22120
CONTACT: Al Brown @ 630-781-2176

MARYLAND
Southern- 11 Ops, 3,500 sq ft, GR $1.8M #29101
CONTACT: Sharon Mascetti @ 484-788-4071

MASSACHUSETTS
Boston- 2 Ops, GR $252K, Sale $197K #30122
Boston Southshore- 3 Ops, GR $300K #30123
North Shore Area (Essex County) 3 Ops, GR $500K+ #30126
Western Massachusetts- 5 Ops, GR $1M, Sale $514K #30116
CONTACT: Dr. Peter Goldberg @ 617-680-2930

Middle Cape Cod- 6 Ops, GR $900K, Sale price $677K #30124
Boston- 2 Ops, 1 Hygiene, GR $302K #30125
Middlesex County- 7 Ops, GR Mid $500K #30120
New Bedford Area- 8 Ops, $628K #30119
CONTACT: Alex Litvak @ 617-240-2582

MICHIGAN
Suburban Detroit- 2 Ops, 1 Hygiene, GR $213K #31105
CONTACT: Dr. Jim David @ 586-530-0800

MINNESOTA
Crow Wing County- 4 Ops #32104
Fargo/Moorhead Area- 1 Op, GR $185K. #32107
Central Minnesota- Mobile Practice. GR $730K+ #32108
Twin Cities- Move in, practice immediately GR $800K #32110

CONTACT: Mike Minor @ 612-961-2132

MISSISSIPPI
Eastern Central Mississippi- 10 Ops, 4,685 sq ft, GR $1.9M #33101
CONTACT: Deanna Wright @ 800-730-8883

NEVADA
Reno- Free Standing Bldg.,1500 Sq Ft, 4 Ops, GR 763K #37106
CONTACT: Dr. Dennis Hoover @ 800-519-3458

NEW JERSEY
Marlboro- Associate positions available #39102
Mercer City- 3 Ops, Good Location, TurnKey, GR $191K - #39112
CONTACT: Sharon Mascetti @ 484-788-4071

NEW YORK
Brooklyn- 3 Ops (1 Fully equipped), GR $175K #41113
Woodstock- 2 Ops, Building also available for sale, GR $600K #41112
CONTACT: Dr. Don Cohen @ 845-460-3034

Syracuse- 4 Ops, 1,800 sq ft, GR over $700K #41107
CONTACT: Marty Hare @ 315-263-1313

New York City - Specialty Practice, 3 Ops, GR $502K #41109
CONTACT: Richard Zalkin @ 631-831-6924

NORTH CAROLINA
Charlotte- 7 Ops - 5 Equipped #42142
Foothills- 5 Ops #42122
Near Pinehurst- Dental emerg clinic, 3 Ops, GR in 2007 $373K #42134
New Hanover City- A practice on the coast, Growing Area #42145
Raleigh, Cary, Durham- Doctor looking to purchase #42127
CONTACT: Barbara Hardee Parker @ 919-848-1555

OHIO
Medina- Associate to buy 1/3, rest of practice in future. #44150
North Central- GR 619K, 4 Ops, Well Established #44159
CONTACT: Dr. Don Moorhead @ 440-823-8037

PENNSYLVANIA
Northeast of Pittsburgh- 3 Ops, Victorian Mansion GR $1.2M+ #47140
CONTACT: Dan Slain @ 412-855-0337

Lackawanna County- 4 Ops, 1 Hygiene, GR $515K #47138
Chester County- High End Office, 4 ops, Digital, FFS + a few PPO's #47141
Philadelphia County (NE)- 4 Ops, GR $500K+, Est 25 years #47142
CONTACT: Sharon Mascetti @ 484-788-4071

RHODE ISLAND
Southern- 4 Ops, GR $750K, Sale $486K #48102
CONTACT: Dr. Peter Goldberg @ 617-680-2930

SOUTH CAROLINA
HHI- Dentist seeking to purchase a practice producing $500K/year #49103
CONTACT: Scott Carringer @ 704-814-4796

Columbia- 7 Ops, 2200 sq ft, GR $678K #49102
CONTACT: Jime Cole @ 404-513-1573

TENNESSEE
Elizabethon- GR $333K #51107
Memphis - Large profitable practice GR $2M+ #51112
Suburban Memphis- Leading practice in area. GR $1M #51113
CONTACT: George Lane @ 865-414-1527

TEXAS
Houston Area- GR $1.1M w/adjusted net income over $500K #52103
CONTACT: Deanna Wright @ 800-730-8883

VIRGINIA
Greater Roanoke Valley- 2500 sq. ft., GR $942K updated equipment #55111
CONTACT: Bob Anderson @ 804-640-2373

For a complete listing, visit www.henryschein.com/ppt or call 1-800-730-8883

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