The practice I just purchased has a different way of doing immediate dentures. They charge approximately $100 to 150 more than a regular complete denture and will make the patient a new denture at six months to one year. This doesn’t seem like it leaves any profit after the lab costs and chair time for two dentures. Do any of you do this in your office? How much more do you charge? Instead, do most people include a reline with an immediate or do you bill that separately as well? Thanks.

Here’s how one of my accounts likes to do immediates:

We mount the casts, remove the teeth from model, postdam, and vacuum form a .100-inch baseplate. We then set up the denture(s) as if we are going to do a try-in. After the set-up and wax-up are complete, we make a cold cure duplicate of the wax-up... similar to the Lang Duplicate Denture technique only with reversible hydrocolloid and a “Pour technique” flask, The doc uses these for his “Band-Aid” denture, and has the set-up on hand to show the patient the premium teeth he will be getting after the healing. After the healing, he uses the wax try-in as a custom tray and takes a wash and a check bite. The normal “extra” lab fees are: the AED (Avoid Embarrassment Denture), stone models (new masters), a new baseplate (if we are doing another try-in...usually about 80 percent of the time), and a reset. The AED with its healing relines (hydrocast) can be kept by the patient (in his freezer) for a spare.

Below is an old photo of the try-in side-by-side with its AED:

We charge more than a standard denture due to the many more adjustments and soft relines as the bone remodels. At about six to eight months, we do a hard reline and charge the patient for this. I like billing it separate because there is a percentage of patients who never get this procedure done due to death or moving.

I have a small practice in an older area of a large city; my patients have aged along with the neighborhood.

I do about a denture a month and learn from each, because each is so different.

My immediate fee is usually about the same a standard denture and I include as many soft liners (functional, then Coe-Soft, then Pro-Tech)
as needed and one hard (lab or chairside) reline within a 12-month period. I think most folks do it for six months. Three weeks ago I picked up an old patient that had gone to a less expensive DDS but who started charging him for a denture adjustment just two months after the extractions.

But I do charge separately for the extractions, of course, and for any alveoloplasty prn [as needed]. I try to see any relines during my non-staff time or lab time.

Some things to warn them about in the beginning are to plan on a new denture at the 12-month point, but hardly anybody follows through. My immediates usually will last three to five years unless there is a lot of resorption; most of the patients will hang onto their teeth until there’s hardly any ridge left. Then I point out during all those relines that it takes three days for a lab reline and five to seven days for a rebase. They don’t want to be without it for more than an hour. Chairside relines have their place but they will be thicker than they want. Usually I stock a Triad VLC material and the S/S powder/liquid material. It also gives me a chance to see what limits their mouth has with acrylic.

I’ll charge for a whole new denture when I do a whole new denture. It is one of the most challenging things I do.

I like Tim’s deal; I see it for the patient who has a 12-month view of the clinical decision. That AED looks very good.

I also think that it is the best role of an AED that I’ve seen. But the problem that I smell is that the final thickness will be pretty thick if you shoot for a VLC lab base-plate with a wash and resorption.

My idea of the ideal thickness should be 3mm. Is this unreasonable? Am I gagging on gnats? ■ Allen R., DDS

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Hi, I have an immediate case in progress, but have not done one for some time.

I am really intrigued with Tim’s lab approach. I just want to be sure we’re saying the same thing. Basically, you are saying to make a duplicate denture to use as the immediate. Do some soft relines initially, and then use the duplicate as a custom tray (or perhaps with hydrocast) to make a final working model. You transfer the initial wax-up with premium teeth to this working model, do a try-in, and then process. Is that correct?

My plan had been to deliver the premium teeth denture immediately, soft reline early on, hydrocast in six months and do a hard reline. I already built in a fee for hard reline in the plan. However, I like this a lot better.

Thanks for any clarification. ■ Jim

Jimeaker, let the patient keep wearing the duplicate denture.

Use the initial wax-up, that the AED was made from, as your custom tray and bite registration.

Jimeaker
Posted: 5/12/2007
Post: 12 of 74
Total Posts: 7

Jim

Cynosurer
Posted: 5/12/2007
Post: 14 of 74
Total Posts: 385

Jimeaker, let the patient keep wearing the duplicate denture.
If everything is perfect, after you take your wash, you can go straight to processing. Generally, though it is best to do another try-in. Although we always re-wax the case to reduce labial and palatal thickness, it’s always good to confirm the labial thickness with a try-in. Some elderly patients may have become used to the thickness of the AED and the plastic ‘surgery’ effect it may have had in removing wrinkles.

Duplicate denture, AED, transitional, temporary, band-aid dentures...all good names. Anybody got more?

In the lab we refer to them as “garbage dentures” because that’s where they need to go as quickly as possible. But they do serve a purpose. It may take a while for your lab (if they aren’t used to the technique) to get decent looking results. Of course, the worse they look, the more the patient will appreciate his permanent set. And, as the hydrocolloid technique is used in a lot of same-day denture clinics (though they “process” to the stone model and use manufactured teeth instead of cold cure) many docs make sure that the patient’s are aware of this.

I have 25 years experience and find that for the patients that I see it is a much better service to make a transitional denture. Have them wear it during healing and then come back and make the new denture. Celera system can be helpful here as you can use transitional in this system and modify your set-up. Patient ends up with one very aesthetic denture and one that is pretty good as a back up. I also treatment plan mini implants on every lower case, if they do not want them right away they usually want them after they wear the transitional for a while. Our immediate fee is higher by at least $450 per arch...Our team makes great dentures that look great...It takes care, skill and training to do these right. There are 36-40 million dentures out there that are going to need to be done or redone at this point. You just need to decide what part of that market you want and go for it. The folks that want a lower fee, I refer to the denture center.

I quit doing full-arch “immediate dentures” as a final product quite a few years ago. The reasons: Even though most of them did well, all it takes is a few problematic patients to ruin profitability and give you that, “Oh, no. Mrs. So-and-so is on the schedule again.” You also can’t predict prior to the extractions which patients will have the greatest changes in their residual ridge. This leads to occlusion and tooth position problems, etc. Some of these patients will be the kinds who insist that “it’s your fault they don’t fit/look horrible.” If they become disgruntled enough to leave you, they are the ones who either won’t pay or demand a refund. If they don’t leave they want a free remake/reline, or expect free adjustments forever.

So here is what we do now. If a patient needs extractions and a denture, I always remove posterior teeth first. Sometimes I will leave first premolars as vertical stops, but it depends on the individual teeth.

We then wait for six months for the ridge to heal and mature. Doing these extractions first and allowing for healing gives a stable base, and greatly reduces the number of adjustments needed when the interims are placed.

The second phase involves the fabrication of what we call an “immediate interim complete denture.” This interim denture is designed with less expensive acrylic teeth, and we only replace the six anterior teeth. Posterior teeth are replaced with acrylic pads. Once fabricated we remove the remaining teeth, do any alveoloplasty, and insert the denture with a “temporary soft tissue conditioning liner.” I usually use Lynol.

The beauty of doing an “interim” denture with acrylic pads in the posterior is that it does not look like a regular complete denture to the patient. I always tell them...
ahead of time that interims will look and function anywhere from “pretty good to really bad.” I purposely set their expectations low, so if it does better, then great. But in the patients mind the interim is just a step in the whole process. It is not the final product. It won’t look, feel, or fit like the final denture. The interim is worn for another six months.

After this second six-month healing period we fabricate their new dentures. You now have posterior ridges that are 12-months post extraction. Fabrication is able to get VDO [vertical dimension of occlusion], occlusion, and aesthetics right where you want them.

I also explain to the patients that a majority of the people will need to have their denture relined at some point during the first year or so due to continued changes in the ridge.

Patients are charged separate fees for: the interims, the soft liners, and the regular complete dentures. We do “post insertion denture adjustments – PIDA” at no charge. Because we have only removed the six anterior teeth at insertion there are typically also fewer adjustments and things fit better – no PITA.

Another great advantage to the patient with dental insurance is that the extractions and dentures can be split up between two and sometimes three years of insurance benefits. It’s less money out of their pocket which they appreciate.  ■ Wade

Whatever works in your practice is what you should do. I have been successfully doing outstanding dentures for 28 years. Immediates, or whatever term you use in your office, are a great service for the patient and an excellent profit center for the dentist. You need to know what you are doing and have a great lab to back you up. With that combination you will win almost 100 percent of the time. I forewarn the patients that the immediate denture encompasses a lot of guesses on my part and the labs part, as no “complete try-in” is available. There are no guarantees that they will be happy and there will be a charge if they want any changes or a different denture. This has occurred only a small number of times. Typically the patient is very pleased and a hard lab reline is done, at additional cost after three to six months. I use the traditional rules of extract posteriors, leaving 6-11 and 22-27 (in most cases). Take primary impressions (using periphery wax border molding) at extraction visit – five days later take secondary impressions. I use custom trays with no handle (gets in the way), green stick compound border molding (active manual and patient movement) and pvs medium body for the final impression. I have tried the two-step alginate with the preformed anatomical trays, Celara, Dentsply’s bite and impression in one and many others. They all work at times. There are other short cuts that work some of the time. The only 100 percent predictable A-1 outcome is the traditional primary, secondary, bite, try-in, delivery, 24-hour and 72-hour post op. The occlusion is typically 100 percent. Subtle balancing of the occlusion is done at the 24-hour visit. Using this formula I generally have zero-2 spots of denture base adjustments. It is rare that I have a patient call after the 72-hour visit with a problem.

In creating immediates you have to be able to visualize where you want your teeth (especially the upper anteriors) and be able to communicate this accurately to your lab. You have to communicate parallelism with the eyes and the ala-tragus line. Dentures are a compromise between aesthetics and function. You have to know where and when and how far you can slant your creation between these two (usually) opposing directions. My patients usually are wowed by my dentures. The comments usually include statements such as “they don’t look like dentures,” “they look better than my real teeth,” “doc – I can talk clearly and you just pulled my teeth and put these in.”

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I charge a healthy fee for my traditional dentures. There is an up-charge of $150 for an immediate denture. Relines are additional. I rarely if ever need to use a soft liner. I do use tissue conditioner on pre-existing ill fitting denture cases as needed. I do my own surgery short of tori removal. Extractions and alveolectomies are straightforward and allow you to control the supporting tissues as you see fit. It is a great service for the patient to sit down and have the extractions and denture delivery without having to transport between an Oral Surgeon and your office.

After the basics of denture construction are learned the best teacher is “doing.” You really must be able to visualize what you are shooting for to create excellence. I hope this has been helpful.

To make a temporary maxillary full denture I do the following:

1. I take an alginate impression before the extractions and then inject temporary crown material into the tooth areas of the impression to form the denture teeth.
2. Then the impression is poured in plaster.
3. Then I use the Densply Triad system. I first use the Triad gel around the teeth to get a strong bond. Then I use the denture base material to complete the denture. It is very easy and only takes about 10 minutes.

You can even add a few more teeth if you wish using regular composite.

I think we all know that while it does matter some what we call these dentures (immediate, provisional, band-aid, etc.), I think what really matters is the info we give the patient. I have my patients watch CAESY, then I play devil’s advocate and tell them all the shortcomings of this process, including that we might end up making new dentures after you heal (making sure to tell them that they will have to pay for them too.) I then tell them that they will have to learn to live with this as an amputee has to learn to live with a new prosthetic. This usually sets the right mood for an exchange of information in which the patient realizes that dentures are difficult to make and to wear.

1. Take VDO measurements, jaw relations, etc., Extract posterior teeth, take impression for custom tray, let heal for two to three weeks.
2. Take final impression, send case to lab
3. Get case back to verify denture and surgical stent (a must)
4. Take out anterior teeth, place denture
5. Back 24 to 48 hours later for post-op
6. Two weeks post-op
7. In-office reline after tissue completely healed over
8. After six months to one year permanent reline vs. remake (I charge for these)

I charge a few hundred more for my immediates because of the in-office relines, but I never charge for adjustments unless I didn’t make the dentures. Scott Lopshire, DDS