RESNIK IMPLANT INSTITUTE

NEWSLETTER

June 2026 / Vol 33

MASTERING THE BUSINESS OF DENTISTRY

ROGER P. LEVIN DDS

Hello Readers,

I am very excited to provide the latest installment of "Mastering the Business of Dentistry" in the Resnik Implant Institute newsletter. I have great respect for the educational importance of the Institute, and I sincerely hope that I will be able to contribute ideas on the business of dentistry and increasing practice production that will benefit all students and alumni. My own career as CEO of Levin Group began with one question that I am still asking 40 years later – how do you increase production in a dental practice while reducing stress? Based on this critical question, I look forward to providing more practical recommendations that can be implemented quickly to benefit all your practices.

All the best,
Roger

THE OFFICE MANAGER IS YOUR CHIEF OPERATING OFFICER *... or should be*

In recent years, Levin Group recognized that an overwhelming number of dental office managers—nearly 90%—had no prior management experience or background. As a result, we spent the past two and a half years conducting extensive research on this issue. One critical finding was that, in most cases, dental practices promote office managers from within the existing administrative team rather than hiring experienced candidates from outside. The result? The majority of dental office managers have limited management knowledge, experience, or expertise.

Using the data from our study, we developed a comprehensive educational program that fully trains a dental office manager within 12 months. But what exactly is the role?

It is widely accepted that dentists are overwhelmed. The pressures of managing patient volume, navigating insurance reimbursements, and overseeing staff can be enough to exhaust anyone. When dentists attempt to manage all of this while also seeing patients all day, sustainable practice growth becomes nearly impossible.

For a practice to succeed, the dental office manager must function as the chief operating officer (COO) of the practice, managing all non-clinical aspects. In the business world, the COO has a standard role on the organizational chart. When an office manager effectively fills this role, it allows the dentist to focus solely on patient care—where their attention belongs. Any operational issues that arise should be handled by the office manager. That is the role of the COO.

Imagine an office manager who is responsible for:

- Running all day-to-day operations of the practice
- Implementing non-clinical systems, documenting them, and tracking performance metrics
- Managing and controlling overhead by analyzing expenses and negotiating costs
- Tracking the practice's key performance indicators (KPIs) on a weekly, monthly, and annual basis, and taking corrective
- Recruiting, interviewing, and hiring new staff as needed
- Overseeing human resources compliance and regulations

(cont'd pg 3)

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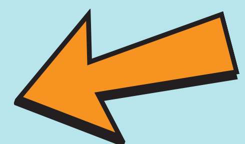

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- Screw/Cement Prosthetic Protocols
- Digital/Scanning Protocols
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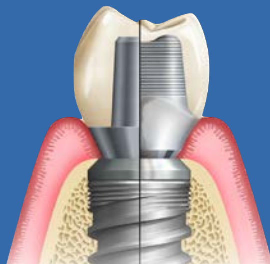
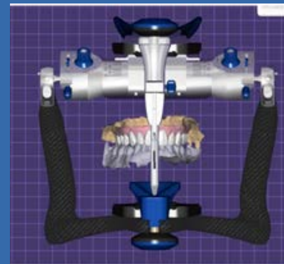
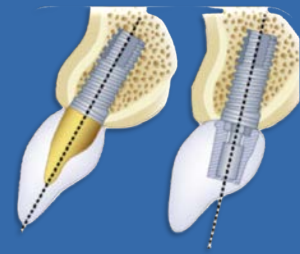
- Evaluation of Vertical Dimension
- Facial Measurement Labs
- PMMA Interim Prosthesis Protocol
- Development of Occlusion Protocols
- 3D Printing in Implant Prosthodontics
- Overdenture Attachment Selection
- Custom Healing Abutment Lab
- Removal of Stripped/Fractured Screws







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Imagine an office manager who is responsible for:

- ·Meeting regularly with team members to provide coaching and support
- ·Addressing team member underperformance and resolving internal issues
- ·Establishing and managing key meetings (e.g., daily morning huddles and monthly staff meetings)
- ·Fostering a positive culture, motivating the team, and maintaining an engaging work environment
- ·Leading the annual goal-setting process

The key takeaway is simple: the office manager's role is to function as a COO. Anything less ultimately shifts the burden back onto the dentist.

The office manager's role is to function as COO

COMPREHENSIVE OFFICE MANAGER TRAINING

Most existing office manager training consists of short online courses, webinars, and written materials. We believed a more comprehensive approach was necessary, so our comprehensive training program uses a different methodology that includes:

Individualized support. Each office manager is paired with a dedicated consultant who provides one-on-one guidance throughout the program.

Hands-on implementation. Consultants work directly with office managers to implement and refine systems within the practice. This approach not only teaches foundational concepts but also improves efficiency, productivity, and profitability in real time. We believe that actively performing the role of a COO is essential to master it. This includes:

- Implementing systems such as scheduling, collections, hygiene, case presentation, no-shows, and new patient onboarding.
- ·Handling staff management, including recruiting, onboarding, training, motivating, and addressing performance issues.
- ·Developing the practice strategy and vision by aligning practice goals with daily execution and driving progress toward those goals.
- Steering financial management, including analyzing KPIs and determining whether the practice is on, above, or below target

OUTCOMES OF COMPREHENSIVE TRAINING

Upon program completion, office managers will be equipped to manage all non-clinical aspects of the practice, allowing dentists to focus entirely on patient care. Clinical dentistry is complex and advancing technologies make focused attention even more critical. Dentists should not have to operate under constant stress or risk burnout.

SUMMARY

The days of simply "hanging a shingle" and expecting immediate success are over. Dental practice management now demands much more time and effort in order to be effective. The good news is that a comprehensively trained office manager gives practice leaders the best opportunity to focus on what they trained for: being dentists.

With a strong foundation of knowledge and skills, office managers can continue to grow alongside the evolving demands of the profession—while dentists regain the ability to enjoy their careers at a level many have not experienced in years.

ROGER P. LEVIN, DDS

Roger P. Levin, DDS is the CEO and Founder of Levin Group, a leading practice management consulting firm that has worked with over 30,000 practices to increase production. A recognized expert on dental practice management and marketing, he has written 67 books and over 4,000 articles and regularly presents seminars in the U.S. and around the world.To contact Dr. Levin visit www.levingroup.com or email rlevin@levingroup.com.

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IMPLANT QUESTION OF THE MONTH

Question: In this comparative study, which implant body material is more reliable overall for long-term clinical use when post-op complication risk is considered?

Answer: Titanium implants has been shown to be more reliable as it has a stronger long-term clinical track record and slightly better survival in this study, even though zirconia showed somewhat better soft-tissue health findings. The study reported very similar outcomes, but titanium still had the edge in survival and remains the more established option when balancing complication risk, predictability, and evidence

Sailo JL, Bembalgi M, Behera SSP, Khetani P, Mohanty AK, Dewan H, Kommuri S. Evaluation of Long-Term Success in Zirconia Implants Versus Titanium Implants: A Comparative Study. J Pharm Bioallied Sci. 2025 Sep;17(Suppl 3):S2488-S2490. doi: 10.4103/jpbs.jpbs_1847_24. Epub 2025 Jun 20. PMID: 41164498; PMCID: PMC12563459.

PROSTHETIC QUESTION OF THE MONTH

Question: A recent study evaluated the post-operative occlusal adjustment of implant prostheses using a subjective technique (articulating paper) and objective technique (T-Scan Computerized Analysis). Which technique resulted in less technical complications?

(Lerner, Henriette, et al. "Implant Complications After Installation with Traditional Vs Digital Occlusal Indicators." Advanced Dental Technologies & Techniques (2024): 1-15.)

Answer: This study evaluated whether computerized occlusal analysis with the T-Scan 10 could reduce prosthetic implant complications compared to using articulating paper alone. Over a 3-year period involving 306 implant restorations, the digitally guided approach significantly reduced complications from 24.5% to 1.8%.

The authors concluded that subjective interpretation of articulating paper markings is unreliable and predisposes implant restorations to mechanical failure, whereas combining articulating paper with objective digital force and timing analysis provides a more precise and predictable method for implant occlusal adjustment.

ZIRCONIA QUESTION OF THE MONTH

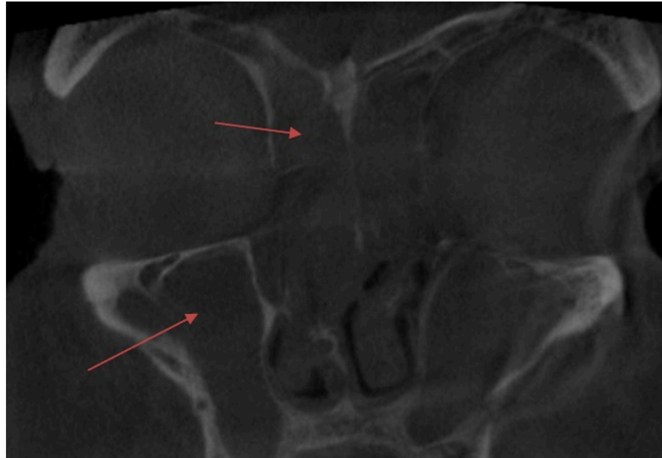
Question: Does polished monolithic zirconia cause clinically significant wear of opposing enamel compared with other restorative materials?

Alqutaibi, Ahmed Yaseen, And Ramy Moustafa Moustafa Ali. "Polished Monolithic Zirconia Crowns May Cause Less Antagonist Enamel Wear Compared To Metal-Ceramic Restorations." Journal Of Evidence-Based Dental Practice 25.1 (2025): 102088.

Answer: The best available evidence suggests that polished monolithic zirconia does __not__ consistently produce clinically excessive antagonist enamel wear, although wear can still occur and is strongly influenced by surface finish, with polished surfaces generally performing better than glazed or rougher zirconia. A 2025 review also notes that polished monolithic zirconia may cause less antagonist enamel wear than metal-ceramic restorations, supporting the idea that finish quality is a major determinant of wear behavior.

Case of the Month

By: Ethar ElShennawy, BDS, MSc



Case of the Month Complete Opacification of the Paranasal Sinuses

Clinical Presentation: A 58-year-old male presented for a consultation regarding dental implants in the posterior maxilla (sites #2, #3, and #14, #15). The patient reported a history of "chronic allergies" and mid facial pressure.

Radiographic Findings

A routine preoperative CBCT was performed to evaluate the available bone height for potential sinus augmentation. The scan revealed:

- **Total Opacification:** Complete loss of pneumatization of the bilateral maxillary sinuses.
- **Pan-Sinusitis:** Extension of the opacification into the ethmoid and frontal sinuses.
- **Ostium Obstruction:** The osteomeatal complex was completely occluded by thickened mucosal tissue.
- **Bone Sclerosis:** While the sinus floor was intact, the lateral walls showed reactive thickening.

The Diagnostic Dilemma

Mucosal thickening visualized on a cone-beam computed tomography (CBCT) scan typically represents a transient inflammatory response. Conversely, complete opacification indicates absolute failure of the maxillary sinus drainage system. Any surgical treatment plan involving the sinus cavity is strictly contraindicated in the presence of complete opacification. Introducing an implant or bone graft material into a sinus with compromised mucociliary physiology may precipitate severe complications, including graft infection, rhinosinusitiss, or ocular involvement.

Radiology Tip of the Month

The Post-Op Blueprint: Standards for Implant Assessment

Following surgical intervention, obtaining a high-quality baseline radiograph is imperative. This iniitial image serves as a crititical reference point, enabling the longitudinal evaluation of healing, marginal bone changes, or potential peri-implant infection on subsequent postopera1ve radiographs.

1. The Geometry of Success: Parallelism

The most common error in post-op assessment is an angled periapical (PA). If the X-ray beam is not perpendicular to the implant body, you will see "overlapping" threads or a blurred crestal interface.

- The Goal: You must clearly see the sharpness of the threads on both the mesial and distal sides.
- Clinical Criteria: Clearly defined implant threads confirm an accurate, non-distorted projection suitable for evaluating crestal bone levels.

2. Establishing the "Zero Point"

A baseline radiograph should be taken at two cri1cal stages:

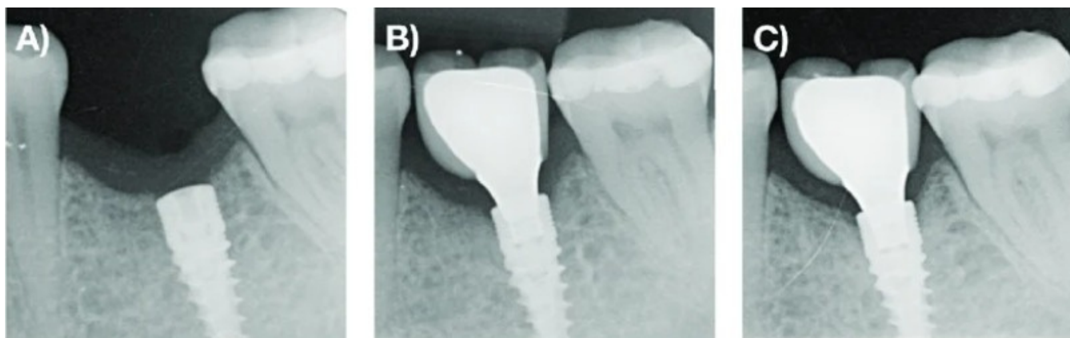
1. At Implant Placement: To verify the implant posiition to the crest and proximity to vital structures (the "surgical baseline").
2. At Prosthetic Loading: To establish the "remodeling baseline." Most implants undergo minor physiological remodeling after the abutment is connected. This is your "Year 0" baseline for future comparisons.

3. The Anatomy of Integration

When reviewing the post-op image, use a systematic checklist:

- **Crestal Bone Height:** Is the bone at the level of the microthreads or the polished collar?
- **The "Halo" Check:** Is there a radiolucent line (fibrous encapsulation) around the implant? A successful implant (fully healed) should show **functional ankylosis**—direct bone-to-implant contact with no intervening PDL space.

Summary: Although cone-beam computed tomography (CBCT) serves as the primary modality for preoperative treatment planning, the conventional parallel periapical radiograph remains the gold standard for monitoring long-term bone stability. Standardization of the imaging technique is essential to accurately differentiate physiologic bone remodeling from active peri-implant disease.



A: Implant Placement. B: Prosthesis Delivery. C: 12-months follow-up.

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MODULE # 3

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- Master Guided Bone Regeneration (GBR) and ridge augmentation techniques.
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CHAT GPT ADVERTISING IS HERE! WHAT YOU NEED TO KNOW!

by Mark Romano, CEO of NOW MEDIA

OpenAI launched ChatGPT Ads to general availability in May 2026, and Now Media Group is among the first dental marketing agencies to manage campaigns on this brand-new channel.

In a significant shift for digital advertising, businesses can now pay to appear as sponsored results within ChatGPT conversations. For dental practices, this is a live channel available to use today.

What Are ChatGPT Ads?

When a user asks questions such as "Who is the best dentist near me?" or "What should I look for in an implant dentist?", ChatGPT can now surface sponsored results alongside its organic AI-generated answers.

These recommendations are woven directly into the response and labeled as sponsored. This puts your practice's name and call to action directly inside the answer to a patient's specific question.

Why This Matters

- Scale: With over 400 million weekly active users, a growing percentage of people are using ChatGPT to ask health and local service questions.
- High Intent: Users asking for recommendations are in active decision-making mode, providing an intent signal as strong as a branded search on Google.
- Competitive Advantage: Most practices are not yet on this channel. Early movers can establish a presence before the market becomes crowded and expensive.

What Should Your Next Step Be?

Now Media Group is currently onboarding clients for ChatGPT Ads management. We are limiting early access to ensure each campaign receives dedicated attention.

To see whether ChatGPT Ads are right for your practice and whether your market is still available, you can book a free strategy session with me directly. Call or text 858-352-8474 or email mark@nowmediagroup.tv

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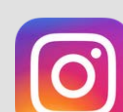

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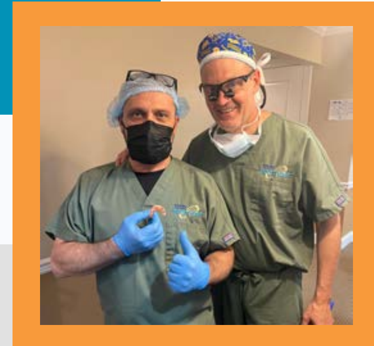
By Nemer Hussein, CDT

Lab Technician to The Stars!!



SIMPLIFIED CORRECTION OF OVERCONTOURED PMMA INTERIM PROSTHESIS

PROBLEM:

Even with guided surgery, in some cases the resultant implant position will result in an overcontoured interim prosthesis. When this occurs, patients often will complain about speech problems and irritation from the overcontoured part of the prosthesis. (Figure 1)

Figure 1: (a) Pre-op image prior to extraction of mandibular teeth, (b) lingually overcontoured PMMA prosthesis (green circle).

SOLUTION:

STEP #1 Instead of fabricating a new PMMA prosthesis, a modified conversion may be completed. On the original master cast, more ideal angled abutments may be selected (buccal version). A placement jig maybe fabricated to allow ideal intraoral abutment placement. (Figure 2)

Figure 2: (a) More ideal abutment selection and positioning, (b) placement jig.

STEP #2 After the new abutments are inserted, a chairside conversion (new abutment pick-up) is completed (Figure 3)

Figure 3: Chairside pick-up with more ideal angled abutments

(cont'd. pg 12)

CONCLUSION:

A simplified chairside technique has been discussed to correct an overcontoured PMMA interim prosthesis due to non-ideal implant positioning. Instead of fabricating a new PMMA prosthesis, more ideal angled abutments were placed and the prosthesis was converted to a more ideal contour. Always verify complete seating of the abutments via intra-oral radiographs. If in doubt of the passivity, complete a new scan in case a new PMMA is required at a later date. (Figure 4)

Figure 4: (a) Existing lingual positioned implants or abutments (green arrows), (b) Chairside conversion with more ideal angled abutments.

Please note that Resnik Grand Rounds will be on summer hiatus and will resume in September. We look forward to reconnecting with you then and sharing another exciting season of educational programming.

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