

**Howard Farran:** I am, uh, thrilled to death to be interviewing today, Armen, who's, um, a pioneer in everything, everybody knows him in Dental Town. How many posts do you have on Dental Town, Armen, like seven or eight thousand?

**Armen Mirzayan:** Uh, if you combine all of my accounts over the years, probably 20,000.

**Howard Farran:** Oh my God, thank you so much, Armen, for doing that. You are seriously the heart and soul of Dental Town, even though I say that cracking up because when anybody, uh, hits the Report Abuse button, and you get a complaint, um, I have to tell you, you're the honoree that's about, uh, I don't know...what percent of the complaints do you think you are?

**Armen Mirzayan:** No idea. I'd love to know.

**Howard Farran:** (Laughs) It, it's up there. I think you're definitely number one, and every time I read the complaint of whatever you wrote, I just bust up laughing and I just think, this poor guy doesn't know. Armen, you are the funniest guy. I don't know who's more funny – you or Mike Ditolla, but uh...

**Armen Mirzayan:** Ditolla for sure. I don't hold water against Ditolla. He's, he's very comical.

**Howard Farran:** Oh my God, you're, you're uh, I don't know, that might be a tie, as the two funniest guys in dentistry. Man, you're both extremely funny because you're both wickedly, wickedly smart. I mean, you are smarter at another level than us mere mortals, and uh, you just have the, uh, actually you have British humor. You have a very dry, cynical British humor. I don't know, has anybody told you that before?

**Armen Mirzayan:** Uh, I've heard it all. Actually I've heard most is when people meet me personally, they're disappointed, but \_\_\_\_\_ person and expect this really rambunctious person, though when they meet them and they're frankly disappointed.

**Howard Farran:** Yeah, that is true. You're, you're a, uh, in print or web is different medium, and uh, you are, uh, a shy, quiet, down-to-earth humble guy. Love you to death, love everything you do for dentistry, and once again, you're pioneering the way, um, with the new 3D x-rays and surgical guides and, uh, you wanted to pioneer, uh, all my podcasts have had the same format, I think I've done thirty, and you're, uh, you're going to do it differently, so I'm just going to let you go and, uh, show, show us how you can, uh, run with this podcast format on teaching us everything that you do.

**Armen Mirzayan:** Sure, uh, well uh, as you mentioned, I started this imaging center, and I know for myself, uh, there are quite a few imaging centers around, and I'd done just that modality of work, there's no way I would have survived. So, what we do is, uh, it's one thing to get images taken from an imaging center; it's a completely different process to take those 3D scans and do the implant designs and then fabricate or manufacturer a stent and have it delivered to the dentist. So, we're an A-Z solution. Quite simply, any doctor at any stage of their career, whether they are one day out of dental school, they have 30 years in practice, they have technology or they don't, they can refer a patient to us. We scan them with a cone beam, we scan with a CAD-CAM machine, we do the perfect ideal implant

placement, and then upon their approval, uh, we fabricate a stent and send it to them so they can do guided surgery.

**Armen Mirzayan:** The thing you are going to love about this, Howard, is I can do this and guarantee that every single implant is placed with the least liability, the most predictability, uh, with a profit margin for every single case that a doctor does. Uh, I think that's pretty profound because for myself, when I started, uh, placing implants a good dozen years ago, uh, I probably, it took me a good two years to reach the return on investment with all the equipment and the fixtures I've purchased, uh, and uh, it took a while to, to reach a margin of return, whereas with this, it can be at any stage of your career, you just need a hand piece, obviously need sound principles in implantology. I'm not trying to make this sound ridiculously simple, you need to know basic implantology, you need to be well educated, but I can get that stent in a doctor's hand with our services and they can place the implant with the least amount of liability, the most predictability, it's done fully guided. Is that a good broad overview for you, Howard?

**Howard Farran:** You're, you're amazing. Uh, I'm going to stop you right in your tracks. Um, first of all, for that dentist that's, um, ready to start, what do you recommend for the basics of implant training? Anything, uh, any courses, any hands-on, uh, to get them ready to place their first implant?

**Armen Mirzayan:** Well, all of those things, so I encourage all those. We have so many different implant manufacturers that have their own courses, uh, that you can attend as long as you've purchased their fixtures. They have so many different options. Uh, the one thing I'd like to add is that the, the maturity of an implant curriculum is, uh, all about anatomy and what to avoid and what, uh, what to look out for. When you see it in three dimensions on a 3D x-ray, um, it's, it probably alleviates about 2/3 over any implant curriculum. I mean, you still need to know sound principles of bone biology, you still need to know, uh, all of the basics, you need to know how to lay a flap – I'm not saying you can use our services and not know anything about implantology and succeed right away. Uh, so I'm impartial. I'd say take as many courses as we know everything about dentistry is a continuum. You're always improving by taking courses. This is not a substitute for a sound foundation in surgery and implantology.

**Howard Farran:** Very good. I did the, uh, I did the Misch institute, uh, out of school and got my fellowship at Misch Institute, and then I joined the, uh, and got my Diplomat International Congress for Implantology, and I always say the same thing about CE. Looking back at all the CE I took over the years, I probably learned the most from just making life-long friendships with somebody I met in the class, and I always think that was the biggest value of, uh, those courses is, uh, going through it with a buddy, and then, uh, and the course is just the beginning, and then it kicks off a long career of, uh, a friendship and new technology and a new service, but implants are exploding, and I love them to death because, um, dentistry again, is a biology problem, it's a problem where teeth are attacked by a bacteria, and dentists seem to always treat it as a mechanical engineering problem, and what I like about implants is they're not going to get a cavity. And when I go into these nursing homes and look at, uh, the little old ladies that I did all those root canals and crowns on, they were usually destroyed by root service decay within a year or a year and a half, and the ladies that I did, uh, implants on, they're, sometimes they're...the only teeth left in their mouth is implants. So, I think, I think implantology is the future just because of the biology problem. Would you agree with that?

**Armen Mirzayan:** Uh, I completely agree with it. I also think, uh, I've read quite a few studies that we anticipate implant dentistry to be the largest growth in our, in our profession over the next five to ten years' time. I still think there are plenty of problems you can have with, uh, placing implants, and I'll run you through this. The whole reason we set up this, uh, um, this conference is...so, I'm going to take you through the perfect implant placements. Now, the trouble with implants is you might have great success early on with a proper placement, but if you don't have the proper contours...like you see this x-ray up here with this huge potbelly contact – this implant will likely suffer long term because it's a food trap, it doesn't have the proper contours, and I think one of the biggest underestimated things with implantology is, uh, um, uh, the proper location, the proper placement of implant, we want it to draw with the tooth. We want to be able to form a nice emergence profile, we want it to for, uh, have nice contacts so it doesn't trap food or anything like that, so uh, what I want to show you here is, this is how we approach it. You know the crown down technique when planning for implants - here's exactly what we'll do, and I wanted to show this and showcase this to you so, uh, your doctors who are watching this can, uh, look at it, uh, in their own free time, but here's what we do when the patient comes in. We'll take a, a CAD-CAM machine, a CEREC machine, and we'll start scanning the, uh, the occlusion, the uh, this is called a buccal bite, uh, we'll scan the opposing arches, we'll scan the, uh, dentulous area, uh, here you can see the CAD-CAM capturing all that data. Uh, we'll fast forward through this and show you here's where we capture the dentulous ridge, the opposing, and we articulate all those things together and, um, we've designed the perfect placement for the, uh, implants. Here you're seeing the image of the dentulous area being scanned. Here we're leading the, uh, the buccal bite for the opposing to the dentulous arch, and this is very, very important. As we delineate where we want the implants to go, or the restoration to go as the final prosthesis, we get a proposal for this tooth here, and now what we're going to do is we're going to combine this data of this restoration, the ideal placement of this tooth, with our 3D x-ray. Are you following me?

**Howard Farran:** Absolutely.

**Armen Mirzayan:** Alright, so next step from there, we'll proceed to, uh, the design of the, uh, placement, and what's really important for dentists and all of us, spend a little bit of time, of uh, time on this, as here, you're seeing the 3D x-ray, and with a 3D x-ray, this DICOM data here, five, ten years ago, uh, the surgical stents were manufactured off of this data alone, and as you have seen with the Columbian machine you have in your own office, Howard, you get a lot of artifact around metal and opaque materials, and that causes, uh, a lot of artifact and, uh, a lot of distortion in the data, and when you manufacture that surgical stent, more often than not it wouldn't fit. What we're doing now, the progress that's been made is we're integrating the CAD-CAM data of the intraoral scan – I know you have a CEREC machine yourself, you know how accurate it can be, we bring in the restorations within microns, uh, with an optical scan. But, when we integrate these two things and you do your implant design, when you get the stent manufactured, it's manufactured off the CAD-CAM data, and that's all I've ever known for the last six, seven years in my private practice, is the CAD=CAM data that's used for the stent manufacturing fits perfectly into the patient's mouth. So, there's no more ill-fitting issues from the stents that surgeons tried. You know, that's one of the biggest things I run into, is I run into I run into

oral surgeon who tried guided surgery with stents years ago and gave up because it didn't fit, it was inaccurate for them. Does that make sense?

**Howard Farran:** Yes.

**Armen Mirzayan:** Okay, so here we are at the stage of this process here, and what's \_\_\_\_\_ we're designing in 3D we can see where the gum tissue is, we can see where the nerve is, we can see where the outline of the tooth is, and we're going to go ahead and plan the implant for this, uh, for this particular case, and nothing is more compelling when we do these designs for our doctors and our referring based and we show them the relationship of the implant, uh, with the, uh, nerve taken into consideration, the bone taken into consideration, the restoration taken into consideration, and uh, we design the ideal placement. At this point, the doctor logs inner mold. We have many ways we communicate with them, and uh, once they approve the placement of this implant digitally, we get a surgical stent that's manufactured for them to do the surgery. I want to make one thing very clear – there's many different types of, uh, surgical stents. There's the pilotral stent that only allows you to place the very first drill within the bone, and then everything after that is done freehand, where as a fully-guided stent lets you use all the drills in the sequence with the stent in place, and the implant is placed through the stent. The reason I like to differentiate those two is when you use a fully-guided stent, you can replicate this design perfectly. If you use a pilot drill, you can, uh, after you take off the stent, you can obviously widen that osteotomy in a non-symmetric fashion or even get off tract. So, a fully-guided surgery, fully-guided stent is what we recommend which allows you to replicate that surgery. And I'll show you this view from here. This is my favorite view. I can see the long axis of the implant drawing through the center of that tooth. That's going to make restorative super easy for me and it's going to allow me to form all the proper contours for the restoration when we're ready to, uh, restore it. Now, the next step from here, after we've done this design, is we get a stent made, and I'll proceed to the next video here on our site that shows you how the surgery is performed. So, do you have any questions for me? Was that over...was I going too fast or perfectly dead-on?

**Howard Farran:** No, you're going perfect. I was just wondering, are you making these, uh, stents by hand on a lab or are you milling these down or...

**Armen Mirzayan:** Oh no, uh, these are made quite a few different ways. Uh, there's different ways to make tooth-born stents versus edentulous ones. Edentulous ones are, uh, much more advanced and complicated. We need a, a denture duplicate, there's many different ways we approach it. These are milled stents, we can print them, we use quite a few different manufacturers, we use Burbank Dental Lab for some, we use, uh, C-Cat in Germany for some others, so there's many different ways to fabricate a stent. And what's really important for you to realize is this little thumb nail that you're watching is the implant being placed through the stent, and you see that sleeve, that silver, round, uh, sleeve that's in the stent – when we design this implant placement, that sleeve is placed in a very specific position, and it retrofits a very particular protocol of surgical drills that are formatted, uh, to be used in this fashion, and when you use those drills in the proper sequence and the proper protocol, you create that perfect osteotomy, and when you deliver the implant through that sleeve, you bottom out, that implant is placed exactly where you designed this. There's a lot of math that goes in the, uh, placement of these

sleeves within the surgical stent. So, I'll take you through that process right now. Let's blow this up to full screen so you can, uh, see this a little bit better. So, here we have the, uh, the surgical stent in place. This is called a tissue punch. Many practitioners, uh, prefer to do a flap. It's completely up to you. What you're seeing here – and I'm getting a close-up for you, is the drill that's being used with a stop, and we use sequential drills and we drive that drill until it touches the sleeve and it bottoms out. You start with a short drill, you go to the next longer one, next longer one, so I don't have to stop and take, uh, x-rays interim films, I don't have to use any guide pins to, uh, verify my path and draw, all that was done in the design. So, it's as simple as this, I use those drills, I bottom out, I use the implant, uh, I drive it down, and when that carrier touches that implant, uh, I've gone to depth and that implant is seated exactly where I've designed it.

**Howard Farran:** Armen, are you implant agnostic or are there systems, uh, that you prefer?

**Armen Mirzayan:** Yeah, I play very Swiss neutral, I've had to learn, uh, all these different, uh, guided kits. So, this is a guide, fully-guided approach, and you have all the major players here that you see that fully guided systems, and I've used every single one just so it can provide the service that we do, uh, for our doctors. For instance, if Dr. Ordell orders a Nobel implant, I need to know exactly, uh, how the system works so we can stage the case properly. There's a kit for the Taper, there's a kit for the Nobel Active, and I have all those, uh, that I've used. I've used every single one with the exception of one or two, and I have to play the Swiss neutral role because we have quite a few implant manufacturers who are referring their clients to use out services, so I have no preference. Uh, I'm more interested in, uh, being a facilitator for doctors who want to place implants in a very predictable manner with the least liability and serving their patient best, so uh, very simply, I don't care what implant line doctors choose.

**Howard Farran:** I do notice on your list though you have, uh, Implants Direct and Nobel Biocare, and Implants Direct just bought Nobel Biocare. I thought that was, uh, that was an interesting move I did not see coming.

**Armen Mirzayan:** Uh, I did know that Implant d...well, I guess the owners of Implant Direct bought Nobel.

**Howard Farran:** Danaher.

**Armen Mirzayan:** Danaher bought Nobel. Uh, yeah, actually quite honestly, uh, Howard, you would know more about that business than I would. You're probably more in tune with what's going on there. Um, Danaher runs quite a few implant companies. You have Shine that owns, uh, Bio Horizons and, uh, Camlog, you have, uh, you know, it is a constantly changing field.

**Howard Farran:** Correct. And, Armen, you have implant centers...now, you, you, now you live in LA, right...correct?

**Armen Mirzayan:** Yes.

**Howard Farran:** And that's now, um, you were going to open these up in other cities – have you branched out of LA or....I live in Phoenix – are you in Phoenix yet or...?

**Armen Mirzayan:** Uh, so...a phenomenal question. If I had 40, 50 million dollars, yes, I'd be there right now. So, I'm slowly working my way up to it. I need to improve the business model first before I start expanding, but if you notice here for locations and contacts, I opened one in Los Angeles a year ago, in December I open one in Chicago, and then in the spring, one in Beverly Hills, and then last month in Burbank, uh, so we have three in Los Angeles, one in Chicago, and the sole reason I opened one in Chicago is I wanted to make sure I have all the infrastructure, the legal structure of the corporations to legally image and do the things that I want to do out-of-state so I can scale it. So yes, uh, I do have plans of expanding to other cities, but obviously with any business, you've got to pace yourself so you don't drown in, uh, in debt and losses and all those things. So, uh...

**Howard Farran:** Now, are these franchises or are you going to be the, uh, are you going to be the 100% owner?

**Armen Mirzayan:** They're not franchises. Franchises, uh, there's a lot that goes with it. It's about...I have quite a few options. It's about the least appealing way of expanding this, but I would say, uh, three times a week I get a doctor contacting me for a franchising opportunity, uh, in other cities. So, I'd like to be the owner or part owner in every single, uh, location, have many different structures set up and I'm about to perfect it so I can grow properly. So, I'm fantasy...if you ask me what my fantasy is, my fantasyland would be centers all across the country in all the major cities so that, um, guided surgery becomes the standard of care. And I know that's a very sensitive word amongst dentists, but I strongly believe every implant should be placed through a guide. I've seen the benefits and I've seen quite a lot of mishaps, seen quite a lot of well-respected surgeons. You know Jay Resnick very well, uh, you've might have even done, uh, one of these with them, he readily admits he placed...actually, when I got my own implant five years ago, I went to Jay and had him do it fully guided. There is no way you're drilling into my skull without doing it fully guided. And after he did mine, that's when I got into purchasing my own cone beam and doing it myself, as well. I was convinced every implant should be done that way and we're seeing a small movement towards that slowly but surely, but Jay as an oral surgeon, he only places them fully guided, and that's my philosophy as well.

**Howard Farran:** Well, Jay says that...I love the way Jay says, um, he says, you know, let's say that you can get it right free-handed 95% of the time. That means every time you place 100 implants, five of them aren't right.

**Armen Mirzayan:** Yeah.

**Howard Farran:** And uh, that's just well said. And by the way, a lot of dentists throw around the term standard of care, but they don't, don't really think of it from a legal point of view. Can you give a legal definition of standard of care?

**Armen Mirzayan:** Uh, oh that's such a gray, uh, gray zone. I mean, the standard of care is what's commonly practiced amongst your colleagues within your community, and that's such an old definition, especially now with what you do with Dental Town, I mean, the...where's my community? My community's worldwide, so it's really impossible to, uh, to define that. I do think that legal issues, certain standards and certain precedents that are established by, uh, by lawsuits will kind of dictate

where that goes. Um, I mean, I can see a particular lawsuit where there's a settlement because, uh, the doctor had a choice to use a surgical stent, didn't, and especially now that you can get it so readily and so cheaply, uh, if there's a verdict against the doctor, well, why didn't she use a surgical stent, um, and there's a settlement that way, that might set the precedent. I'm not trying to scare anybody, I'm not trying to, uh, say that's the way it's going to go. It's a slow adaptation. We as a community, as professionals, establish that ourselves. If it becomes, uh, very common that every single implant in your community is done through a guide, then it behooves you to do it yourself. A lot of us see the writing on the wall. It's very hard to find standard of care, and I don't like to force it or shove it down anybody's throat, but uh, I believe for myself it is the standard and I wouldn't place an implant without it.

**Howard Farran:** Well, I, it's reminds me of the old IRS adage, you know, dentists are always saying, Is this tax deductible and I would say, Everything is tax deductible until you're audited. And then it's you, the IRS, judge, no jury, and you're going to lose. So, it's, it is going to be a very hard thing to explain to a jury of why you didn't have 3D x-rays instead of 2D x-rays, and guided versus non-guided. I mean, obviously that's where the market is completely going and I'm sure the lawyers will get there first.

**Armen Mirzayan:** Right, and don't get me wrong, there's still mistakes you can make when you're doing them fully guided. The most common one is you place the stent in the patient's mouth, you do the surgery, you don't verify that the stent was indexed and seated all the way. Uh, you can screw that step up. You can, well, when you're doing the CAD-CAM integration and the cone beam integration, you can actually misalign those two data...it's actually pretty elaborate. There are some machine's out there that have so much scatter and artifact, you don't know if you've clearly related those models together and they're perfectly stitched, so if you do the design off an improper stitch, you get a stent made and you use a stent, you could actually do the surgery wrong. Uh, so it's not fool-proof, you definitely need to have, uh, some good basic skills. Uh, but in terms of, uh, reducing your liability, it's a phenomenal way to go.

**Howard Farran:** Fantastic, Armen. I love this. Keep going.

**Armen Mirzayan:** Alright, so uh, personally, I start to tell you my story where I started placing my own implants and, uh, uh, after about five years into it, I placed quite a few...I had a few mishaps and I stop placing them, I was doing them free-hand, they were poorly placed. Luckily I didn't hit the nerve or do anything, uh, serious, uh, but I just wasn't liking how I was placing them, so I virtually stopped, and like I mentioned, once this cone beam guided surgery came about, I, uh, started placing my own implants again. Now, I'm doing anteriors, last Friday I did a ten-unit case under sedation, fully-guided, so, and it's really ramped up what I do in my practice, and the whole idea for \_\_\_\_\_ came about because when I had this technology in my office, all my buddies around me, even my specialists were referring patients to me. Um, my specialists were referring patients from other dentists to, uh, to my practice to do all this workup, and I'm a dental geek, I'd do it, they wouldn't worry about me poaching patients off of them. So, I converted quite a few, uh, of my close friends and colleagues to doing everything guided, and I thought to myself, Well, if this was a standalone business on its own where it's not within my dental [practice, I'd likely get a lot more dentist refer to me, and that's exactly what's happened. Uh, so the main principle for, uh, getting the cone beam in my office was to, uh, place implants fully-guided, and

one of the huge benefits, uh, as a side adjunct was the incredible amount of diagnostic, uh, information brought with me, and one of the ones I'm sure you've heard is, uh, the endodontic applications. So, this is my favorite picture. This one completely derailed where I was headed in my professional life with, uh, CAD-CAM and CEREC dentistry, uh, that completely moved over to focusing on 3D imaging. Uh, Howard, you've been practicing for a while, uh, did...you're not a radiologist, I know you have a cone beam, but isn't this, this x-ray here extremely compelling, that first, first molar, the mesiobuccal root that has my, that has some radiolucency, what's pretty evident on a periapical, that's after I took the scan, I wanted to see the extent of it, uh, that second molar to me was coincidental finding. Uh, can you tell me what you think is going on here? You're not a radiologist, you're a dentist – what do you think is happening in that second molar?

**Howard Farran:** It looks like an oral-entero communication.

**Armen Mirzayan:** That's exactly where it is. I mean, clearly the floor of the sinus is perforated and we have an active infection draining into the sinus, and what's interesting, the path of least resistance, uh, for the infection to spread in the maxilla...in the posteromaxilla is towards the sinus. It's draining into the sinus. We don't see a draining sinus tract that we'd see in the buccal vestibular molar, but up here, it's draining to the sinus, there's no pressure build-up, the patient is symptom-free, and obviously there is a nonvital tooth there that needs to be addressed. And this is very, very common. I am very suspicious of all root canal treated teeth, and the posterior maxilla, I find periapicals to be very useless, uh, and I see quite a lot of lesions and lots of failing root canals that are asymptomatic, and this is a lot of fun to, uh, post on the endo forums at Dental Town. You get, uh, it gets pretty heated where, uh, we have some interesting discussions, uh, but I'm suspicious of every root canal in the maxilla, like I mentioned, the posterior...I find periapicals useless for diagnosing up there, and I rely quite a bit, uh, on 3D imaging to see, it's a very simple principle, right? You have a bolus of infection between three roots on a maxillary molar, you take a regular conventional PA, you overlap all that opacity on that radiolucency, and you try to take it from different angles, you just can't see it, uh, it's all superimposed, a two-dimensional picture of a three-dimensional object, you left a lot to interpretation. You take a 3D scan, you can look at it in different slices and you can clearly pick up where the lesion is.

**Howard Farran:** Now, Armen, now Armen, just to be clear about that, because this is hugely controversial on the internet. There's just a lot of people who don't even believe in endo anymore. If your second molar died, uh, say obviously it's not going to be interproximal decay for you, but it would probably be \_\_\_\_\_ or old age or a cracked root – would you get a root canal on your maxillary molars, or would you extract and do an implant, if it was for Armen?

**Armen Mirzayan:** Oh, no, I would absolutely try the root canal first. It's the most conservative way to approach it. Obviously it has to be restorable. Uh, if it's got a poor prognosis from the restorative, then it's no question it comes out, but if it's restorable, uh, I don't see, uh, why you shouldn't have the endodon...actually, I, I've got the worst mouth out of most dentists. I had a full-mouth rehab done, uh, four years ago, I have six root canal-treated teeth, I have two implants, and every one of my, uh, teeth in my skull have been restored to their proper vertical dimensions. So, if I felt that way, I would have ripped out the root canal-treated teeth already, so no, I still find plenty of room for root canal therapy.

**Howard Farran:** You posted that case on Dental Town. That was amazing. I've always loved how you're so open, honest, transparent, uh, it was amazing. Every...I think about 10,000 dentists followed through your full-mouth rehab.

**Armen Mirzayan:** Uh, yeah, that was a lot of fun. Um, actually what I did is, uh, interestingly enough, because remember I mentioned how, uh, restorative has, uh, a lot of artifact and a lot of, uh, distortion? So, when I set up this business, I wanted to find the machine with the least amount of scatter and distortion, so there's a...here...a video here, our machine of choice, I literally stuck my head in a bunch of different cone beam machines so I could compare and contrast the, uh, amount of, uh, beam hardening and the amount of scatter we get around our materials, so uh, if your doctors are watching this, if they're bored, they can watch this and see the difference of scanning a person's, my own skull, uh, with e-max's on every one of my teeth and implants and root canals, uh, but they'll pick up quite a bit of, uh, of irrelevant information there.

**Howard Farran:** Fantastic. So, when you said you get three requests a week for a, um, a franchise opportunity, how many of those three a week are me asking for one in Phoenix? (Laughs)

**Armen Mirzayan:** Uh...well, this is the first one you've technically asked me...

**Howard Farran:** No, I've sent you an email and a private message asking this.

**Armen Mirzayan:** Okay. Uh, my apologies. Uh, the way I see it is I want to perfect this, that whoever comes on as a partner, as a franchisee, uh, I can show them a cookbook recipe of how to set it up. I'm very, very close. Um, there's quite a few things involved in the process, so let me just run you through what we do. When you refer a patient to us, and we scan them, we just charge \$150, and that includes a radiologist fee of, for a radiologist report for reading the pathology on this, because we're all scared, we're all conservative as dentists. I don't want to miss a tumor or something else that I just can't read off a cone beam, so every one of our scans is read by a, uh, radiologist, uh, to limit our liability and reduce it for the referring doctor. So, you can imagine, at \$150, I'd have to do millions of scans to make up for the start-up costs of each facility. Well, what we also do is we bill medical insurance, and regardless of...I'll keep it very simple – regardless of how much medical insurance pays, the most the patient pays is \$150, and that's a pretty elaborate structure. We want to make sure we follow all the state laws with, uh, everything that's involved in that, um, but that's the first comp in making sure I can do certain things in certain states that's fully legal. I spend quite a bit on legal funds so that I can, uh, uh, scale this to other states. The, um, like I said, the whole purpose of setting up in Chicago was to, uh, show that I can, uh, scale. I know there are some states I cannot run this facility in, and in some states, you can be a non-dentist or non-physician and set up imaging centers, and other states you need to. So, every state I expand to, I've got to spend easily fifty to one hundred grand to study the laws and have the appropriate legal structure in place to do it.

**Howard Farran:** I know, and it just, it just really, uh, made me excited where, uh, oh, what the name, um, oh, I think it was, um, was it Tennessee where the dentist just went to the, uh, the Attorney General and said, Wait, you're telling me that the pharmacist at Walgreens can give a flu shot, but a dentist can't? Can you please explain that? And it was indefensible. So now, the dentist in, uh, Tennessee are

the first dentists in America where they can now, uh, start giving flu shots. I mean, so a lot of this division of labor with the lawyers is really, uh, um, restrict free and fair trade.

**Armen Mirzayan:** Yeah, there is definitely some states, uh, I know for Michigan, yeah, I just learned this, you need a Certificate of Need to get a cone beam machine for your office, there's many dentists out there who don't have access to cone beams, and they're falling behind, both where the rest of the country's going. I know certain states didn't have, uh, laws that allowed dentists to have them, and certain dentists have gone and, like in Connecticut, uh, a townie, Pete Gardell, went to the Connecticut Dental Board and got the laws changed, they can actually put a cone beam in his office. Uh, I believe every dentist should have a cone beam, uh, so the way my business model is structured, uh, I worked with cone beam owners or those who don't, I make more on the tail end of this business process with the, uh, the design of the implants and the scanner, so uh, if anything, when somebody buys a cone beam machine, it's, uh, helps me in a much better manner than they would if they had just used my imaging services. So, it's set up in such a way that everybody wins, the patient wins, the dentist wins, a cone beam owner wins by using our services, uh, and I can scale it, uh, when I'm ready.

**Howard Farran:** But Armen, let me ask you this. Um, well first of all, what percent of...there's 150,000 dentists in America, two million around the world; in America, 30,000 are specialists of the \_\_\_\_\_ are specialists and 120,000 are general dentists, what, how many units are in the United States for, uh, out of that 150,000 total? What do...do you think it's ten grand, twenty grand?

**Armen Mirzayan:** No, it's at about seven or eight thousand last time I read. Again, uh...

**Howard Farran:** \_\_\_\_\_ specialists and general dentists?

**Armen Mirzayan:** \_\_\_\_\_ specialists, yes it does. Uh, you would know this better than me, less than 30% of the dentists in the country have digital x-rays. Is that...can you confirm that, Howard? You would probably know that...

**Howard Farran:** Yes, yeah, that's right on.

**Armen Mirzayan:** So, we've got 70% of the dentists who don't even use digital x-rays right now, so no, I don't see it being half the dentists in America having cone beam, but what I do see, in ten years from now, is more cone beams than panos. I think panos are a complete waste of, uh, resources and funds for the doctors. If the doctor's about to buy a, a panoramic machine, a complete waste, uh, they should budget for it, plan for it, spend a few hundred dollars more and pick up a smaller field, uh cone beam that gives you so much more information than a pano.

**Howard Farran:** So, Armen, when Armen says panos are now obsolete then, no more need for buying a new pano.

**Armen Mirzayan:** I think it's a complete waste of your money.

**Howard Farran:** Okay, but tell me this though, um, what if you are a dentist and you've been out, and you have a pano, and you...say it's a pano and digital x-rays and everything, and you don't place

implants. Um, tell that dentist why they would need a CBCT, I mean, can they still be a good dentist, a good dentist, high tech dentist, and have a, uh, digital pano and bitewings and not a, and radiographs and be 2D radiographically, or does that person really need to upgrade to 3D?

**Armen Mirzayan:** So, I, I never try and force them to do anything. They have to come to that conclusion by themselves. I can give you my opinion. My opinion is absolutely not, I think it's, uh...and I get flamed for this all the time on your website, I think, uh, you are crazy to place an implant with just a pano and, uh, PAs. There's...

**Howard Farran:** No, I'm saying if you don't place implants. I'm talking about the dentist who says, Look, you know, everybody...you know, they totally understand a C...going from 2D to 3D for placing implants, maybe even also if you're an endodontist and trying to see if this tooth, if this root is fractured or needs a retreat, but if you're not doing molar retreats and you're not placing implants, does a dentist really need to upgrade from 2D to 3D radiographs?

**Armen Mirzayan:** Uh, I would s...my answer with that and my personal opinion to that is yes, and actually you just defined my business model. I've set this up to cater to that dentist who may not be ready to go to a 3D machine just yet, they can utilize my, uh, services until they get comfortable and they're ready to invest into the 3D technology, so uh, yes on those fronts. That's how I've positioned this business is to be the facility that takes five to ten thousand dentists into guided surgery no matter where they are in their careers and what kind of equipment they have. So, like I said, with all the thing that I've defined for simple surgical case, uh, I can get you a scan, I can get you, uh, a path report, the implant design, and a surgical stent for \$500. You can charge \$1,200, \$1,500, \$1,800, \$2,000 for the implant placement, use a stent, and still have, uh, a nice margin for your profit by utilizing our services.

**Howard Farran:** Did you say that includes the implant?

**Armen Mirzayan:** That does not include the implant.

**Howard Farran:** Does not include...what, what is that, \$500 includes the scan, the surgical s...

**Armen Mirzayan:** Scan, implant design, surgical stent, for tooth-born cases. Edentulous cases, you can double the stent cost to about \$400-\$500 to start with. Edentulous cases are much more different than tooth-born cases.

**Howard Farran:** Correct, and also, um, something you said earlier about, um, um, flap versus non-flap, to me, it seems like the, um, placing a flap if you don't need to really increases postoperative, uh, complications. I mean, obviously when you're opening up the body and letting in saliva with a billion bacteria per cc, what percent of these surgical guides are people like, uh, Jay Resnick, the oral surgeon on Dental Town or yourself, what percent of these cases can you do flapless?

**Armen Mirzayan:** Um, a phenomenal question, again, a hot topic for a lot your, uh, users on Dental Town. My perspective on flapless is, uh, um, it is significantly less postop discomfort for the patient when it's flapless. Uh, the predominant reasons, uh, you flap, one is to visualize the bone. In my perspective is, hey, if you visualize it on a 3D x-ray, do you need, do you really need to lay a flap to see

where the bone is, and the other reason is if you don't have enough keratinized tissue, you flap it and you place the implant and you can, uh, place the healing abutment and advance the tissue so you can get more attach of keratinized tissue. Uh, so, from my perspective, it doesn't matter. You can do it any which way you want. Uh, I will admit most of mine are tissue punches, most of my cases are single units, two units, they're done in ten, fifteen minutes time, and the postop recovery is...I'll put it to you this way, I hardly pull any teeth – a year, maybe 10-15 teeth a year, they have to be simple extractions, uh, and on average, I think this guided surgery stuff is much easier than, uh, the average extraction. I dread extracting root canal-treated teeth because I never know what I'm in for and how long it's going to take. It's unpredictable, whereas when I do all my work before I do the guided surgery, I know exactly what I'm in for.

**Howard Farran:** I probably pull 15 teeth a week including impacted thirds and failed root canals and, and, I'm tell you, I've had people...I have people all the time for second opinions after implant placement from other dentists or oral surgeons, they've got bruising half way down their neck. I mean, these, these flaps are, they're brutal, and, and they're just, you know, first do no harm, and I think laying a huge flap to, like you say, to visualize it with your monkey ape eyes when you've already visualized it on a three-dimensional CBCT, it's just, you don't need to.

**Armen Mirzayan:** Completely agree. So, that's a hard one to convince periodontists though. Periodontists love to flap, and you're not going to win that argument.

**Howard Farran:** Because they've been flapping their whole lives, and they just...

**Armen Mirzayan:** Yeah.

**Howard Farran:** ...they just love to do it. So, continue with your presentation. This is outstanding, Armen.

**Armen Mirzayan:** Alright, fantastic. So, uh, a couple of things, uh, actually I'd love to get your input on this, uh, so I took a few things that I can't stand about my own dental practice, and uh, what I did is I built it into this website. So, what we do now is I'd love to find a way to figure this out for my private practice, is our patients book themselves an appointment. So, they can choose their own location, they go here, and the click on a, uh, the procedure they want to have done, and they can pick the day and the time, and self-book the, uh, time that they want to come in for a scan. Once they do this, they pick noon, uh, we still take it conventionally, but they can enter in their user, uh, their name, their birthday, and then we process a payment, so before they come in, most of them have paid. Some still prefer to come in and pay, uh, on-site, but uh, we love the, uh, the scheduling of your appointment this way, and I'd love to have this set up for my private practice where we have specific slots just for, uh, patients for new exam, for a nominal fee they secure their appointment for that time. So, I think online scheduling, uh, will have a bit impact for us. What's your opinion on that yourself?

**Howard Farran:** Well, I mean, my biggest pet peeve with the, uh, um, I mean, with all the management information systems that if you go into a, just a, a standard Dunkin Donuts or a Long John Silver's or an Arbys or McDonalds, they all, all management information software is connected to accounting, so in

dentistry, you pay all this money for Dentrax owned by Shine or Softend or Eaglesoft owned by Patterson, and the software can't even generate a payroll, a paycheck to pay for itself. Um, your largest cost is labor, uh, your staff don't clock in or off the machine. You know, you walk into a McDonalds and some 25-year-old punk manager has a management information system says, Hey Armen, it's 9:00, you close at midnight, um, every Wednesday from nine to midnight, you're only going to do this many hundred dollars in sales, we want to have an 18% crew labor, you still got six people clocked in, send home Amy up front because you got two girls up there collecting money and Amy's always \$3 short and Mary's always \$2 long, so let's send home Mary, and then you've got three cooks in the back, let's send home Frank 'cause he's part time, and, and...these million dollar franchises run the tightest profit margins and it's very predictable, and then you go talk to any dentist, say, what's your overhead, what's your return asset, what's your return equity, how many incoming calls did you have last year, you did a new marketing thing, did it increase your incoming calls, what percent of calls went to voice mail, I mean, you ask them any simple question that every franchise in America has, they don't have an answer, and then you go to a new Dentrax, Eaglesoft softend update and they're telling you that the seven new features like the voice-generated perio, it's like they just don't...how can you not be connected to an accounting software? That's just...that's my pet peeve that just drives me crazy. So, yeah, online scheduling, what you just said, is just genius, it's obvious, we should have had it years ago, it should be, um, that, you know, if every dentist had a phone system on an IP address via the internet, when that dentist, when that patient calls the office, the screen should pop up, a picture of the patient, um, how many, how many times did it ring before you had to answer, I mean, the, the list could go on for eternity of how much dentistry could be better served if it had a management information system, and dentists, you know, our franchisee is a non-profit American Dental Association, and if you owned an Arbys, your franchisee would actually be in it for a profit. (Laughs)

**Armen Mirzayan:** Yeah.

**Howard Farran:** You know? So don't get me going on that, that is a raw nerve for me.

**Armen Mirzayan:** Nice, I loved it. And then I took the, uh, the registration form, I automated that so patients fill that out, it's on a secure portal through, uh, Adobe Ecosign, they just fill in all this, uh, the health history here, uh, it's not exchanged by email, you've got to follow the HIPPA laws. I've got all that stuff automated. What I want to show you is the predominant way, uh, the doctors refer to us. So, if we're in your community and you want to refer a patient to us, um, you click on this Online Referral form and you fill in the patient's first name, last name, date of birth, their phone number, their email, you do want to enter these because our staff will hunt down the patients. We have quite a few specialists who are traveling specialists, they do, uh, implants for different dental offices and, uh, some of them figured out, what they do is, uh, before they even meet the patient for a consult, the general dentist refers a patient to us, we scan them, we get all that information set up so when the specialist finally meets them, they have all the data, and they go straight into the procedure after that initial consult. No more running around trying to get, uh, all this data. So, a couple of specialists have figured this out really nicely and have taken it to their advantage. Plus, they screen the patients to see how serious they are with the work. If they've come to us for a scan and they meet them afterwards, they're

more than likely they're going to pursue the treatment. So they fill out the, uh, this information, we recommend...

**Howard Farran:** Now Armen, I, I want to say to you...that's kind of what the Nobel Biocare's, uh, um, what is it called? Uh, all on four?

**Armen Mirzayan:** Yeah.

**Howard Farran:** That's kind of their franchise model, isn't it? Where they have, they find specialists out in the rural areas that want to be busier and so they set up centers in the major cities, and the, uh, the center lines up a bunch of surgeries and then the specialist comes in and, uh, places a lot of implants, correct?

**Armen Mirzayan:** Yes, there are quite a few centers – there's Clear Choice, I think it's called, there's quite a few different models, and they're run by prosthodontists and oral surgeons, very well backed, and that's exactly what they do is they just do the full mouth rehabs on all-on- fours and on multiple implants. Uh, but it's not really a traveling surg...well, maybe a surgeon travels from office to the next. Uh, again, you've, if you're one of the most business-inclined people I know, so you'll probably know more, uh, than I would with regards to how that works.

**Howard Farran:** Well, I think it's a model that lots of dentists can have, is that, you know, uh, a specialist who places implants in a different county who needs the work, um, are often very willing to come over and visit your office one day a month and do these surgeries for you.

**Armen Mirzayan:** Yeah, so to continue with this, then, uh, the doctors can, uh, can screen the patient for TMD, TMJ, for endodontic reasons, uh, for that, they either select screen only or they have to select implant planning and the fee is displayed for them. The only reason I took you through this is to show you, uh, the whole website is built around this Online Referral Form. So if somebody's new that's never used us, they want to order a, a surgical stent and they're like, Well, what in the world is a pilot versus a sleeve-in-sleeve versus a fully guided stent, they click on this and it defines for them what they're ordering. So the whole purpose of the site is to facilitate the whole work flow and show them, uh, um, exactly what they need to order and how, so it defines for them what a fully guided stent is, what a pilot sleeve stent is, and what a sleeve-in-sleeve system is. So, everything on the site revolves around, uh, the implant planning for the doctors. Um, let's go back to the endodontic one, I want to show, uh, a case to you that I think you'll get pretty excited...um, here's one, uh, where I had a patient and, uh, one of the things that I constantly hear from, uh, from people who are somewhat, not critical, but they're not believers of cone beam yet, is when you take a single x-ray on, uh...you're just taking a snapshot of something at a particular point in time, and they're like, you can't draw conclusions from that, uh, because you don't have the Delta, you don't show the difference five, six days later or a month later. So, I have a few cases documented where I show you scans at different points that show a lesion healing. I won't bother playing the video here for you, but here's a case where you can clearly see from where you are at in this thumb nail, do you see the lesion at the apex of this tooth? I already showed you the very first one where you've clearly defined an OA communication, right? So, all this cloudy stuff in the, in the sinus is a inflammatory response to, uh, dental infection, and uh, here we can see the

gutta-percha parts just sticking out, the, past the apex, and what we did for this particular case is we actually extracted this tooth and, uh, you can see the granulation tissue, you can see the gutta-percha sticking out, what I did is I, uh, cut the root tip off, debrided the area, and actually reimplanted this, uh, tooth. It was a brand new crown I'd placed seven months prior, with a root canal that I was invited \_\_\_\_\_, an abscess on the patient, she was in pain and it was a last-ditch effort to save this tooth and the crown that we had just done, and worked quite well. So, this one shows you, uh, the sequence of, uh, different scans showing that this infection of baseline, it shows it growing over the next six days, and then at a six-week postop that shows you how this has completely healed from, uh, the treatment of the extraction and the reimplantation.

**Howard Farran:** Armen, that's very interesting case. You're talking about, um, to our viewers who are not aware of this, I don't think a lot of viewers understand, you're talking about an intentional replant.

**Armen Mirzayan:** Yes.

**Howard Farran:** And this, this is a great case because, um, you know, you don't think of a molar root canal tooth as a case for an intentional replant, but here the, the roots all come together, the maxillary bone is like Styrofoam compared to the mandibular bone that's more like oak wood, and divergent roots and a mandible, you'd probably not have attempted this, correct?

**Armen Mirzayan:** Exactly.

**Howard Farran:** And, and conical roots in the maxillary, that's a very easy tooth to extract, um, do an apico or um, a retrofill – did you do a retrofill on this or just apico?

**Armen Mirzayan:** Uh, no, I did not do a retrofill. Just apico, clean it out, disinfected the area, use a laser to really debride the area and, uh, didn't even graft bone to the area, and it healed really, really nicely. I just cleaned up the source of the infection...and we didn't treat an MB2 canal.

**Howard Farran:** Not as a, uh, that's probably the most beautiful intentional replant case I've seen in a decade.

**Armen Mirzayan:** And uh, and uh, you can see the followup scan that shows how it's healed. Now, if you like that, you'll like this one even more. Uh, so I showed you guided surgery, right? Uh, and that's for placing the implant, and this one here shows you how...we actually a surgical stent made, uh, so we can do guided apicoectomy. I designed this surgical stent so my drill goes to the very tip of the root that's the offending root, the mesiobuccal of the first molar. So, I'll just show you the little snaps shots.

**Howard Farran:** Wow.

**Armen Mirzayan:** Uh, so here's a snapshot of it. Uh, here the green arrow points to, again, the inflammatory response in the sinus. The little opaque arrow shows the radiolucency, and take a good look here. The buccal bone is intact here. So, we did the guided surgery, I just went in and debrided the area, uh, this x-ray is an immediate postop. You can see the red arrow points to the area where my drill penetrated through the buccal bone, so I don't have to go fishing around to find a lesion. With the

guided surgery, I've pinpointed where the source of the infection was, you can see the perforation in the bone, we debrided the area, did the root, uh, cut off the root tip, and then this is a, I believe, a six-month postop, you see the sinuses perfectly clear, you see the orange, uh, arrow points to the bone being intact, and a resolution or a diminishing size of that lesion, and imagine we could parlay this that, uh, bone healing and the window closing and the reduction of the radiolucency and a clear sinus is a clear indication that things are healthy. Uh, so you can, uh, watch the surgery performed here. I got a huge kick out of that. And then the other one that's, uh...

**Howard Farran:** Wait Armen, I've just got to stop you and tell you that, uh, I said to myself before this started, I said I wonder what new thing Armen's going to turn me on to that I've never even thought of before, and I, I have to be honest with you, I'm 52 years old, a dentist for 27 years, and I never even thought of a guided surgery apico arterial retrofill. You have an amazing mind, buddy.

**Armen Mirzayan:** Thanks, uh, I've, I'm the classic dental geek, I like to play around, I'm a nerd with this stuff and, uh, I can imagine this surgery, you have to lay a flap – again, it wasn't perforated through the buccal, uh, so you'd have to conventionally, uh, fish around, try and measure and find which, where's the...and you know, run the risk of perforating other root tips that are close to this area, so pinpoint precision, we got to that. Uh, but to parlay this side, I mean, this is very rare. Uh, I might be lucky with two or three of these a year, but the bigger one is, uh, we all, as dentists, have root canal-treated teeth with crowns, with open margins or recurrent decay, and you want to, uh, replace the crown, and you don't know whether it is warranted to have, uh, the retreat for the root canal or do you just go straight to doing the new crown. Well, you take the area, if you don't see any lesions, it looks perfectly healthy, that's a green light, go ahead and replace the crown with minimal consequences and risks, whereas if you see a lesion, now you've got to talk to the patient, Well, you've got a broken-on tooth, I don't know what's underneath that crown, and on top of that, this root canal hasn't healed yet, so your odds of keeping this tooth are not that high long-term.

**Howard Farran:** Armen, let me stop you there and tell you, on these CBCTs, sometimes, I mean, what is your thinking when, you know, sometimes a root canal, the way it healed up is the periapical area has fibers, connective tissue, uh, Shawneen was talking about that. She's a, uh, oral radiologist, sometimes it's bad bad stuff, it's bad bacteria that's growing, uh, on a CBCT, what are you thinking when you see some of the apex of an asymptomatic tooth on a CBCT?

**Armen Mirzayan:** Uh, great question. Um, we have small, uh sizes that are, can be very easily just apical scarring from endodontic therapy. Um, this is probably the best argument for an initial scan, and then if they're asymptomatic, you see it, you can take a postop scan a year later and judge and see if it's grown or changed in size. You're always looking for deltas, so if it's a small enough radiolucency and the patient is asymptomatic, I'm more likely to leave it alone and consider a postop scan at somewhere down the line so see if, uh, there's been a changes in it. Uh, if the patient is symptomatic or it's pretty large, then you have pretty clear evidence that, uh, you have granulation tissue between the roots or whatever it may be that it needs an intervention, even though the patient might sometimes be asymptomatic.

**Howard Farran:** And you know, we talked about standard of care, and this is a great business opportunity because with a cleaning, we schedule them for a recall to come back in three to six months before they leave, and standard of care, every endodontist I know schedules a one-year periapical x-ray to make sure it all healed up, and when you go into a dental office, the average office has 5,000 charts, and 4,000 of them have not been in a single time in 24 months, after every root canal, it's a perfect opportunity to say, Hey, you paid for this, I need to see you one year from now to make sure it worked, and now you're guaranteed to have, uh, a high chance of getting that person back in the office again.

**Armen Mirzayan:** Uh, agree with that. The only catch to that is, you don't want to see your own root canals in 3D. (Laughs)

**Howard Farran:** (Laughs) That's a good one.

**Armen Mirzayan:** Yeah. I always joke and say, uh, I stopped root canals after I saw that.

**Howard Farran:** That's true.

**Armen Mirzayan:** And the other thing I just want to tie in as we're running out of time here, Howard, uh...

**Howard Farran:** Well, no, no, we, with you, buddy, we're not running out of time. This is...I know you're busy, I know you're a practice, but uh, there's...

**Armen Mirzayan:** You should see the stink eye my hygienist is giving me right now, waving in the hallway.

**Howard Farran:** Okay.

**Armen Mirzayan:** Should we set some other time or is this...

**Howard Farran:** Well, you tell me, Armen. I'm...you've been on for, uh, 55 minutes, um, did you...do you feel like you, um, laid out what you wanted to talk about, or do you want to schedule a Round 2?

**Armen Mirzayan:** Oh...I could, I could talk for days, I love this stuff. Uh, so, I've got plenty of other material that would, uh, be interesting to you. Uh, I think I've covered the, uh, the overall aspect of what I'm trying to accomplish. Uh, there's just one thing that I want to throw in with what my motto, uh, it baffles me with implant dentistry...with crown and bridge, we sweat 10, 20, 30 microns, but we just don't care if we're off by millimeters with implants, and I don't understand that, uh, frame of mind. I think the implants should be placed with just as much accuracy and precision as we do with our crown and bridge stuff. I don't understand why being off a couple of millimeters or being off on an angle is completely acceptable to use as a profession. That's what I'm trying to change.

**Howard Farran:** Well, Armen, you are changing it, and I just want to add one step to it. Um, it is true, dentists are, uh...I call them 20-20-20 dentists, they, you know, the always talk about how their materials don't wear 20 microns a year, that their adhesive dentistry is greater than 20 megapascals, how their indirects fit within 20 microns, and then nine out of ten times it fails from a biological invasion

of some form of streptococcus mutans or actinomyces and, you know, my deal is also, you know, dentistry is a biology problem, not a mechanical engineering problem. But Armen, um, this is the hottest topic in dentistry. You've seen that tread on Dental Town. What does that, what does that, um, company with the, uh, building surgical guides, Blues...Bluesky or something...

**Armen Mirzayan:** Yep.

**Howard Farran:** I mean, I mean, everybody is wondering about this because of, um, it's just a great service, so if you, um, you know, whether or not to buy a \$100,000 machine, that gets every dentist's attention. I mean, you know, if you're thinking about a laser, I mean, my gosh, you can get one from ADM for three grand, I mean, who's going to care about that decision, what is that, a root canal build-up and crown one time? Uh, but to get \$100,000 CBCT and then to go from being a restorative dentist to actually getting into blood and guts and, uh, doing, placing an implant, it's just the absolute biggest...it's where the football is in the arena, and if you were going to look at the football game of dentistry, the ball is exactly you, and surgical guide implants, so if you want to come back and schedule another hour presentation or two more or three more, whatever, it is an honor and a privilege...I know the townies love you, they worship you, uh, just email me and tell me another time and I will be there with bells on my feet, waiting.

**Armen Mirzayan:** Oh, I'd be thrilled to do it. Thanks for the, uh, offer.

**Howard Farran:** Alright, and tell your lovely wife I said hello, and you have a rocking great day.

**Armen Mirzayan:** Thank you, she's waving at...oh, they've just paged me, and I've got to go.

**Howard Farran:** Okay, buddy, bye-bye.

**Armen Mirzayan:** See ya.