SPECIAL AGD EDITION

DENTAL TRIBUNE

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

JULY 2009 www.dental-tribune.com VOL. 4, NOS. 15 & 16

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Gums gardening
Antimicrobials enhancing the outcomes of nonsurgical periodontal therapy.
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Treatment acceptance: could have, should have, would have

By Sally McKenzie, CMC

When it comes to treatment acceptance — or lack thereof — it seems as though a lot of time and energy are wasted on that familiar trio "could have, should have and would have." You spend hours analyzing how things could have been if you had just used a different approach. How things should have been if you had just taken more time to educate the patient on why the treatment was necessary. How things would have been if you had listened more carefully to the patient.

Oftentimes, dental teams mistakenly view the treatment presentation as a one-time event that is a make-it-or-break-it situation. You either win or you lose based on that 15 minute song and dance. In reality, patient treatment acceptance begins long before you sit across from him or her eager to present the best that your dentistry has to offer. Consider our patient, Mary, who goes to Dr. Smith's office.

"Dr. Smith's office is great for cleanings and that, but he always seems so rushed. He takes a quick look at my teeth after the hygienist cleans them and sends me on my way. I want to ask about veneers, but I never feel like I should bother

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Journeés dentaires internationales du Québec

Participants in a hands-on workshop at the Journeés dentaires internationales du Québec, held May 23–26 in Montreal, learn about periodontics and esthetics. Read the event review online at www.dental-tribune.com/articles/content/scope/news/region/usa/id/428. *(Dental Tribune photo/Fred Michmershuizen)*

Fetter retires from National Museum of Dentistry

Rosemary Fetter, executive director of the National Museum of Dentistry for the past 10 years, is retiring.

"We have benefited enormously from her commitment and passion for our museum," said Board of Visitors Chair Michael Sudzina. "Under her leadership, the National Museum of Dentistry has become the premier dental museum in the world."

During Fetter's tenure, the National Museum of Dentistry became an affiliate of the Smithsonian Institution and was designated by Congress as the official museum of the dental profession in the United States.

"I leave with a tremendous sense of pride and appreciation for the work of our friends, supporters and staff in helping to bring the museum to this level of accomplishment," said Fetter, whose retirement is effective June 30.

The museum is located on the campus of the University of Maryland Baltimore, home of the world's first dental school.

To learn more about the museum, visit *www.smile-experience.org*. DT

(Source: National Museum of Dentistry)

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Dentists and cardiologists should work together to prevent disease, experts say

By Fred Michmershuizen, Online Editor

The cooperation between the cardiology and periodontal communities is an important first step in helping patients reduce their risk of these associated diseases, according to a consensus paper developed by the American Academy of Periodontology (AAP) and The American Journal of Cardiology (AJC).

"Inflammation is a major risk factor for heart disease, and periodontal disease may increase the inflammation level throughout the body, said Kenneth Kornman, DDS, PhD, editor of the Journal of Periodontology and a co-author of the consensus report. "Since several studies have shown that patients with periodontal disease have an increased risk for cardiovascular disease, we felt it was important to develop clinical recommendations for our respective specialties. Therefore, you will now see cardiologists and periodontists joining forces to help our patients."

The paper is published concurrently in the online versions of the Journal of Periodontology (JOP), the official publication of the AAP, and AJC, a peer-reviewed journal circulated to 30,000 cardiologists.

Developed in concert by cardiologists and periodontists, the paper includes clinical recommendations for both medical and dental professionals to use in managing patients living with, or who are at risk for, either disease.

As a result of the paper, cardiologists may now examine a patient's mouth, and periodontists may begin asking questions about heart health and family history of heart disease.

Specific clinical recommendations include the following:

• Patients with periodontitis who have one known major atherosclerotic cardiovascular disease (CVD) risk factor — such as smoking, immediate family history for CVD or history of dyslipidemia — should consider a medical evaluation if they have not done so within the past 12 months.

• A periodontal evaluation should be considered in patients with atherosclerotic CVD who have signs or symptoms of gingival disease, significant tooth loss or unexplained elevation of hs-CRP or other inflammatory biomarkers.

• A periodontal evaluation of patients with atherosclerotic CVD should include a comprehensive examination of periodontal tissues, as assessed by visual signs of inflammation and bleeding on probing; loss of connective tissue attachment detected by periodontal probing measurements, and bone loss assessed radiographically. If patients have untreated or uncontrolled periodontitis, they should be treated with a focus on reducing and controlling the bacterial accumulations and eliminating inflammation.

• When periodontitis is newly diagnosed in patients with atherosclerotic CVD, periodontists and physicians managing patients' CVD should closely collaborate in order to optimize CVD risk reduction and periodontal care.

The clinical recommendations were developed at a meeting held in early 2009 of top opinion leaders in both cardiology and periodontology. The consensus paper also summarizes the scientific evidence that links periodontal disease and cardiovascular disease and explains the underlying biologic and inflammatory mechanisms that may be the basis for the connection.

Although additional research will help identify the precise relationship between periodontal disease and cardiovascular disease, recent emphasis has been placed on the role of inflammation — the body's reaction to fight off infection, guard against injury or shield against irritation. While inflammation initially intends to have a protective effect, untreated chronic inflammation can lead to dysfunction of the affected tissues, and therefore to more severe health complications.

Cardiovascular disease, the leading killer in the United States, is a major public health issue contributing to 2,400 deaths each day. Periodontal disease, a chronic inflammatory disease that destroys the bone and tissues that support the teeth, affects nearly 75 percent of Americans and is the major cause of adult tooth loss. While the prevalence rates of these disease states seem grim, research suggests that managing one disease may reduce the risk for the other.

"Both periodontal disease and cardiovascular disease are inflammatory diseases, and inflammation is the common mechanism that connects them," said Dr. David Cochran, DDS, PhD, president of the AAP and chair of the Department of Periodontics at the University of Texas Health Science Center at San Antonio.

"The clinical recommendations included in the consensus paper will help periodontists and cardiologists control the inflammatory burden in the body as a result of gum disease or heart disease, thereby helping to reduce further disease progression, and ultimately to improve our patients' overall health. That is our common goal." DT

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The World's Dental Newspaper · US Edition

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Endo is on the menu at Dental Study Club of N.Y.

By Fred Michmershuizen, Online Editor

When it comes to stimulating dinner conversation, root canal therapy is not typically considered the most appetizing topic.

That is unless the room happens to be filled with dentists who want to be the very best. Add to that a dynamic and entertaining speaker with years of experience in proper materials and methods of achieving predictable success in endodontics, and you have a most memorable evening.

Dr. Jeffrey Linden, a New York City-based endodontist, educator and lecturer, presented "Revelations in Endodontics: Foundations & Clinical Applications" at the Dental Study Club of New York's meeting in May, held at the Harvard Club. In attendance were 46 dentists, including both specialists and general practitioners.

Linden's presentation was entertaining as well as educational. Included in his slide presentation were pictures of Marilyn Monroe — who, lecture attendees learned, has a figure quite similar to the often-troublesome apical third of a root. Linden showed attendees how to use rotary instruments to properly clean and shape such shapely anatomy. He also discussed irrigation and obturation techniques.

Made up of about 100 members, the Dental Study Club of New York is an active, thriving group of dental professionals who are dedicated to ongoing education and collaboration. Each monthly meeting features a different topic and speaker. DT

Dr. Jeffrey Linden, left, is welcomed to the Dental Study Club of New York by Dr. Steven J. Mondre and Dr. Michaelt Leifert. (Dental Tribune photo/Fred Michmershuizen)

www.dental-tribune.com

Missed the last edition of Dental Tribune? You can now read some of its content online!

Leadership esentials for the 'rookie'
By Sally McKenzie, CMC
www.dental-tribune.com/articles/content/scope/specialities/section/practice_management/id/432

Informatics and IT in dentistry: a look forward
By Dr. John O'Keefe
www.dental-tribune.com/articles/content/scope/specialities/section/practice_management/id/365

Cosmetic periodontal surgery: pre-prosthetic soft-tissue ridge augmentation (Part 1)
By David Hoexter, BA, DMD, FACD, FICD
www.dental-tribune.com/articles/content/scope/specialities/section/cosmetic_dentistry/id/434

White wine can increase tooth staining
Source: New York University
www.dental-tribune.com/articles/content/scope/news/region/usa/id/435

Here's some other online content that might be of interest to you ...

Interview with Dr Jolán Bánóczy, Hungary, about the basics of dentine hypersensitivity
By Claudia Salwiczek, DTI
www.dental-tribune.com/articles/content/id/345/scope/news/region/europe

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him with questions," Mary says.

Dr. Smith, meanwhile, is befuddled when patients don't accept recommended treatment. Yet he gives little thought to the manner in which he and his team build, or erode, the foundation upon which successful treatment acceptance is based.

In Mary's case, Dr. Smith doesn't realize that he is undermining Mary's trust in his care. Mary will be far less likely to proceed with recommended treatment because Dr. Smith has created the impression that he is always in hurry to get to the next patient, which makes her feel uneasy and unimportant. Worse yet, Mary is interested in a certain procedure but doesn't even feel comfortable asking about it.

It's a matter of trust

Certainly, patients trust you enough to come in for routine appointments. But when the patient needs or wants care that goes beyond "routine" procedures, have you and your team instilled in the patient the confidence, the dental education and the necessary trust in you and your practice overall for him or her to accept the treatment recommended?

In some cases, patients are motivated to pursue treatment merely because they seldom question recommendations from their health care providers. But those patients are growing fewer and farther between each year.

Most patients today base major decisions, such as extensive dental treatment, on multiple factors: full comprehension of the need for treatment; the importance of the procedure to them in terms of quality of life, esthetics or health; possible ramifications if they choose to procrastinate or elect an alternative procedure; and how they feel about the practice as a whole.

Recommendation acceptance

When it comes to treatment presentation, we find that most dentists and teams understand the fundamentals of the concept, but they forget that patients base their recommendation acceptance on multiple factors.

In addition to always treating every patient as if she or he is the most important person in the room with you, and always taking the time to solicit questions from the patient, consider a few other ways in which you build trust with every patient and at every opportunity.

Be candid. Most patients are aware of some general risks in treatment so they are waiting for you to be frank about what, if anything, they might be faced with as a result of the treatment. If they are given advantages and disadvantages, research shows that patients are more willing to trust you to deliver their care. Patients always feel better when they know the benefits and risks of proposed treatment.

'don't make the patient feel that his mouth is a 'mess' '

Always speak at the patients' level of understanding. Jargon and "$10 words" can confuse patients and make them uncomfortable because they don't understand, but they likely won't ask you what you mean.

Exhibit clear confidence in your recommended course of treatment. A personal testimonial about recent treatment for another patient and the results obtained, for example, underscores that sense of security. It demonstrates that you have no doubt that you will get a good result for this patient.

Be aware of the perception of "fairness." Many issues having to do with trust are linked to the patients' perception of the value they are receiving. Studies show that patients avoid dental treatment due to cost more than pain. Yet, if they feel that the costs measure up to the service received, there is no complaint. Many patients will not question fees if the practice has demonstrated that they can deliver superior service. From the first phone call to dismissal, consistently demonstrate the "value" for services that the patient is receiving.

Many patients today expect more than just a routine visit. They are smart, savvy and are much more aware of recent advances in dental care and treatment options than patients 20 years ago. Numerous patients would love to change something about their smile or improve their oral health, but few will verbalize those desires without prompting. Others have concerns, but don't want to appear foolish in raising them. Yet, if new and existing patients feel that the dentist and dental team are sincerely interested in their needs, wants and concerns, they are far more likely to be open to the treatment recommended.

Encouraging acceptance

Follow these steps to set the tone for patient treatment acceptance.

- *Create a comfortable, nonrushed environment when explaining treatment.* Don't have the schedule booked so tight that you are perceived as being in a rush. Patients need to feel that they are important

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and worthy of your time.

• *Explain in simple language the reasons the procedures are necessary.* Choose language that fits the patients educational level of understanding and speak slowly, using pictures to illustrate.

• *Explain the steps of the procedures and how many appointments and how long each appointment will take.* Explain to the patient how you will make her/him comfortable during treatment and what options are available, such as anesthetic.

• *Ask the patient questions to detemine if she/he has any false ideas about treatment.* (Many patients still think that root canal therapy involves removing the roots.) Use educational tools, such as chairside videos or other visual aids. When using video or other educational aids, summarize what the patient has viewed and ask if there are any areas that need further explanation.

• *Be empathetic to the patient's concerns about the condition of the teeth.* Don't make the patient feel that his/her mouth is a "mess." Patients who have postponed dental care are often embarrassed and don't want to be perceived as neglectful or hopeless. Encouragement coupled with kind words can build trust and respect.

• *Explain alternatives to the treatment.* Make sure the benefits and the possible risks to the procedures are understood. Informed consent in writing is necessary when there are risks and when the outcome could be less than favorable.

• *Look the patient in the eye when discussing treatment.* Sit at the same level as the patient and lean slightly forward to show interest and care. You will be able to listen to and observe the patient's response more readily.

• *Smile and nod your head in understanding as the patient responds to the presentation.* This is proof to the patient that you are truly listening to each word said.

• *Never turn away from the patient while she/he is speaking.* Not only is this rude, but it also shows that you are not listening to what the patient is telling you.

Certainly, presenting treatment to patients requires skill and understanding of patients' needs. Many people learn these skills by trial and error, which can be quite costly. If treatment acceptance is a struggle among either new or existing patients, or both, it's time to find out exactly where this critical system is breaking down. DT

About the author

Sally McKenzie is CEO of McKenzie Management, which provides success-proven management solutions to dentistry nationwide. She is also editor of The Dentist's Network Newsletter, *www.thedentistsnetwork.net*; the e-Management Newsletter from *www.mckenziemgmt.com*; and The New Dentist™ magazine, *www.thenewdentist.net*. She can be reached at (877) 777.6151 or sallymck@mckenziemgmt.com.

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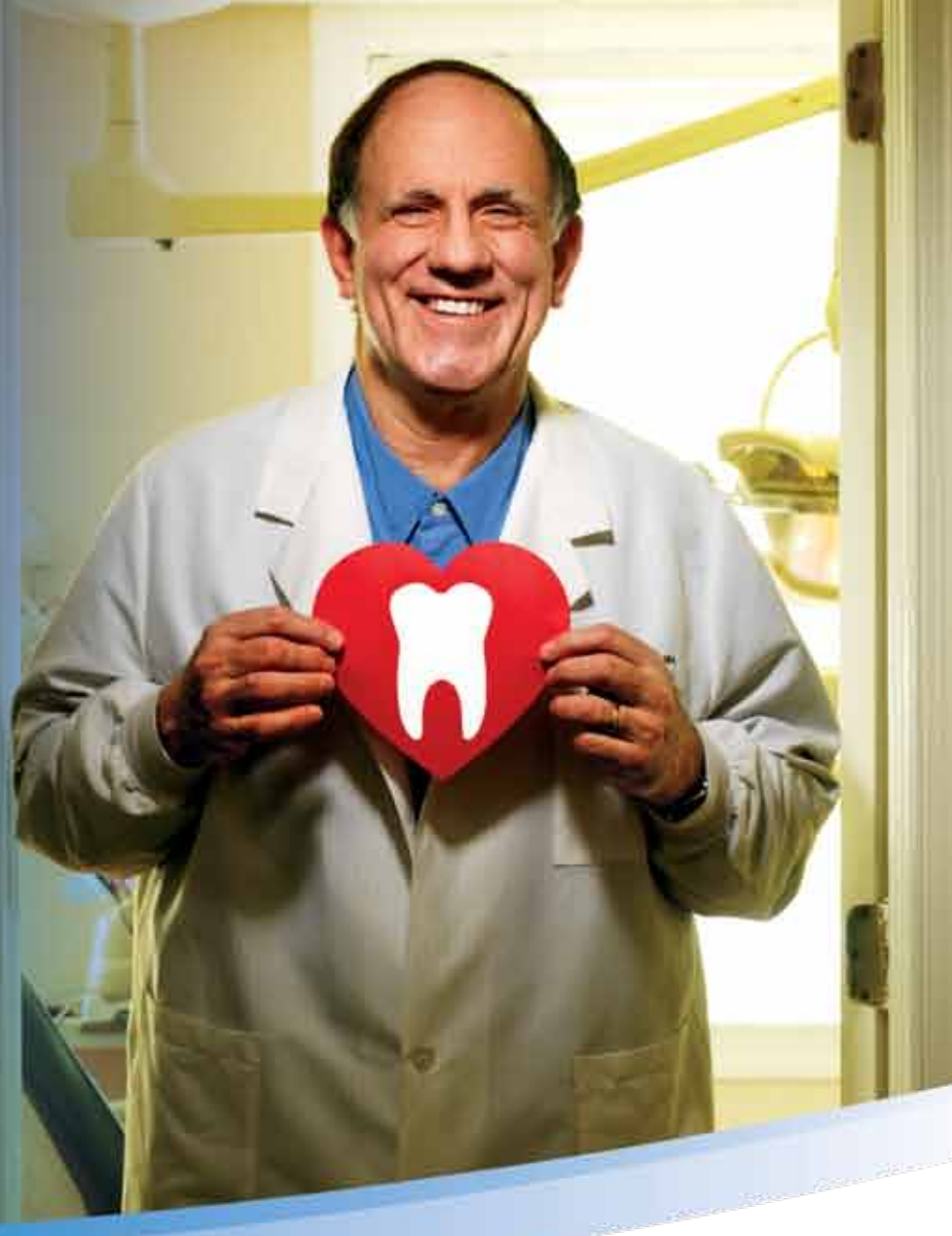

Dr. Neil Gottehrer knows the power of the toothbrush. Not only can it destroy plaque build-up and protect you from gingivitis, but it may also be a vital weapon for fighting cardio-vascular disease. His research suggests that with a mixture of power brushing, irrigating and rinsing, patients can reduce their periodontal risks associated with heart disease – which is great news for the eighty million Americans suffering from it. But, to give patients the best care possible, their dentists and their doctors have to communicate. That's why Dr. Gottehrer created the Stat-Ck™ periodontal risk exam. During this exam, a patient's dental health is examined and assigned a letter grade – A through F. Like any test, failing grades may help warn dentists and physicians of potential heart risks. Dr. Gottehrer works to give people better smiles and healthier hearts, which is why Smile PA is an Advance Practice.

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Five of the top 10 reasons why associateships fail

By Eugene W. Heller, DDS

The "American Dream" is still to own a home. The "Dentist's Dream" continues to be the ownership of a practice. Thirty years ago, the dream was to graduate from dental school, buy equipment, hang out a shingle and start practicing. Today the road to ownership is a little different.

Due to extensive debt, most new graduates enter practice as associates to improve their clinical skills, increase their speed and proficiency and learn more about the business aspects of dentistry.

Most hope the newfound associateship will lead to an eventual ownership position. Instead, many find themselves building up the value of their host dentist's practice, only to be forced to leave. This forced departure is the result of a non-compete agreement when the promised buy-in/buy-out doesn't occur.

The following reveal the first five of the top 10 reasons many associateships fail to result in ownership or partnership.

Reason No. 1: purchase price

If the purchase price has not been determined before the commencement of employment, the parties find themselves on different ends of the spectrum as to what the practice is worth and what the buy-in price should be.

When purchase price is established before the commencement of employment, three out of four associateships lead to the intended equity position.

Conversely, if the purchase price has not been determined, nine out of 10 associateships lead to termination without achieving the ownership intended or promised.

Reason No. 2: the details

The more items discussed and agreed to in writing beforehand, the better the chance of a successful equity ownership occurring as planned.

The written instruments should be two specific documents — an Employment Agreement detailing the responsibilities of each party for employment and a Letter of Intent detailing the proposed equity acquisition.

Reason No. 3: insufficient patient base

Approximately 1,000–1,200 active patients are required per dentist in a dental practice. If the senior dentist does not intend to restrict or cut back on his/her number of available clinical treatment hours, then the conversion from a one-dentist to a two-dentist practice requires an active patient base of approximately 1,400–1,800 patients and a new patient flow of 25 or more new patients per month.

Many senior dentists count their number of active patients by counting the number of patient charts on a wall. However, the best way to estimate the active number of patients involves utilizing the hygiene recall count.

Insufficient numbers of patients and/or an insufficient new patient flow signals that all expenses relating to the new dentist are coming directly out of the bottom line. The practice then begins to experience financial pressure.

Creation and maintenance of a sufficient patient base is an extremely important aspect of the business. If the senior dentist is nearing retirement with the intent that, within one to two years, the senior dentist will turn over total ownership of the practice and intends to cut back shortly after the beginning of the second dentist's employment, this problem is not as critical.

Often the senior dentist brings in an associate dentist as the answer to increasing business. A practice with insufficient new patient flow that experiences the addition of a new practitioner may result in termination of employment for the associate.

Reason No. 4: incompatible skills

The incompatibility in clinical skills between practitioners may include the possibility of one practitioner's skill level being below standard, but it may also include different practice philosophies. On the surface, it would appear that having different skill levels and philosophies might be desirable. In reality, the patient base available to the younger practitioner may not lend itself to various types of dentistry.

Most hope the newfound associateship will lead to an eventual ownership position. Instead, many find themselves building up the value of their host dentist's practice, only to be forced to leave.

Reason No. 5: timeframe

The failure to identify when the buy-in or buy-out is to occur and when to execute it can result in failure to achieve an ownership status.

The Letter of Intent may have stated that the buy-in was to occur in one to two years, but certain behaviors and signs during the continuing employment relationship might give an indication that the senior doctor is having difficulty honoring the intended buy-out or that the associate does not feel ready to consummate the transaction within the original outlined timeframe.

Either position might result in the demise of the buy-in as involved parties lose patience over such delays.

Summary

This article has been aimed primarily at a one-dentist practice evolving to a two-dentist practice; however, the issues apply equally to larger group practices.

One-to-two-year associateships with the senior dentist retiring at the end of the associateship and a three-to-five-year partnership ending with the new dentist purchasing the remaining equity position of the senior dentist at the end of five years can also benefit from the insights provided in this article.

Unfortunately, nothing can guarantee a successful outcome will occur. However, by identifying the potential pitfalls at the beginning of the relationship, chances of success can be greatly improved. DT

Look for the remaining five reasons in the next edition of Dental Tribune.

About the author

Dr. Eugene W. Heller is a 1976 graduate of the Marquette University School of Dentistry. He has been involved in transition consulting since 1985 and left private practice in 1990 to pursue practice management and practice transition consulting on a full-time basis. He has lectured extensively to both state dental associations and numerous dental schools. Heller is presently the national director of Transition Services for Henry Schein Professional Practice Transitions. For further information, please call (800) 730-8883 or send an e-mail to hsfs@henryschein.com



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Atlanta Suburb- 3 Ops, 1,270 sq ft, GR $438,563 #19131
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INDIANA
St. Joseph County- GR $270K on a 3 1/2 work week. #23108
CONTACT: Deanna Wright @ 800-730-8883

KENTUCKY
Eastern Kentucky-3 Ops, Good Hyg. Program, Growth Potent.#26101
CONTACT: George Lane @ 865-414-1527

MAINE
Auburn- Looking for Assoc.GR $2 Million #28111
Lewiston- GP Plus real estate, state of the art office #28107
CONTACT: Dr. Peter Goldberg @ 617-680-2930

MARYLAND
Southern- 11 Ops, 3,500 sq ft, GR $1,840,628 #29101
CONTACT: Sharon Mascetti @ 484-788-4071

MASSACHUSETTS
Boston- 2 Ops, 2 Hygiene, GR $650K. #30113
Boston- 2 Ops, GR $252K, Sale $197K #30122
Lowell- GR $400K #30106
Middlesex County- 7 Ops, GR Mid $500K #30120
Somerville- GR $700K
Sturbridge- 5 Ops, GR $1,187,926 #30105
Western Massachusetts- 5 Ops, GR $1 Mill, Sale $512K #30116
CONTACT: Dr. Peter Goldberg @ 617-680-2930

New Bedford Area- 8 Ops, $650K #30119
CONTACT: Alex Litvak @ 617-240-2582

MICHIGAN
Suburban Detroit- 2 Ops, 1 Hygiene, GR $325K #31105
Grand Rapids Kentwood Area- 3 Ops, Building available. #31102
CONTACT: Dr. Jim David @ 586-530-0800

MINNESOTA
Crow Wing County- 4 Ops #32104
Hastings- Nice suburban practice with 3 Ops #32103
Minneapolis- Looking for associate #32105
Rochester Area- Looking for associate #32106
CONTACT: Mike Minor @ 612-961-2132

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

NEVADA
Carson City- 5 Ops, 2 Hygiene, 2,200 sq ft, GR $1 Mill #37105
CONTACT: Dr. Dennis Hoover @ 800-519-3458

NEW HAMPSHIRE
Rockingham County- 2 Ops, Home/Office #38102
CONTACT: Dr. Thomas Kelleher @ 603-661-7325

NEW JERSEY
Jersey City- 2 Ops, GR $216K, 2 days a week #39107
CONTACT: Dr. Don Cohen @ 845-460-3034
Marlboro- Associate positions available #39102
CONTACT: Sharon Mascetti @ 484-788-4071

NEW YORK
Bronx- GR $1 Million, Net over $500K #41105
Brooklyn- 4 Ops, 2 Hygiene rooms, GR $1 Million, NR $600K #41108
Dutchess County- 80% Insurance, GR $200K #41106
CONTACT: Dr. Don Cohen @ 845-460-3034
Oneonta- 3 Ops, Approx 1200sq ft. #41101
CONTACT: Deanna Wright @ 800-730-8883
Putnam County-6 Ops, GR $1.7 Million #41102
CONTACT: Dr. Peter Goldberg @ 617-680-2930
Syracuse Area- 6 Ops all computerized, Dentrix and Dexis #41104
CONTACT: Donna Bambrick @ 315-430-0643
Syracuse- 4 Ops, 1,800 sq ft, GR in 2007 over $700K #41107
CONTACT: Richard Zalkin @ 631-831-6924
New York City - Specialty Practice, 3 Ops, GR $400K #41109
CONTACT: Marty Hare @ 315-263-1313

NORTH CAROLINA
Charlotte- 7 Ops - 5 Equipped #42142
Foothills- 5 Ops #42122
Foothills- 30 minutes from Mtn. resorts #42117
Near Pinehurst- Dental emerg clinic, 3 Ops, GR in 2007 $373K #42134
New Hanover Cty- A practice on the coast, Growing Area #42145
Raleigh, Cary, Durham- Doctor looking to purchase #42127
Wake County- 7 Ops, High end office #42123
Wake County- Beautiful Cutting Edge Digital Office #42139
Wake County- 4 Ops #42144
CONTACT: Barbara Hardee Parker @ 919-848-1555

OHIO
Akron- Excellent Opportunity, 2,300 Active Pts, 6 days of Hyg. #44141
Columbus- 4 Ops, FFS practice for sale #44125
Darke County- 35 yrs, 1200 Act. Pts, GR $330K #44139
Dayton- 10 Ops, Associateship with buy-in option #44121
North Eastern- 2 Yr. Old Facility, State of Art Tech. GR $830K #44143
North of Dayton- 6 Ops, 15 days of hygiene/wk #44124
South of Dayton- 6 Ops, 4,000 sq ft, GR $3 Million Plus #44145
Toledo- 2 Ops, GR $225K, Est in 1988 #44147
CONTACT: John Jonson @ 937-657-0657

Medina- Associate to buy 1/3, rest of practice in future. #44150
CONTACT: Dr. Don Moorhead @ 440-823-8037

PENNSYLVANIA
Beaver County- Ortho practice for sale. #47118
Mon Valley Area- Practice and building for sale #47112
Pittsburgh Area - High-Tech, GR $425K #47135
Pittsburgh- 4 Ops, GR over $900K #47114
70 Miles Outside Pittsburgh- 4 Ops, GR $1 Million #47137
Northeast of Pittsburgh- 3 Ops, Victorian Mansion GR $1.2+ Mill #47140
Robinson Township Area- GR $300K #47108
Somerset County- 3 Ops, 2006 GR $275K+ #47122
Southside & Downtown Pittsburgh- 2 practices for sale. #47110
CONTACT: Dan Slain @ 412-855-0337

Dauphin County- 6 Ops, GR over $1,100K, Sale price $718K #47133
Harrisburg- 3 Ops, GR $383K, Listed at $230K #47120
Lackawanna County- 4 Ops, 1 Hygiene, GR $515K #47138
Lancaster County- Associate positions available #47116
West Chester- 3 Ops, 10 years old, asking $225K. #47134
CONTACT: Sharon Mascetti @ 484-788-4071

RHODE ISLAND
Southern Rhode Island- 4 Ops, GR $750K, Sale $456K #48102
CONTACT: Dr. Peter Goldberg @ 617-680-2930

SOUTH CAROLINA
Charleston Area- 8 Ops fully equipped #49101
Columbia- 7 Ops, 2200 sq ft, GR $678K #49102
CONTACT: Dr. Jim Cole @ 404-513-1573

TENNESSEE
Chattanooga- For sale #51106
Elizabethon- GR $400K #51107
Loudon- GR $600K #51108
Spring Hill- 4 Ops, Good Hyg. Program, Fast Growing Town #51103
Suburban Knoxville- 5 Ops #51101
CONTACT: George Lane @ 865-414-1527

VIRGINIA
Burgess- General practice #55101
Danville Area- 3 Ops #55105
Newport News- 2 Ops, GR $804,433, Est 1980 #55109
CONTACT: Bob Anderson @ 804-640-2373

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