Dr Nathan Tobler,

Here is a packet of information that you requested a while ago. Sorry it has taken me so long to get it together. Enclosed is pictures of all the setups we use and the names of all of the intruments. This will help you get aquainted with Stonehaven Dental setups.

Every month we also do a training for the assistants on things like taking impressions, making temporaries, and ortho. Dr. usually makes a handout for us, and so I have also included that in the information. I know that you are an expert in these types of things, but it nice to have. Every month I will be sending you the handout that we go over for training just so that you can stay up with us.

Also Emily and I have been making a systems manual for the office. This goes over everything from how to turn on the nitrous, answer phones, to how to use the computer. I thought it also might be helpful for you to have that. So, as I finish sections up I will be sending them to you.

If you have any questions or you would like to add anything to what I have sent you please let me know. It is always great to have input from our dentists. Thanks.

Love, Carrie

Composite Tray

1. Mirror
2. Explorer
3. Howe plyer
4. Cantwell
5. Mircobrush
6. Clamp forcep
7. Articulating paper
8. Flowable
9. Heliomolar A1
10. Heliomolar A2
11. Wedges
12. Bands
13. Ring
14. Prime and bond

Endo Tray

1. Paper points
2. Gutta percha points
3. Backfill points
4. Sealapex
5. Root canal drill
6. Isopropfol alcohol
7. Endo condenser
8. Endo spoon
9. Irrigant
10. Hands files 21 mm
11. GT files 25 mm
12. Gates Glidden
13. Heater

IV Setup

1. IV solution
2. IV set
3. Torniquet
4. Alcohol prep pad
5. IV tape
6. IV syringe
7. Various drugs (versed, Demerol, dex, diprivan)
8. Arm board

NOT SHOWN: IV catheter

WT Tray

1. Anethstic
2. Mirror
3. Explorer
4. Surgical scissor
5. Surgical hemostat
6. Blade handle
7. Upper retractor
8. Elevator
9. Luxator
10. Lower retractor
11. Blade
12. Marcaine
13. Suture
14. 2X2

NOT SHOWN: Periosteo elevator

Graft Tray

1. Anethestic
2. Mirror
3. Explorer
4. Surgical scissor
5. Surgical hemostat
6. Blade handle
7. Resorable sutures
8. Lido 1:50,000
9. Blade
10. 2X2

Cerec Restoration

1. Anesthetic
2. Explorer
3. Mirror
4. Cerec Liquid
5. Cerec Etch
6. Ceramic Primer
7. Microbrush
8. Greenie
9. Porcelain Paste Brush (buffer)
10. Whitie
11. Brownie
12. Tofflemier
13. Cerec Band
14. Wedge
15. Prime & Bond
16. Cerec Burs
17. Porcelain Paste
18. Porcelain Milling Block
19. Brush
20. Variolink Cement
21. Powder Meister

NOT SHOWN: Unicem cement

Child Prophy Tray

1. Flouride tray
2. Patient bib
3. Prophy paste
4. Air/water syringe
5. Suction tip
6. Prophy cup
7. Mirror
8. Sickle scaler
9. Jacket scaler
10. Gracie scaler
11. explorer

Adult Prophy Tray

1. Patient bib
2. Suction tip
3. Air/water syringe
4. Prophy paste
5. Prophy cup
6. Mirror
7. Perio probe
8. Explorer
9. Jacket scaler
10. Sickle scaler
11. Gracie scaler

Sealant Tray

1. Patient bib
2. Suction tip
3. Air/water syringe
4. Mirror
5. Explorer
6. Clinpro sealant
7. Etch
8. Prophy angle
9. Prophy paste

Perio Tray

1. Patient bib
2. Suction tip
3. Air/water syringe
4. Cotton tipper applicator
5. Irrigation needle
6. Irrigation syringe
7. Antesthetic
8. Mirror
9. Sickle scaler
10. 11/12 explorer
11. Posertior curet
12. Gracie scaler
13. Explorer
14. Perio probe

Ortho Instruments (A)

1. Cotton pliers
2. Arch wire director
3. Band seater
4. Spatula
5. Measurer
6. Wire Gauge (?)
7. Boone Gauge

Ortho Instruments (B)

1. Weingart
2. Pin & Ligature Cutter
3. ?
4. Band Remover

Ortho Instruments (C)

1. Hollow Chop
2. Mosquito Hemostat.
3. Bird Beak
4. Distal End Cutter

Ortho Instruments (D)

1.
2. Crown Crimper
3.
4.
5.

Ortho Instruments (E)

1. Ligiture wire
2. Kobeoshi Hook

Temporary Crowns

Making temporary crowns should be a quick and easy procedure to complete if a few guidelines are followed.

1. Prior to starting the procedure know what you are going to use for the matrix and get whatever is needed
    a. Suck downs (bleaching trays) are used for most often for multiple unit replacement. Take an alginate impression and pour it up. A bridge pontic space can be filled with wax prior to the alginate impression or with custom tray material on the model prior to the the suck down. The same is true for a tooth with a broken cusp or large hole. Either patch it with wax prior to taking the impression, with acrylic on the stone model or you can contour (cut) it out of the impression with a cord packer or similar instrument. The temp won't fit if you don't address these problems!
    b. Vanilla bite impressions taken with sectional pink trays (usually for single unit restorations). Same as above when dealing with a broken cusp/tooth.
2. Decide what material you will use. Integrity is used for most restorations except bridges with 2 or more pontics (4 or more units total). Jet acrylic for bridges & occasionally multiple unit temps.
3. Prepare the teeth for temporization. This would include filling in any undercuts that would "lock in" the temporary when set and usually require breaking the temporary to get it off. Lubricate the teeth and gums with Vaseline if you are making the temporary out of "Jet" or "Snap" acrylic and then blow it off prior to insertion. Vaseline over any <u>composite buildups</u> so the acrylic doesn't bond to them!!
4. Try in the matrix! You know it will fit but you need to know exactly how it goes in. You may even need to mark the matrix with a sharpie (aligning it with a specific tooth/frenum etc.) so that you get it inserted right the first time. You will get air bubbles if not inserted correctly the first time.
5. Pick a shade, mix the acrylic, load the matrix and insert it into the mouth.
    a. Integrity: Keep the mixing tip in already extruded acrylic to avoid getting air bubbles in the mixture. Overfill the matrix slightly, insert and set the timer for 1 minute.
    b. "Jet" acrylic: Mix it in the matrix using a liquid then powder, liquid then powder technique. overfill the matrix slightly and finish your mixture by drying out the monomer (liquid) with powder until the powder just barely gets wetted. Bring excess monomer to the surface by tapping on or flexing the matrix, blow dry and then insert. Monomer can burn the tissue. That is the reason for drying it out and covering the tissue with vaseline.
6. Let temp set and remove it. This is a critical step
    a. Integrity: Wait exactly 1 minute and be ready to remove it. At 1 minute the acrylic is somewhat set, yet flexible. Work it off by getting the sharp end of a band remover or a jackette scaler in between the gums and temporary interproximally and working (not forcing) it off. Work both mesially and distilly if needed. If you are doing multiple units, you need to loosen the temporaries carefully in multiple locations before "prying" it out in order to avoid breaking it. It may help to have a second assistant helping as you try to remove it without breakage.

b. "Jet" temps: Jet acrylic both heats up (considerably) and shrinks as is sets. It is desirable to insert the acrylic, let it set for maybe a minute and then carefully unseat it just 1-2 mm and then reseat it. Every 30 seconds you will repeat this process until you feel the acrylic start to heat up (3 minutes or so). Keep a finger on the thickest "glob" of acrylic and feel for warmth. If you leave it on when it gets hot it could potentially overheat the tooth and will also be impossible to remove because it shrinks as it sets. When it heats up run it under cold water, Reseat it, repeat 1-2 times until it is completely hardened.

7. Check for bubbles and correct (flowable composite) or remake. If a bubble extends into the preparation but the temp is saveable, Vaseline the prep, seat the temp, add flowable and cure in the mouth.
8. Trim the temporary. Be careful but not shy!
   a. Bulk acrylic: break it off or use a pin & ligature cutter to cut it off where you want it to break.
   b. Margins: Where are they? It takes a little time and experience to be able to "read" margins and trim them properly. Ill fitting temporaries cause the gums to recede &/or extreme sensitivity. Use a large sharp acrylic bur for this step. Some hints:
      1. Take the temp off and on, off and on as you are trimming to see how close to the margin you are. Don't overdo it. Its easier to go slow than to redo it or add a margin w flowable!
      2. Use an eversharp pencil on the inside of the temp to outline the margin and then cut with confidence (if you can see the margin in the temp).
   c. Embrasures (in between the teeth)- for multiple unit temps only: Use a separating disc on a mandrel for this step. This makes your acrylic "blob" start to look like teeth. It's easily done
      1. Turn temps over so you are looking at the tissue side of the temps
      2. Cut in between temps with disc. You may need to clean up the margins interproximally at the same time
      3. Turn temps over to the occlusal side and carefully make a notch between the same 2 teeth with the same disc
      4. Connect the 2 "notches" facially with the disc to mimic the embrasure.
      5. Refine as needed. Usually gingivally at the mesial facial and distil facial margins.
9. Check the bite and adjust as needed. Use occlusal tape, acrylic bur, high speed drill with diamond etc. to reduce temp where it is high. It is critical to get it out of occlusion or it will break. Be careful not to over reduce it to the point that you "break through" the temp or leave only a sliver of acrylic
10. Polish. Use the muslin wheel and wetted pumice. Be careful not to break the temporary after all this work! It sounds dumb but it's real easy to do. Be careful.
11. Cement: Select an appropriate cement for what you are doing. Is there much left to cement to? Is the preparation quite angled or is it fairly parallel? Multiple or single units? How long does it need to be temporized? Is the tooth vital or non-vital. The goal is not to have the patient return with a Broken temp or one that has come off. Make sure tooth and temp are dry for cementation!
    a. Tempocem & other eugenol based temp. cements: Great for vital teeth w retentive preps or multiple units. <u>Poor bet for anything that needs a strong cement.</u>
    b. Durelon: Stronger cement good for sensitive teeth. Takes longer to set
    c. Zinc Phosphate: Strong but causes sensitivity (vital teeth only)
12. Recheck bite w articulating paper, have Dr. adjust if needed, dismiss pt.

Topical Anesthitic Application

Topical anesthetic takes about 3 minutes to work effectively and works best on dry mucosa (gums). Salivary glands are located on the buccal (facial)of maxillary 1st molars and lingual to the mandibular incisors and all oral fluids tend to accumulate in the back of the mouth. Generally speaking, it's easier to keep the mucosa dry in the maxillary arch by just dabbing the mucosa with a 2X2 in the anterior/bicuspid region or placing a 2X2 in the vestibule in the 1st molar region to soak up saliva from the glands. Maxillary injections are usually given in the vestibule adjacent to whatever tooth/teeth are to be anesthetized.

The mandibular block (nerve block) is usually given to numb mandibular teeth.

The entry point is located just behind and buccal to the lower 2nd molar-half way between the lower 2nd molar and the upper second molar (this area is called the muccobuccal fold). This is an area that is bathed in oral fluids since it is near the back of the mouth. This makes it more difficult to keep dry.

The procedure I use for the lower arch is as follows: place a 2X2 behind and lingual to the lower 2nd molar, lingual to the muccobuccal fold. For patients who are gaggers do so carefully! With the 2X2 in place, I carefully move it toward the tongue to make enough room to place my cotton applicator between the 2X2 and the mucosa and have the patient gently bite down. If they are juicy (salivate a lot) use 2 2X2's. Have them hold if for 3 minutes. If you want to be sure the topical gets it's maximum effect, change the 2X2 at 90 seconds.

Palatal injections hurt! Topical alone will not do the job. Pressure anesthesia is needed. It takes about 3 minutes also. Take a cotton applicator with topical on it and place it between the maxillary 1st & 2nd molars half way between the teeth and the roof of the palate. Put gentle pressure on the tip and steadily increase the pressure until it is firm but not enough to hurt them. Hold for 3 minutes then inject into the blanched area under the applicator.

Nitrous oxide is always helpful. Usually 30-35% for 3 minutes (notice the 3 minute theme). Do not leave the patient on high levels of Nitrous Oxide for more than 5 minutes. Some will vomit, others will start to feel poorly. If they want to stay on the Nitrous after 5 minutes, turn it down to 20-25%. Patient should never be left while on Nitrous!

RADIOGRAPHIC IMAGING (X-RAYS)

The two biggest challenges in obtaining X-rays are patient comfort (not hurting them) and getting quality images that show what we are looking for (cavities, abscesses, bone loss, etc.).

PATIENT COMFORT: Patients dread going to the dentist because they anticipate that we are going to hurt them with the shot, the cleaning on sensitive teeth, drilling on their tooth before it's numb etc.. It is our job and our mission to alleviate their fears by treating them carefully, gently as we would like to be treated if we were the patient. X-Rays are one of the first experiences our patients have with us. We need to be careful to make it a good experience.

-Inform the patient that you are going to get some X-Rays and that you will make it as comfortable as possible (letting the patient know that they may have a little bit of discomfort)

-Look inside the patient's mouth to see if they have tori, a shallow palate, a tiny mouth etc. that might alter your technique. How big is their tongue? You can avoid a painful experience by looking first and then adapting your technique to fit individual needs and anatomy.

-Prepare the sensor/positioner and take it to the patient's mouth. When placing the sensor remember that it is hard and we need to avoid contact with bony areas (the hard palate and the inside of the mandible). This is best avoided by placing the sensor near the midline necessitating moving the tongue carefully out of the way. If the sensor is positioned too far forward it will hit the anterior mandible/maxilla when they close down and it will hurt.

-Have the patient slowly bite down and ask them to hold the positioner (especially helpful for anterior and maxillary posterior PA's). Know that as they close down on the positioner that it may move the sensor and hurt them. Watch both the sensor and the patient as they slowly close down. Does it need to be repositioned? Is it hurting the patient as they close? Ask them, "is that O.K. Mrs. Jones". If it is, have them hold the sensor so they are in control and if it is hurting them they can at least keep it to a minimum.

-This is the time to be quick. Hurry and expose the sensor and remove it from their mouth. If you are doing kids, you may want to have someone already at the trigger ready to fire.

-What adjustments are available? They make foam protectors to cover the edges of the sensors. You could use a smaller sensor, reposition, get a panorex instead of bitewings or decide not to get any X-rays at all. We could delay getting X-Rays until the patient is numb or asleep. Maybe just repositioning or adjusting your technique just a bit will make the difference. **Getting good X-Rays is a technique sensitive procedure!** Remember, if someone else can get the X-Rays that you cannot or if they can do it without hurting the patient, you can learn something from them and improve your own technique. Your goal should be to be the best and to share your knowledge with the other assistants.

ALGINATE IMPRESSIONS

1. **Gather necessary materials:** Smaller size rubber bowl, spatula, H2O measurer, alginate with alginate measure scoop.
2. **Determine Tray Size:** Examine the patient's mouth and estimate tray size. Also look for any anatomical problems such as mandibular tori (bony growths) and determine how best to deal with them (periphery wax, different tray size or brand etc.) Select appropriate tray and try tray in patient's mouth. Look for any problems. Will the tray get the needed landmarks (tuberosity, retromolar pad, vestibule, etc.) Is it too marrow or does it hurt the patient on insertion. Will it fit nicely up into the vestibule? Will the patient be a gagger?

GIVE THE PATIENT A PAPER TOWELL!!!

3. **Select appropriate trays and measure alginate and water.**
   -water temperature is important in taking alginate impressions. Hot water makes it set fast and cold water makes it set slowly. You want luke warm water. You want to quickly spatulate it, place it in the mouth and have it set quickly so that it can be removed fairly quickly. You will have to experiment a bit. Our goal is to get it in the mouth before it begins to set but not to have it in the mouth for long before it can be removed. Too cold a temp. will lead to alginate impressions of the uvula, an unhappy patient (or assistant if they throw up) and a procedure that takes too long.
   -Alginate should be measured in a "fluffed" state, devoid of air pockets but not firmly packed. Pre "fluff" it by turning the can of alginate or spatulating it dry prior to measuring. Get a measuring cup over full and tap the air out by gently hitting the top of the cup with the side of the spatula. Remove the excess by scraping it off with the flat edge of the spatula and just slightly packing it at the same time. 2 scoops of powder and a corresponding amount of liquid are usually sufficient. Use 3 for size 11 trays and occasionally a size 12.
4. **Quickly mix, fill the lower tray, take it to the mouth and insert it.**
   Lower first so that if they have a gagging problem (usually with the upper impression) the procedure is pretty much finished anyway. Make sure that you insert it fully (teeth touching the bottom of the tray) carefully without hurting the patient (especially lingually). Hold the tray in place until the alginate starts to set. At this point make sure the patient is ok, and then leave the alginate to set while you quickly clean the bowl, measure and mix for the upper impression. If you time it right the alginate in your bowl & on your spatula will not be set yet and can easily be removed with a paper towel. There should be no mess! Throw the towel away and move on!
5. **Take the filled upper tray to the mouth and insert it.**
   Note: the lower impression is still in the patient's mouth. You may want to use slightly colder water so that you have just a couple of seconds to remove the lower tray while the loaded upper tray is set aside. If you get it too cold it will be a poor experience for you and your patient. If the patient is a gagger mix it thicker by eliminating water or adding powder. Insert the tray using the same guidelines as above. Wait for it to begin to set. Make sure the patient is ok, then leave it to set as you again clean your cowl/spatula and mix enough stone to pour both impressions. If the patient struggles with gagging have them lean forward, breath through their nose and make sure you help them through it prior to leaving them!
6. **Remove the maxillary impression & check both for accuracy.**
   This is critical. The patient cannot leave without an accurate impression. Retake as necessary. Get help etc. If there is any question whether the impression is adequate either take another one or show it to someone who knows if it is adequate. **DO NOT DISMISS THE PATIENT IF THERE IS ANY QUESTION!!!!!**
7. Pour up the impressions following pouring guidelines making sure the poured impressions are properly labeled. The whole procedure should take less than 7 minutes!

POURING MODELS

1. Check the alginate for accuracy prior to pouring and label a model slip.
2. **Thickness of mix:** Plaster needs to be runny enough to flow into the incisal edges of the teeth without trapping air! If patient has single teeth (such as in a partial denture) the mix may need to be thinner to flow into the incisal edge without trapping air. The mix will need to be somewhat thicker to make the base of the model. Add plaster to the mix if needed or get good at mixing it just so that it will both flow as needed yet be thick enough to not "slough" or run when making the base of the model. Mix fast plaster thinner than yellow stone.
3. **Vibrating Mix:** Vibrate long enough to vibrate out any large air bubbles in mix. Must be fairly quick with fast plaster in this step or it will start to set up.
4. **Flowing plaster into impression:** pull up a small amount of stone on your spatula and hold it against the model as it sits on the vibrator. Let it vibrate off the spatula and slowly into the bottom (incisal edges of the teeth) of the impression. As you do this, it is imperative that you watch the plaster slowly run through the incisal edge of **each and every tooth!** If the plaster is too thick, you have too much on your spatula, or you let it run in to quickly; air will get trapped into the bottom (incisal edges) of the teeth. This step is critical!
5. **Adding bulk and a base to the model:** After you have flowed plaster through all of the teeth, a bulk of stone is needed to fill up the impression and to then create a base to make the model thick enough that it doesn't break when you try to separate it or as the lab is using it. On upper models the base needs to be thick enough that there is an adequate thickness of stone to totally cover the palatal tissue that sticks up in the impression. Flow additional stone into the impression making sure that it blends well with thinner mix and flows well over the alginate or PVS without trapping air anywhere. When the stone has filled the impression up, use your spatula to add additional stone to make it thick enough for a good base. Then flip the model over and set it on a flat surface that you will be able to get it off of when it dries. Be super careful not to trap the edges of the impression trays in the plaster! This will make it very difficult to remove the tray once the plaster has set. This is a very common mistake/problem that is easily remedied. If you do trap a little of the tray edge in the base, thicken up the mix and try again or if the mix is thick enough, simply use your finger spatula or knife blade to relieve the trapped edge before the stone hardens. Check the back of the model to make sure that there is not an undercut between the base of the model and the top of it. Add a bit of stone to fill in the void if there is. Make sure as you turn the model over and set it on the counter that it is flat on the counter and not angled in any direction.
6. **It will take about 10 minutes for the plaster to harden.** Do not try to hurry it. You can check the hardness by touching the plaster to see if it's started to set. If it is hard to the touch, you may remove it from the counter and try to break off a small piece of extra stone to the base of the model to see how "crisp" the break is. You will be able to tell how hard it is by how it breaks. One other thing to look (or feel) for is the temperature of the stone. It warms us for a few minutes as it sets. If you feel the base of the model and it is still warm, let it set for a couple more minutes. If you try to separate it too early, the teeth will break off the base of the model. Let it set!
7. **Separating the tray from the hardened model:** The goal is to separate the tray without breaking any teeth or the model itself. Check that the edges of the tray are not trapped in the stone and relieve any place that is with a lab knife. Hold the base of the model against the counter as you carefully pull up and a little toward you on the tray. Remember that the anterior teeth are not straight up and down but are angled a bit. Try to remove the tray at this angle. If it doesn't come, carefully get a lab knife under an edge of the tray and carefully start to pry it apart without prying it enough to break the teeth or the model itself.
8. **Trimming the model:** If you have gotten this far with a good impression and a good pour up, no bubbles, no broken teeth etc, don't trim the outside edges of the teeth away, or if the models are for dentures, important anatomy. Trim the tray so that the excess bulk of the base is removed without trimming anything important away!
9. **Labeling:** Use a model slip to identify the model. This is critical! Patient's name, your name, the date, what the model is for etc. The model will be no good to anyone unless we know who it belongs to and what it is needed for.

LAB CASE MANAGER

1. You can find the lab case manager in the appointment book. It is the icon on the top that look like two teeth and above it is two green arrows facing away from each other. Click on it and it will bring up the lab case manager.
2. On the left hand side the top icon is for new lab cases click on that and it will bring up the patient names. Find the patient name and click ok
3. This will bring up the lab case manager for that patient. Once you are here click on provider and select which Dr. prepped the tooth.
4. Then click on category and select what type of case this was
5. On the lower left side you will see a box entitled enclosure. Please indicate what was sent to the lab. (bite, implant part, impression, model, pt. denture, photos, preliminary impression.) Please mark whatever was sent.
6. At the bottom of the lab case manager it say LAB. Highlight that and pick what lab it was sent to. Then go over to the right and find the receive from lab date and write down the date the case should be back to our office. Remember to include travel time for cases sent out of state.
7. In the middle of lab case manager is notes. Insert dateline and write important information like the shade what the restoration is made out of, etc. Anything that you find important to this case. IF THE CASE IS SENT OUT OF STATE WE NEED THE TRACKING NUMBER OF THE BOX. The notes is where you would indicate that.
8. That is the end of the lab case manager. With the paper form of the lab slip please make sure that the original copy is sent with the lab and that the carbon copy is put in the PLEASE SCAN pile so that we can get the lab slip scanned into the patients chart

WRITING A PERSRCRIPTION

1. To write a prescription for a patient you will need to either be in the patients chart or in the appointment book on the day that the patient came in.
2. To write a prescription for their chart you will click on the icon that has a capital R with a lower case x going through the bottom of the R.
3. This will bring up the prescription pad for that patient. Hit new down at the lower left hand corner and this will bring up all of the drugs that we can prescribe.
4. Enter in the first three letters of the drug that the Dr. would like to prescribe and then hit the arrow pointing down on the right hand side.
5. Highlight the drug and make sure that it is the right amount of drugs the Dr. would like to prescribe.
6. Go down to the very bottom of the prescription and choose which provider is prescribing this patient the prescription
7. Look over the prescription and hit print. The back computers and not set up to print so you will need to do this from a front computer.
8. Once it is printed out let the Dr. Sign it.

Treatment Plan

Patient Name-
Date-
Assistant-

Dr. signature-

TOOTH # / TREATMENT	ADDITIONAL INFORMATION
1	
2	
3	
4 A	
5 B	
6 C	
7 D	
8 E	
9 F	
10 G	
11 H	
12 I	
13 J	
14	
15	
16	
17	
18	
19	
20 K	
21 L	
22 M	
23 N	
24 O	
25 P	
26 Q	
27 R	
28 S	
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