1 **The Patient Visit**

2

The patient visit
is the hub around which
the success of a dental practice
revolves.

3

• The efficiency of the dental office,
• the profitability of the practice,
• the stress level of the work environment.

all correlate with the smooth handling of
the patient visit.
•

4

Patients generally think they have been to a good dentist

• if the treatment didn't hurt,
• and the work holds up for a reasonable length of time.
•

5

The opportunity
to build a highly successful practice
lies in all other areas of the patient's contact with the office.

6

The key is not how to get people to come to you.

It is what you do once they get there.

7

I want everyone that leaves my office so impressed they can't wait to tell their friends, relatives, neighbors and strangers that I should be their dentist.

8

New patients join my practice through one of two types of initial appointments.

•

9

The first visit may be for an examination.
This is usually done in conjunction with the first hygiene appointment.

When the first available hygiene appointment is too far off in the future the exam is done alone so that other treatment can begin.

10

For those patients presenting for treatment of a specific problem the first appointment is dedicated to that problem.
The comprehensive exam is deferred to another time.

Emergency patients phoning are asked to come right in.

11

I will take a chance on getting paid for the first appointment.

I do not want anyone leaving my office at this point because they don't have cash on them, don't have an insurance form with them or forgot their cheque book or credit cards at home.

•

12

I try not to keep any patient waiting beyond their appointed time. . .

By concentrating on the scheduled ending rather than beginning time of the appointment I am usually able to meet this goal.

13

Any patients that will be kept waiting receives

•

- an apology,
- an explanation of why they are being kept waiting
- and a realistic estimate of how long it will be before they are seen.

14

They are also given the opportunity to reschedule their treatment if they are unable or unwilling to wait.

15

When I come in I introduce myself using my first and last name.

The patient is then free to address me by my first name or as Dr. Antel.

They establish the level of formality not me.

16

I ask the patient what I can do for them and

let them talk.

•

17

I find out their chief complaint.

More interesting and helpful,
I find out about their attitudes, values and dental awareness in how they describe what has brought them to my office.

18

I follow this with one or two basic diagnostic questions.
The information necessary to diagnose their problem will be ascertained later.
At this point I just want to avoid appearing to quickly change the subject from what they are saying.

19

The medical history comes next.
I use a written questionnaire and discussion.

20

In discussion I can

•

- see body language and facial expressions
  hear their tone of voice
- generally get a sense if something is being held back and needs further probing to get accurate information.

21

The discussion is also another chance to get to know the patient and let them get to know me prior to starting treatment.

22

Following the medical history

I move on to the dental history.

23

Here I get a sense of what problems I may have to avoid or watch out for.

24

Here I get a sense of what problems I may have to avoid or watch out for.

- I also get great gossip about what has gone on in other dental offices.

25

Most importantly
I get a good idea of their
perspective of dentistry.

26

- At this point the patient may feel extra attention has been paid to them over and above what they have seen in other offices,

27

but the topics are nothing new to them.

28

When I get into a discussion of their apprehension about dental treatment

it is usually the first time they have heard such a thing.

29

It is often the first time
they have felt someone
really cared
about this aspect of their treatment

30

This discussion gives me a very good idea
of how to treat this person in a way

•
• that decreases their apprehension during treatment
•
• and locks them in as a long term patient of mine.
•

31

I explain that not only does
their caries, periodontal disease, etc
need to be treated,

equally important
their apprehension must be treated.

32

Otherwise the neglect
that was a major contributing factor
to their dental disease
will continue.

33

We begin to discuss
the coping strategies

the patient will need
during treatment.

34

The patient benefits by having a major barrier to treatment removed.

I benefit because they will be seeking the care they require in my office.

•

35

Once their treatment for the day has been completed I sit the patient up and ask them to rest for a few minutes while I make a few notes in their chart.

•

36

The front desk staff should not have to spend time
• looking up procedure codes
• interpreting multiple abbreviations all meaning the same thing
• reading through the chart looking for information
while the patient is anxiously waiting to leave the office.

37

Beside treatment it is important to note
• the length of time to be booked for the following appointment,
• who the next appointment should be booked with
• and what it is for.

38

When I finish entering my chart notes I sit down facing the patient. I review
• what has been done,
• what post treatment home care is necessary
• and what signs and symptoms can be expected.

39

Before the patient leaves the operatory I discuss
• *what treatment is planned for the following appointment,*

- *the importance of that treatment*
- *and the consequences of delaying or avoiding treatment.*

40

- I accompany the patient to the front desk.
-
- At the reception desk I will explain to the front office staff what is required.
-
- I then tell the patient the receptionist will take care of them and set up their next appointment.

41

- The patient's next appointment will be arranged

- payment or specific arrangements regarding payment will be made.
-

42

Patients who attend the office for the first time for non-emergency care
are processed through the front office
and waiting room into the operatory
essentially the same as emergency patients
-

43

Once seated the same greetings and discussions take place.
-

44

Once the examination begins
each step is identified
and explained to the patient
before beginning.
-

45

To begin I determine if radiographs will be required and if so which will be necessary.

I explain that the x-rays will be taken first so that they can be developed and reviewed prior to the patient leaving.

46 ☐

If the first hygiene appointment is being done in conjunction with the examination
the exam is completed prior to the radiographs being taken.

They can then be processed and reviewed while the hygienist is treating the patient.

47 ☐

I introduce the person who will be taking the radiographs

and leave the patient with them.

48 ☐

Films are never taken without my speaking with the patient first.

49 ☐

Many patients have told me of their experiences in other offices.

- They had x-rays and a cleaning done as the first step.

50 ☐

Many patients have told me of their experiences in other offices.

- They had x-rays and a cleaning done as the first step.

They were not sure if they had even seen the dentist.

-

51 ☐

I want my patients
to be comfortable with my staff
but the primary relationship
has to be with me.

52

The examination starts with a cursory TMJ examination.

- I ask about any clicking or grinding that they may be aware of in the TMJ area.

53

The examination starts with a cursory TMJ examination.

- I ask about any clicking or grinding that they may be aware of in the TMJ area.
- I ask if they get any pain in that area or ever have their mouth lock open or closed.

54

The examination starts with a cursory TMJ examination.

- I ask about any clicking or grinding that they may be aware of in the TMJ area.
- I ask if they get any pain in that area or ever have their mouth lock open or closed.
- I ask if they are wondering why I am asking these questions
-

55

There are the obvious advantages to including this segment of the examination.

Discomfort and dysfunction that the patient may have assumed was normal or may have accepted as something they just had to live with can be alleviated.

56

Not as obvious
is the groundwork laid
for later discussion
of the need to establish and maintain
a stable occlusion.

57

The TMJ exam is followed by an examination of the soft tissues of the mouth, occlusal and periodontal evaluations, and assessment of existing restorations and caries status.

•

58 ☐

Each step of the examination
is explained
prior to being done.

•

59 ☐

60 ☐

Once the radiographs are reviewed
and the treatment plan developed
the proposed treatment
is reviewed with the patient.

61 ☐

More complex treatment plans
or more complex aspects of the treatment plan
are reviewed at this first appointment.

However, full discussion is deferred
to a separate consultation appointment.

62 ☐

As part of the treatment plan review I discuss
- the patient's preferences for long or short appointments,
- how long they like to wait between appointments
- and what time of day they prefer to be seen.

63 ☐

Any special considerations affecting appointment scheduling are determined at the same time. For example
- appointments for any procedures where I have a preference for the time of day
- treatment must be coordinated with a specialist or dental laboratory.

64 ☐

I also warn the patient that certain peak times of day are booked very far in advance.

They may need to adjust their personal schedule to avoid detrimental delays in treatment.

65

Following treatment
the discussion takes place of

what treatment is planned . . . the importance of that treatment and the consequences of delaying or avoiding treatment

66

The goal laid out for the patient visit
is to assure that every patient
becomes and remains
a long term patient of my practice
•

67

As in other businesses
it is easier and more cost effective
to support and strengthen existing accounts
then it is to attract new people

68

The patient visit process
addresses any future treatment
or account considerations
in a manner that avoids potential difficulties
for the patient and for me.

69

Significantly
this is done in a way
that strengthens the bond
between the patient and my practice
in a way that avoids problems
but
does not deter patients.

70

No treatment begins at any appointment

until I have spoken with the patient.

71

The appointment ends with an explanation from me of

- *what treatment is planned,*
- *the importance of that treatment*
- *and the consequences of delaying or avoiding treatment.*

72

The patient will leave with

-
- The patient's next appointment scheduled
- arrangements in place for how and when the account will be paid.
- Steps will have been taken to avert any predictable problems that may arise.

73

The relationship between
the patient and the practice
will have been
enriched and preserved.

-

74

QUESTIONS?

1

Case Presentation

2

•
• Case presentation,
•
• treatment conference,
•
• consultation

3

Call it what you will

but don't call it

selling.

4

Case presentation is an educational process.

5

overall dental health can only improve

when a comprehensive treatment plan is presented

6

and the patient becomes knowledgeable

about the state of their mouth.

7

The role of the dentist
is as much that of advisor
as it is to be
the provider of dental treatment.
•

8

Knowledge of the sales process
has a place in preparing us
to educate our patients.

9

The sales arena has produced a mass of readily available books, recordings and courses.

As with most courses each of these will have things that don't apply to us and things we disagree with.

There will also be the few ideas that put into use are invaluable.

•

10

I begin all cases
by establishing the treatment plan
I would want
if I were that patient

11

I then proceed along the maxim:

"if they knew what I knew
they would want the same thing."

12

The goal is an
overall healthy, stable, comfortable mouth
with future treatment needs
minimized and predictable.

•

13

After all diagnostic records are completed and reviewed,
the estimated fee and estimated insurance benefit are determined.

14

A treatment conference is then arranged.

15

Treatment can be reviewed with patients
equally effectively
in a consultation room or in an operatory.

16

Any models, photographs or diagrams
that may be needed when discussing treatment are close at hand.

17

I enter the case presentation meeting prepared,

erring on the side of being
over prepared if anything.

18

I have all the information gathered at the examination appointment with me.

19

- Treatment planning forms,
- diagnostic records,
- x-rays,
- photographs,
- etc.

20

The treatment planning form
specifies all of the treatment required.

Where options exist they are all listed.

•

21

Fees are prepared

for all treatments and treatment options.

22 ☐

The number and length of appointments
needed, as well as the time required to
complete treatment is estimated.

23 ☐

If predetermination of insurance benefits has been received
the information relating to each of the treatment options is ready
in easily presented and understood form.

24 ☐

As in any educational experience
it is necessary to have two or three different approaches
prepared and ready to use
when explaining things.

25 ☐

I break the treatment plan down into sections.

26 ☐

The first section consists of the basic treatment required to eliminate pain and obvious disease.

•

27 ☐

The next section comprises treatments required to provide long term stability and predictability.

28 ☐

The final section consists of treatments that will be required at a undetermined later date or are discretionary.

•

29 ☐

Fee estimates include
any diagnostic procedures and treatment
already completed
but still part of the current treatment plan.

30 ☐

- The estimates are divided up into several parts:
- Diagnostic procedures.
- Periodontal treatment.
- Endodontic treatment.
- Basic restorative services.
- Surgery.

31

At this point the fee for the basic treatment necessary to eliminate pain and obvious disease has been determined.

A total is available if the patient wants only the minimum treatment possible.

32

Next individual fees are listed for

- Crowns,
- Bridges,
- Dentures,
- Implants,
- Bonding,
- Bleaching.

33

- Estimates of the number and length of appointments required to complete treatment are prepared.

- An estimate of how long it will take to complete the treatment and the time frame for any follow up care are also prepared.

34

Once the patient is seated I start the case presentation by explaining the process we will go through during the treatment plan and estimate review.

35

I will be explaining

-
- the various procedures that I will be making reference to

- the various treatment options,
- the fees
- and the time required for treatment.

36

It will all be repeated
as many times as necessary
for them to become expert
about their particular situation.

37

At first it will appear like a great deal to grasp all at once.

They may not feel they are fully following everything I say.

38

A stage will be reached where they will follow what is being discussed

but may not grasp it at a level
at which they could explain it to others.

39

They will next have an understanding they are comfortable with and would be able to explain it to others if need be.

This is the point they should be at when decisions about treatment options are made.

40

The goal of the review is
- to finalize what treatment will be done,
- when it will be done,
- what the fee will be and
- how it will be paid.

This will allow for the efficient use of time that the fees are based on.

41

Every appointment
should not include
an unscheduled

treatment plan and estimate
review session.

42

Patients who insist on proceeding this way can be referred back to this discussion and made aware there will be a higher fee if the appointed time is not used as planned.

It is then their choice whether or not to have further reviews.

43

The next step is to review any procedures that will be discussed as part of the treatment plan.

I let them know I will be using terms and referring to procedures that they need to be familiar with

44

If it is a procedure with a reputation for pain or discomfort

make the patient aware what they can expect to be told about the procedures by their friends and relatives

45

The basis for the reputation should be explained,

the patient given an idea of what to realistically expect and . . .

46

an explanation of the pain and discomfort
that should be anticipated

if they avoid treatment or choose a different treatment.

•

47

The basic structure I have used hasn't changed much since beginning practice.

I have tried over the years, to develop appropriate explanations for

most situations that will be encountered

48

The biggest strength I have identified in my case presentation is my reacting to the patient's reactions.

49

My original explanations were either overly simplistic,
analogies that were inaccurate,
or were technical and more from a dentist's perspective than a patient's.

•

50

By listening to the patient' s questions and responses

- I determine what their priorities are,
- what they consider important,
- and what motivates them.

51

As much as possible I use models of cases in progress to enhance the descriptions and explanations.

I prefer to use something of which I can say "here is what I'm doing for another patient in a similar condition."

52

For procedures that are fully intraoral I rely on diagrams.

I use intra oral photos more for presenting the overall treatment plan not the specifics of individual procedures.

53

The explanation of procedures is followed by a review of the treatment plan.

A tooth by tooth review with all options for each tooth and tooth space is presented.

54

I sit shoulder to shoulder with the patient,

with a treatment planning diagram,
or intra oral photograph
in front of us.

55

I would rather not point in the patient's mouth.

I want them able to speak during this stage

56

Where there are alternatives I do not present them as good and bad choices.

The second choices are just that, second choices.

There are no bad treatment. They just have different limitations.

57

The advantages to the second choice treatment is lower monetary cost.

The offsetting disadvantages are a less comfortable, less predictable and less stable mouth with an increased need for future treatment.

58

At any stage up to here questions of fees are deferred but only once.

If asked again I give the fee but follow it with
“the fee for just one procedure by itself can be misleading. Neither the fee nor the procedure make sense in isolation from the total treatment plan.”

59

Many consultants say

the dentist should not discuss fees.

60

Dentists discuss fees, straight and simple.

61 ☐

Fees are broken down in categories corresponding to the same categories
as in the treatment plan.

•

62 ☐

I present them clearly,
answer all questions directly,
and immediately move on to the next step.

63 ☐

I want the fees to be clearly presented and understood, with a written record to the patient and to myself, but I don't dwell on them.

•

I spend as much time as is required but as little as possible.

•

64 ☐

I do not use any techniques such as

- asking questions to lead patient into conclusions about the value of treatment,
- analogies of value relative to other items they could purchase or
- how much they can expect to have paid had they sought treatment earlier.

65 ☐

My presentation of fees,
while said in a nicer way, is

“Here's the fee. The treatment is needed. It’s worth the cost. “

66 ☐

I answer all questions directly but I don't try to justify the fees.

If the patient puts too much weight of the fees I guide them back to discussing treatment.

67 ☐

Two effective responses I use are

- "I can't advise you on your finances, only on dental treatment. The decision is up to you" and
-
- "Beware false economy, which may lead to more treatment and expense later.
-
-

68 ☐

The fee discussion includes an explanation that fees are based on the time usually required.

If more time is required due to missed appointments or late attendance then the fee increases accordingly.

69 ☐

If indicated the patient is given a written copy of various payment options.

They are told that payment is expected at the time of treatment unless other arrangements are made before treatment starts.

-

70 ☐

Once the fees have been clarified I immediately move on to the time required for treatment.

This is short and unimportant. It only serves to change the subject away from fees.

-

71 ☐

The last stage is to review

- what treatment plan has been finalized,
- what options the patient is to think about and
- the time frame for making their decisions.

72 ☐

From this point on
I assume the treatment plan and
payment arrangements

are in place.

Detailed notes on the case presentation meeting are recorded in the patient's chart and treatment begins.

73

- I end with "unless you have any questions let's go out to the desk and set up the appointments."
-

74

QUESTIONS?

1

The Recall Program

2

The successful recall of patients following completion of any given round of treatment is essential.

The dental health of the patient and the financial health of the practice are both dependant on it.

3

A successful recall is a win win situation.

I receive the benefits of having busy, productive hygiene and treatment departments.

•

My patients receive the benefit of better dental health.

•

4

The goal of a recall program is

•

• to have as many patients as possible,
• seen as frequently as is reasonable,
• receiving all the treatment they require.

•

5

The aim is to have all of my patients
accept the recall frequency appropriate to their individual circumstances and
attend the office every time they are due for an appointment.

6

There are other goals of a recall program.

•

7

- Successful recall is vital to the maintenance phase of periodontal treatment.

8

- Successful recall is vital to the maintenance phase of periodontal treatment.
- On recall examinations new treatment needs are determined.

9

- Successful recall is vital to the maintenance phase of periodontal treatment.
- On recall examinations new treatment needs are determined.
- Additional discussion of delayed or declined treatment plans, leading to their implementation, can take place.

10

- The repeated exposure to the dental environment increases an appreciation for good dental health and decreases dental phobia.

11

This all leads to a greater acceptance of higher quality treatment plans.

The continuing contact with the patient that recalls provide ensures that the patient will remain a patient of my practice.

12

The most effective recall system relies on:

a) phone contact
b) recall postcards
c) e-mail / text
d) all of the above
e) none of the above

•

13

When I first established
my recall system,
(before e-mail & text)
not wishing to take any chances,
I chose

d) all of the above.

14

Each patient in the recall system was sent a recall postcard the month prior to the recall date. If no response was received. subsequent recall cards were sent the next month, three months later and six months later. Each card was followed by a telephone attempt to contact the patient and arrange an appointment.

15

As my practice (and postal rates) grew my attention to detail and desperation shrank. The frequency of sending cards was reduced to sending the initial card the month the recall appointment was required and a subsequent card six months later. Attempts to contact patients by telephone were made only when time became available as a result of “holes” in the appointment book.

•

16

A dramatic increase in the success rate of my recall system occurred serendipitously
after I started to apply the techniques I used for apprehensive patients to all of my patients.

17

Out of habit I was ending the final appointment prior to recall with this same discussion.

what treatment was planned for the following appointment, the importance of that treatment and the consequences of delaying or avoiding the treatment.

18

Regard the patient's recall appointment as what it really is,

nothing more and nothing less than

just the patient's next appointment.

19

The answer to the question

The most effective recall system relied on:

a) phone contact
b) recall postcards
c) e-mail / text
d) all of the above
e) none of the above

20

had become:

e) none of the above.

21

An effective recall system relies on the patient leaving their last appointment prior to their recall appointment

- Knowing what treatment is planned for the recall appointment,
- knowing the importance of that treatment and
- knowing the consequences of delaying or avoiding that treatment.

22

The patient is, as importantly,
aware of how they will be contacted
to remind them of their recall appointment.

23

The contact made with the patient at the time of recall takes on an entirely different purpose.

The recall postcard, e-mail, text or telephone call does not function to raise the idea with the patient that an appointment is necessary.

•

24

It is the reminder that they were expecting
about the next appointment.

25

How do I contact patients
that did not arrange their next appointment
at the end of their prior appointment?

26

Initial contact attempt:

When the appointment is due a digital version of our recall card is sent.

27

Follow up

A dedicated staff person
- calls overdue patients
-“cleans up” the recall system.

28

Starting with most currently overdue patients
- Book an appointment
- If not,
ask when they would like to be contacted next or
ask if they would like to be removed form the recall system

29

The first step of an effective recall program starts with the initial discussion
with a new patient,
even prior to any examination.

30

After determining the person's reason for coming to the dental office

an explanation of the need for following up the treatment of their immediate concern
with establishing and maintaining a healthy mouth is given.

•

31

The next steps to be taken continue establishing the solid base that makes the recall system work.

During the course of treatment all discussions eventually lead to the need for suitable recall.

32

The continual message
is that proper dental care
is ongoing.

33

Preventive treatment and the maintenance and monitoring phase of periodontal care require the patient to be seen over the long term to be successful.

•

34

A busy, productive and profitable hygiene department also requires the regular return of established patients for on going care.

35

After the initial examination
an explanation of the periodontal disease process
and the need for home and in office care is given to the patient.

36

This must be brief and clear.

An explanation of the role played by regular recalls is an intricate part of this discussion.

•

37

"The days of everyone being seen every six months are gone.
Six months is a good starting point.
Some people need to be see more often, others need to be seen less often.
At six (or three) months we'll evaluate how well home care is being

done and decide on the timing of the next recall.

•

38

This discussion should take place at every hygiene appointment.

I even warn my patients that they will hear it "a hundred times."

39

At every examination
note should be made of any treatment
that may be necessary in the future
and an estimate made
of when that might be.

•

40

The patient should know that
through examination at appropriate frequencies
the need for such treatments
will be determined earlier,
saving them time and money.

41

When discovered later,
through signs or symptoms
that they would become aware of,
more involved treatment is usually required.

•

42

An added benefit of discussing future treatment needs
is an alleviation of the patient's frustration
resulting from the periodic need for new or additional treatment
even though proper care is being taken.

43

Without proper warning
about what to expect in the future
their instinct is to assume they have "bad teeth"
and give up on

"obviously pointless" preventive care.

44

As an added benefit,

when the need for these treatments arises

there is seldom much discussion or delay.

45

The patient will have had the time to decide

what course of action they wish to pursue

as they will have been aware of the possibilities

for quite some time.

•

46

The best efforts at educating patients
can not quickly overcome misinformation,
lack of information,
mythology
and family anecdotes.

47

Most people understand the need for the more commonly known treatments.

They readily accept recommendations for "fillings" or "cleanings."

•

48

The need for treatment of other conditions is often not as quickly accepted.

This is especially true where the consequences of avoiding treatment happen over a longer term.

49

Through repeated contact with
the dental practice
a patient's appreciation for
the need for dental health,
and the steps
necessary to achieve and maintain it,
increases.
•

50

Required but delayed or declined
treatment plans
eventually are accepted
and treatment implemented.

51

The third step in the recall process
is deciding when the patient
needs to be seen next
and the length time required
for the recall appointment.
•

52

Both of these parameters are developed
based on the rational
for seeing the patient again.

53

The timing of the recall appointment is most often set with regard to the patient's periodontal status.

54

There is no one recall interval that is appropriate for every person.

The recall should be set in such a way that the patient is seen as seldom as possible
without going too long between office visits.

55

The days of everyone being seen every six months are gone.

The recall frequency should be based on the individual's specific needs.

56

Six months is a good starting point from which to evaluate the case.
Some people will need to be seen every three or four months,
others will be able to go nine, twelve, or more months between appointments.

57

It is not as common to assign the recall frequency based on restorative criteria as it is to base the frequency on periodontal considerations.
However there are cases where due to the age, size, type or number of restorations present the patient should be seen more often than would otherwise be recommended.

•

58

The interval between periodic evaluations is shorter as well in situations where there are conditions under observation
or recommended treatments have been deferred by the patient for consideration at some latter date.

59

Much discussion takes place amongst dentist
regarding the length of time to be booked
for appointments with the hygienist.

60

This is another area where I mistakenly followed conventional wisdom for too long.

61

Appointments were set at
one hour for adult
Patients
and a half hour for children.

62

This system frequently resulted in a situation
of requiring extra time with a patient
and falling behind in the day's schedule.

63

In other cases the patient's treatment
finished earlier than allowed for
resulting in unproductive time.

64

Both of these situations are avoidable
once the recall is considered
as nothing other than
the next appointment.

•

65

When asked how long they book to do a restoration,
few dentist will answer one set time regardless of the nature of the restoration.

66

A composite resin placed in the occlusal pit of a bicuspid
is unlikely to be done in an appointment scheduled for the same amount of time
as a five surface amalgam on a molar retained by pins and fitted to an existing partial denture clasp.

67

The same thinking
must apply
to the time set aside
for a recall appointment.

•

68

A patient with only a few remaining natural teeth, excellent hygiene and requiring little discussion
will require a different amount of time than
a person with all of their teeth who repeatedly presents with tenacious stain, heavy calculus build-up and lots of questions.

69 ☐

The time appointed for the recall visit
is a prediction of
how long the recall appointment will take.

70 ☐

The rule of thumb that I follow is
to book the recall appointment
for the amount of time spent at the current appointment
if it was completed in one visit.

•

71 ☐

Where more than one visit was required for the initial round of periodontal treatment
the recall is booked for one hour.

•

72 ☐

If a single one hour appointment is not sufficient
the recall frequency is modified accordingly.

The patient is seen again before such a significant build up of calculus is present.

73 ☐

A policy of booking the recall appointment before the patient leaves the office
was instituted at the same time that the policy of booking a standard time for all recall appointments was dropped.

•

74 ☐

There are patients who would rather wait until their recall is due.
They prefer to be contacted at that time to arrange their appointment.

75 ☐

These people are accommodated the way they prefer but before they leave
they are aware of when they will be due and how they will be reminded that they are due.

They are asked to contact the office at that time if they don't hear from us.

•

76

The importance of the recall is emphasized
as are the consequences
of delaying or avoiding the recall.

77

The primary problem with this approach is the increased work load for the person handling appointment scheduling.
Appointments made so far in advance are apt to change as work and personal schedules change.

78

The primary problem with the alternative approach to recalls

is a decreased success rate of recalling patients

resulting in a less productive hygiene
department.

•

79

There are those people who, despite our best efforts, have not come in for their recall appointment.
Attempts to contact these people, are made by phone, e-mail or mail when other patients are not adequately filling the appointment book.

•

80

Any success achieved in this area will be through those patients who intended to keep up with their dental care.
Having missed the recall they just never quite got around to arranging another appointment.

81

The others are going to go by their own agenda.

It is worth the effort to contact them

but I am realistic about
how few positive responses to expect.
•

82

The essential ingredient of a successful recall system is the prior discussion of
• what treatment is planned for the recall visit,
• the importance of that treatment and
• the consequences of delaying or avoiding the treatment.
•
•

83

Prebooking recall appointments
helps increase the success rate
of the recall system.

84

Booking the time required for the planned treatment
rather than booking a set amount of time for everyone
makes the hygienist more efficient and productive.
•

85

The overall result
is a recall system
that satisfies my original goals.

86

QUESTIONS?

1

Accounts Receivable

2

If I had my choice I would come to work in the morning, do dentistry all day and leave at night.

I would have nothing to do with the business side of my practice.

•

3

This is not the reality of private practice dentistry.

The business area is a significant factor.

The accounts receivable segment of the dental practice business demands considerable attention.

4

There is the choice of ignoring this area and accepting all the detrimental effects of inaction.

Collections, cash flow, take home income and ultimately the financial viability of the practice will suffer.

•

5

There is the choice of delegating away all responsibility for this area and accepting the significant cost involved.

With proper guidelines and the right personnel such a system will work but can be expensive.

•

•

6

There is the choice of having a rigid, inflexible "cash only" policy and accepting the loss of business and lack of competitiveness that results.

7

There are many patients who need much treatment,
they want it and are willing to pay for it.

However they perceive such policies as showing too much concern for their money and will choose to be good patients and good accounts in someone else's office.

8

My choice is to attend to the accounts receivable system by setting out the guidelines, philosophies and goals I am trying to achieve.

This allows my input, when it is required, to be minimal, efficient and consistent.

•

9

I have only two goals
for my accounts receivable system.

•

10

The first is to maximize collections.
This can be defined two ways. I apply both.

I want to maximize collections
• as a percentage of fees billed
• as an overall amount.

11

The second goal is to have policies in place

regarding payment of accounts that are

as consistent, broadly applicable and few in

number as is practical.

12

They should be fair,

easy to present to patients,

easy to remember and

easy to follow.

•

13

My original system was not particularly sophisticated.

I did the treatment and pursued payment.

•

14

Over time the original philosophy of easy with credit, tough on collections evolved into
a more explicit philosophy of offering a wide variety of payment options
but having the arrangements for payment clearly in place at the outset
and insisting that they be adhered to.

15

The result is a system with an acceptable collection rate when evaluated by

•

• the amount collected,
• the aging of accounts,
• how collectable the accounts are.

•

16

The few bad accounts that there are
get detected early and dealt with early.

17

These are generally predictable
but only preventable by not doing the treatment in the first place.
I felt the advantages of taking a chance in these cases outweighed the disadvantages.

•

18

My philosophy is that

I would rather collect

less than 100% of what I now bill out
than 100% of less than I now collect.

19

Office financial policies

20

Office financial policies

Office policies are not in place
until the account holders
are aware of them.

21

My office policies are presented in a one page easy to read letter.
It is handed to every new account holder with a courteous request to read it.

22

Account holders are informed there will be a fee that they are expected to pay prior to leaving the office.
If arrangements that vary from this method of payment are to be made they must be in place prior to initiating treatment.
•

23

The availability of payment plans for payment of accounts over time is mentioned in the policy letter but
the details of such plans are described in a separate document.

24

Account holders are made aware
That there will be a fee
for the time lost
to missed appointments
and late attendance at appointments.

25

The other area addressed in the policy letter
is accounts who's dental insurance benefits
will be assigned to be paid directly to my office.

26

There are many business, ethical, moral and comfort arguments
made for and against accepting assignment of insurance benefits.

They all have validity.

27

There are no convincing arguments

that support not helping our patients understand their insurance benefits

or helping them claim their benefits.

•

28

The examination / treatment planning is done without reference to the patient's insurance status.

An estimate of the full fee is presented to the account holder and they are made aware of their responsibility for the entire fee.

29

If there are insurance benefits available the account holder is helped to understand them.

Payment options are discussed and finalized prior to treatment

30

With all these steps in place
the assignment or non-assignment of benefits
is simply another payment option
in which payment of a portion of the fee
is deferred to a later date.

•

31

The assignment of benefits has generally not been a problem except in the very few but very irritating situations
when a cheque intended for my office is sent to the policy holder, cashed and spent.

The account is left outstanding with no payment arrangements in place.

32

The policy of accepting assignment of dental insurance benefits has been modified to
accepting assignment with the provision
that if payment from the insurance company is
not received within forty-five days of filing a
claim the account holder is expected to pay at
that time.

33

I do not have to address the issue of whether or not the account holder has received an insurance cheque.
I just refer to the arrangement made prior to treatment and state that payment has not been received.
•

34

Prior to treatment an estimate of the fee involved will have been presented and
arrangements for how the account is to be paid finalized.

We are now at the point where the patient has received treatment and is at the reception desk.
•

35

If the account is paid in full prior to the patient leaving the accounts receivable discussion is over.

36

The arguments for and against offering payment methods other than cash in full at every appointment can continue endlessly.

The decision for me comes down to a cost benefit analysis of the situation.

37

Carrying receivables
has a cost associated with it.

Carrying receivables
has a financial benefit.

The decision for me comes down to a cost benefit analysis of the situation.

38 ☐

The actual functioning of the accounts receivable system I use is smooth and easy.

A description of the system can be cumbersome

39 ☐

I do not insist that payment be made before the patient leaves the office following their appointment.

I do insist that definite arrangements are made and recorded regarding when payment will be received.

•

40 ☐

The trick is not in knowing how to collect a bad account.

The trick is to keep accounts from going bad .

41 ☐

At the end of each month a dated accounts receivable list must be made up.
Go through the accounts and assign what is to be done with each account based on

- the aging of the account,
- what was done the previous month and
- what arrangements are in place with the account holder.

42 ☐

When the accounts receivable list
has been analyzed
the statements and letters
are produced and sent.

43

In any case where the action taken may result in losing a patient the automatic nature of the accounts receivable system stops.

Any letters that are sent in place of statements are sent over my signature

after I review the situation.

44

Separate accounts receivable lists can be drawn up for payments expected from insurance companies.

Alternatively notations can be made on the overall accounts receivable list that the account is in abeyance pending receipt of an insurance payment or the expiry of the forty-five day waiting period allowed for such payments.

•

45

QUESTIONS?

1

Marketing

2

Marketing and advertising
are not
interchangeable terms.

3

Marketing is everything that is done to encourage the growth and success of the practice.

Advertising is only one small part that

4

Without everything else,

advertising is potentially a heavy investment

with little or no return.

5

A frequently overlooked step is

to determine the target

of the marketing efforts.

•

6

• "I want everyone to be my patient",
• "I want to treat everyone that I can attract to my office"
• "I want as many patients as I can get"
•

All acceptable starts

7

There needs to be

further development

and refinement.

•

8

My ideal practice

•

9

• People that think like I do
• Have similar priorities to mine
• Who make decisions the way I do
• Like minded people whom I understand and can relate to

10

Patients chose our offices for a variety of reasons.

•

They find us through a variety of sources advertising, location, social media, etc.

All are valuable, all have a return on our time, effort and resources.

•

11

Some percentage of patients will be referred by existing patients.

12

The percentage of patients referred by existing patients will be small when a practice is first established.

•

13

These will be the patients predisposed to
- Think like we think
- Have similar values and priorities to ours
- Make decisions the way we do
-

14

Like minded people
whom we understand
and can relate to
-

15

Marketing efforts aimed
at increasing this percentage of new patients will have the best pay off
-

16

Having a target group that I fall into
results in better, easier communication,
lower stress and
ultimately more success.

17

Having a target group that I fall into allows for an initial evaluation of any approach to patients I may want to employ that is relatively uncomplicated.

The simple test is what effect would this have on me as a patient?

18

I aim my marketing efforts at three groups.
- The primary group is made up of patients who want optimal dental health.

19 ☐

I aim my marketing efforts at three groups.

- The primary group is made up of patients who want optimal dental health.
- The secondary group are people who have made an educated decision about the level of care they want even if it is something less than optimal.

20 ☐

I aim my marketing efforts at three groups.

- The primary group is made up of patients who want optimal dental health.
- The secondary group are people who have made an educated decision about the level of care they want even if it is something less than optimal.
- The final group are those patients that only want minimal care to alleviate pain and obvious disease.

21 ☐

I dissuade those patients professing to want minimal treatment but who actually only want minimal fees

22 ☐

- The most basic of the marketing strategies that I employ can not be delegated away.
- No one can be hired to do it for me.
- The planning, implementation and execution must be done by me.

23 ☐

This is possibly the most effective approach to building and maintaining a successful practice.

If properly applied any other efforts are probably unnecessary.

24 ☐

Every patient is presented with the most appropriate treatment plan for them, including sound recall maintenance.

The treatment plan is based solely on their dental needs.

25 ☐

I don't have any "magic" words or phrases.
I don't use any special sales techniques.
I haven't lucked into different patients than everyone else.
•

26

The method I use is simply to evaluate peoples'
•
• attitudes,
• awareness, and
• apprehensions

27

Once I know where they are at

it's an educational process to

get them to where they should be.

28

This is not a quick, fast return for little effort, approach.

Some patients will be immediately responsive,
others will take years to come around.
•

29

In establishing a marketing strategy
it is necessary to identify
any factors limiting
the growth and success of the practice.

30

Most frustrating are the myths and

misconceptions people have

about dental treatment.

31

Most dangerous is the mistake of

my prejudging a person's ability or willingness

to afford and accept treatment.

•

32

The limitations placed on
practice growth and success
by not treating every patient
as someone who wants first class dentistry
are just unacceptable.

33

I am not going to have every patient choose the treatment I consider best for them.

However, every patient will have the maximum amount of that treatment that they are prepared to accept.

34

The friends and acquaintances of the people I treat are even harder to prejudge accurately as I have never met them.

Some of my best patients were referred to me by some of by worst patients.

35

Patients bring a plethora of mythology with them to the dental office.

Too many patients will choose too low a quality of treatment plan if these misconceptions are not addressed.

36

Accepting that these attitudes are unchangeable or insurmountable lets these patients leave the office without the care they need.

The opportunity to provide them with care the need now, as well as their long term care, leaves with them

37

I try to be aware of as many of the dental myths as I can. I am always learning more.

38

For every one I develop an appropriate explanation that addresses the possible origin of the myth.
I can then credit the myth with some factual basis.
This allows me to avoid telling a patient that they are wrong, which would force them to defend and thereby strengthen their belief in what they have said.

39

Their specific circumstances can be contrasted to the general situation that engendered the myth.
The correct information is then more readily accepted.
•

40

Dental Insurance

41

The misconceptions surrounding dental
insurance are so ingrained that they have just
about become dogma to dentists and patients.

42

A highly successful practice

can not be insurance dependant.

43

Basing treatment plans on dental insurance can be the spurious act of shopping the list of insured services to see what can be applied.

44

More likely
treatment planning based on the patient's dental insurance benefits
takes the form of assuming patients will only accept insured services
and presenting treatment recommendations accordingly.

•

45

By imparting the message that treatment is based on insurance coverage the accompanying message is that the treatment recommendations can not stand on their own merit.

It is simple logic that it is harder to convince someone of an idea, spur them to an action or sell them a product if you devalue it in their eyes.

46

Training patients to think "no insurance, no dentistry" risks two protracted blows to the practice's stability.

47

- When benefits are lost dental treatment is seen as an employment benefit that has also been lost.
-
- Many insurance companies are increasing the time between eligible recall appointments.

48

Patients facing this situation will often give warning in advance that a change is eminent.

Review the importance of continuing treatment and maintenance, as well as the consequences of delaying or avoiding treatment, just as with any other treatment presentation.

49

Emphasize that treatment and recalls were never based on insurance considerations in the past.

There is no reason to begin doing so,

especially at a time when the patient is least able to afford the expensive, preventable consequences of neglect.

•

50

The ground work for the patient making proper treatment decisions irrespective of their insurance status

begins when they first become my patient.

51

Customer Service

52

I have built my practice using a customer service rather than a sales philosophy.

•

53

I prefer to have every patient receive the care most suited to their dental needs and personal circumstances.

I am not aiming to have every patient receive the most extensive, expensive treatment plan they will agree to.

54

By accommodating people, treating them fairly, and running an efficient business the bottom line takes care of itself.

•

55

A physician once told me

"if you are waiting for your patients instead of them waiting for you, you are not working efficiently."

56

I remember hearing of a study that asked busy doctors, who were always behind in their schedules, what their patients thought of the situation.

The doctors all responded that their patients understood and accepted it.

•

57

The doctor's receptionists were then asked the same question.

It turned out the patients were annoyed.

They were just taking it out on the staff instead of the doctor.

58 ☐

People leaving my office annoyed

are not going to be

the practice boosters

I am hoping for.

•

59 ☐

I try to keep on time as much as possible.

Fifteen minutes behind time is the maximum I am comfortable with.

60 ☐

Any patient that is to be kept waiting longer than fifteen minutes receives

•

• an apology
• a realistic estimate of how long the wait will be
• the opportunity, if they so choose, to reappoint for another time

•

61 ☐

I do not begin treatment
on patients that arrive late
for their appointment
if it will mean
keeping the next patient waiting.

62 ☐

I am not eager to lose
a good, reliable patient
because I was busy
indulging a disruptive one.

63 ☐

This reasoning emanates from the target established for my marketing efforts.

The patient that arrives on time and would be kept waiting is in my primary target group of patients,

the late arriving patient is not.

•

64

A patient displaying a chronic pattern of late attendance is not discouraged from remaining with my practice.

They are switched over to the short notice appointment system for treatment.

•

65

I want the patient to regard me

as their advisor

on dental matters.

66

Nothing quite undermines attempts to impress

patients and keep them coming back

like a dispute over fees.

67

As good consumers
patients should know
and understand
the costs involved
in their treatment.

68

The better my patient's understanding up front of the fees they will

incur the less chance there is of a misunderstanding later.

No matter how reasonable the fee charged, if it is more than the person was expecting it will appear too high.

•

69 ☐

When disputes do arise it is best to be able to tactfully recall pretreatment discussions and predictions that the fee charged was to be expected.

70 ☐

Prior to treatment every patient is made aware of the costs involved.

If dental insurance benefits will be a factor
these are predetermined.

•

71 ☐

I maintain a list of patients noting any treatments they have put off to a specific time.

The delay may be due to financial or personal schedule considerations or delayed with regard for yearly maximum insurance benefits

72 ☐

When the designated time approaches
the patient is reminded of earlier discussions and ready to make their decisions.

Treatment can proceed without delay.

•

73 ☐

The same philosophy of advice in addition to treatment is applied to people phoning and requesting estimates.

74 ☐

These people are trying to be good consumers.

They are, however, usually not prepared or informed enough to obtain the information they need to make good choices for themselves.

75

When I started practice the advice I received

was to not give estimates over the phone.

76

I don't recall any patient
arranging an appointment
after being told estimates
were not available by phone.
•

77

A patient phoning now
receives an explanation of the difficulty
and misleading nature
of answering such a question.

78

The explanation includes the caution that it is impossible to be accurate without seeing them.
They are offered the opportunity to be seen at no charge.
A rough approximation of the fee is then possible.

79

The image presented
by the dentist, the staff
and the office environment
can enhance any marketing efforts.

80

The wrong image
can negate everything else
and destroy any chance for success.

81

There are dentists who are passionate about dentistry. It is their job and their hobby.

They enjoy practicing what they know and learning more.
They operate modern, well maintained offices staffed by pleasant, caring people.
They appreciate their patients and are concerned for their well-being.
•

82

There are dentists that feel trapped in dentistry.
They are apathetic about continuing education.
Their offices reflect their lack of interest in the work, and their staff is indifferent.
They consider patients a necessary evil.

83

Most of us fall somewhere between these two extremes.
They are, nonetheless, good terms of reference.

84

Which dentists are most likely to be successful?

Which dentists are patients most likely to prefer?

85

The practice image begins with the personal image of the dentist and the office staff.

The image presented by everyone working in my office must be one of good dental attitudes and good dental health.

86

My success is linked to patients accepting my recommendations.
In turn, this acceptance is linked to my credibility.
What I recommend for my patients has to parallel what I would choose for myself.

87

Secondary, but important is the grooming and demeanor of the office personnel.

I want my staff and I to look like we consider the practice of dentistry, the office, and our patients special.

88

The office environment must be harmonized with the target group of the marketing efforts.

I am aiming at a group that considers quality and value first,
there is cost awareness but little compromise.

89

The office environment
must reflect this same thinking
in the choice of location,
and the design of the office.

90

An office that imparts the message
"choose based on price and choose low”
is prone to attracting patients
that decide about treatment that way.

•

•

91

My office is located in a convenient and highly visible spot.
The appearance inside and out is neither lavish nor cheap.
The impression I am trying to give is comfortable, modern and inviting.

92

The only excess is the attention to detail.
Every aspect of the office has a reason behind it. Very little has been left to chance and
it is all focused on improving the patient's dental experience.

93

Starting where the patient feels like they are
"at the office”
everything is as understandable as I can make it.

94

When the person

drives up, walks up or gets off the bus

the office is easily found.

•

95 ☐

The signage is not directed at me.

I don't have my name, my university degree or anything else I'd like to see "up in lights" on my signs

96 ☐

Signage that lists long clinic names, the dentist's name including title and middle initial, and other superfluous information
is not readable from far enough away to be helpful in finding the office.

97 ☐

The signage directed at the sidewalk just outside the office is kept to a minimum.

The more there is to be read the less will be read.

98 ☐

The entrance to the office is clearly marked.

Any other areas that may be mistaken for entrances, such as private entrances or delivery doors, are marked as such and have instructions to the proper entrance on them.

•

99 ☐

The impression made
on the person first entering an office
is the beginning of a progression
of developing attitudes
and making decisions.

100 ☐

People approach this first encounter with the same varying degrees of

uncertainty they bring to all new situations.

For apprehensive patients these feelings are magnified.

101

I have planned my office to make patients feel they are in the right place.

I tried to avoid the perception of entering a private area into which they should be accompanied or summoned.

The waiting room is just enough off to one side to prevent the feeling of standing in front of a room full of people.

102

I avoided both extravagant and cheap décor.

Either might prejudice the patients attitude during case presentation.

The message has to be clean, modern, and well maintained.

•

103

Messages that the fees are going to pay for the fancy office
or that the fees are higher than they need to be in such a low budget operation
are detrimental to the success of the practice.

104

The Waiting Room

105

There are patients with a predisposition for feeling uneasy in close quarters with strangers. The waiting room is set up to minimize this discomfort as much as possible.

106

• Patients apprehensive about dental treatment are not at their best when waiting to be seen. This can be accompanied by a greater need to not have their personal space infringed upon. Others just

need to feel a bit more isolated than such a setting usually allows for.

107 ☐

Individual arm chairs are provided rather than couches.

There is enough separation that arm rests are not shared and foot space doesn't overlap.

There is plenty of room to walk by without anyone having to move out of the way.

A few chairs without arms are available for people of larger stature.

108 ☐

The chairs chosen for the waiting room are comfortable but ordinary.

I have avoided any unusual or unstable looking styles as well as those chairs that one sinks into.

109 ☐

The seating has to suit all patients
including those that may have difficulty getting in and out of a chair or may not trust a chair that doesn't look like a chair.

•

110 ☐

The theme of the waiting room is decidedly dental without being overwhelming so.

111 ☐

The reading material is half general interest half dental.

Only the two most recent issues of any publication are kept in the waiting room.

The next most recent issue is available to be offered to anyone that will be kept waiting in an operatory.

The rest are recycled, not left to pile up and create clutter.

112 ☐

The dental reading material is carefully chosen.

Current, topical areas are addressed with the goal of providing information and stimulating discussion.

113

As with any other marketing approach,
people don't read a pamphlet or poster and show up ready to accept whatever treatment is presented.
All that can be accomplished is to start the process of education that leads to good treatment choices.

114

There are many publications and posters available from private companies and our professional associations.
Many are quite good but they needed to be selected for content that matches the ideas I want presented to my patients.
I never just buy a batch of stuff and display it.

115

I prefer material generated specifically for my office.

This is especially true when examples of treatment are shown.

116

There is a greater impact
on my current and future patients
by showing examples of my work
rather than someone else's

117

Any text on posters or in booklets
need to be synchronized
with discussions that take place.

118

Pamphlets addressing different topics are rotated.
These are either neatly piled in a prominent area or left in a tray with an inscription such as: please read; or take one.
A sample of one is framed and displayed.
•

119

Any posters hanging in my office are framed, mounted or otherwise protected from appearing or becoming tattered.

Those that do age poorly are replaced.

120

There is a case book on the waiting room table.
The cover states what is in the book and credits me as the treating dentist.

121

Each page has the before and after photo of a case.

While not the quality dentists are used to seeing in text books and at courses the photos are adequate for the patient's experience in looking at intraoral photos.

•

122

The book is not organized by procedure, such as all veneers, then all crowns, etc.
That is how a dentist views treatment.
The book is organized the way a patient views treatment.
The groupings are by problem, such as all spacing, then all crowding, etc.

123

Beyond the waiting room
the office takes on
a much more utilitarian look.

124

In today's infection control conscious atmosphere patient's expectations are closer to the operating room settings they see on television medical shows.

125

Plants and ornaments are in areas that are more between rooms than in the operatories themselves.
The overall look is intended to be sparse and clean but at the same time nonthreatening to make the patient feel safe and comfortable.

•

126

The philosophy of being and appearing current extends beyond the

design of the office.

It must be applied to the dentist and staff as well.

•

127

Patients are regularly exposed to media reports about
• dental techniques,
• new technologies,
• controversies both real and created.

•

128

Everyone working in the dental office
must be able to discuss and
respond correctly
to patient inquiries.

•

129

Articles appearing in consumer publications or online can be useful allies in patient education.

Any articles that are particularly good are cut out or printed, referenced as to source and date published, and made available for patients to read in the waiting room.

130

I consider these articles a valuable source for developing my case presentations.

Any ideas that are presented well can be incorporated into my presentations.

Any views that contradict or challenge my position require a ready response for when they come up in discussion.

•

131

Controversial issues are frequently reported in a manner that undermines a patient's confidence in their dentist's intentions.

132

Politicians seeking our vote have detailed written positions available for those that will read them.
However, a major strategy that is forced on them is the need to develop the ten second clip that the media will quote.
Longer dissertations will get edited and accuracy will be lost.
•

133

On the issues that come up I am prepared to talk at length with any patient that is interested.
I will have written material available or on the office website outlining my position.
But first and foremost I distill my position down to the one liner that I will be limited to in most situations.

134

Effective marketing of a dental practice
can be described simply as
customer service.

135

Everything from greeting the patient at the door
through planning and completing treatment
to payment of the account
is geared to developing a long term
mutually beneficial relationship
with the patient.

136

Learning customer service is easy.

Go shopping, go out for dinner, stay in a hotel.
•

137

Anytime I am impressed with the service
I receive when I'm the customer
I consider if I can make use of
what I've experienced

to promote my practice.

138

Conversely,
when the service is bad
I make sure my staff and I
are not making the same mistakes.
•

139

QUESTIONS?