

Aesthetic Excellence
LEARNING BY DOING



Course Preparation Materials

3404 Brecksville Road

Richfield, Ohio 44286

www.exceptionalpractices.com

330.523.5240



Welcome to The Center at Dental Ceramics! This program features live-patient treatment with hands-on learning. You will benefit from one-on-one instruction while working on your own patient, as well as view and help diagnose the other course participants' cases.

This course will emphasize function as well as aesthetics. You will learn subtle porcelain contouring and chair-side customization both before and after final placement that will take a case from good to outstanding. Your experience at The Center will enhance your professional growth, but your patient will be the direct recipient of some of the best dentistry available.

The training of our instructors is quite diverse, from Pankey, Dawson, LVI, Kois and others. We feel that our always-inclusive approach has worked well to teach dentist participants highly esthetic, safe, and predictable techniques that they can take home and use to satisfy the needs and demands of their patients. After the course is completed, our instructors are always available to take your call if you have any questions regarding clinical techniques discussed in this course. Find the "contact sheet" for phone numbers and other means of contacting the instructors.

Please note: integrating new techniques can sometimes be challenging when bringing them into your practice. Please read the clinical checklists carefully and thoroughly and do not go forward with treatment if you do not feel prepared. Again, our instructors are readily available for guidance.



Case Selection & Patient Requirements

This course features live-patient treatment. You will bring a patient from your practice and send a diagnostic cast and photos in advance to The Center for approval. To assist you with choosing your patient for an upcoming course, we have found the following “common denominators” from previous experiences to be most successful:

The Patient Component

- First, you (the dentist) must be 100% comfortable with treating your patient in a hands-on environment.
- A patient who is outgoing, friendly and comfortable with a hands-on learning environment will have the most successful outcome.
- You must obtain consent from your patient prior to treatment (forms enclosed.)
- Your patient needs to be present only during your assigned clinic time.

The Clinical Requirements

- 10-14 units of porcelain veneers and/or crowns.
- The patient should be in good health and have minimal health concerns.
- The periodontal evaluation and charting should be current (within 3-6 months). A healthy periodontium and good hygiene makes the restorative process much easier and more predictable.

Recommended Cases

- Veneer and anterior crown cases, including spaces, closures, discolorations, and anterior bridge(s) are acceptable.
- Complex combination cases where crowns and veneers are needed are also acceptable.

What to Bring

- Your own favorite instruments, favorite burs, loops, light source, etc.
- The Center will provide any necessary and appropriate equipment and instruments for this course. All equipment and instruments provided by The Center will be in good working order.

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



To maximize your investment in this course, please send the following items to The Center:

- Digital Scan and/or Models & Bite Transfer
- Radiographs
- Photos

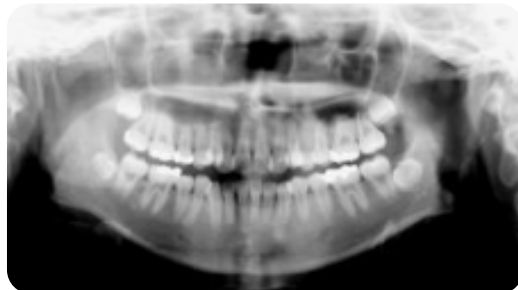
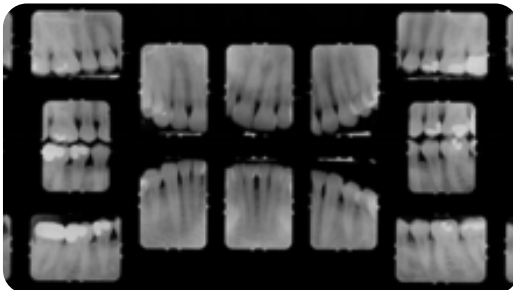
Models & Bite Transfer

A set of upper and lower models with a bite transfer. You may use a PVS Impression or Alginate.



Radiographs

Please send a full-mouth series of x-rays or a PANO with bitewings.



Digital Scan

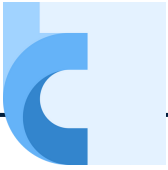
Intraoral scans must be of good quality and include the palate and full clarity of the posterior arch.



Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241

www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Course Preparation Checklist (cont.)

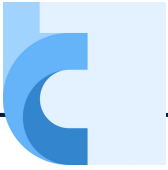
Photos

Below are a series of 12 photos necessary for case approval. Please send these photos in JPG or PNG files to sarah.prkusic@dentalceramicsusa.com. Digital photos are also acceptable via USB Drive/DropBox/WeTransfer. These photos are an example of the 12 AACD Required Views:



Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Assistants:

It is required that participants bring an assistant to the program. As a full participating registrant, your assistant will have access to lectures, meals, and other activities that will occur during the course.

We encourage as many team members as possible to accompany you. Historically, doctors who are accompanied by their entire team start faster and find that it is easier on return to the practice. Your team will return inspired, committed to this high-value dentistry and are able to communicate its value to your patients. Please Note: If you are bringing more than one team member, notify us ASAP to ensure we have the space to accommodate everyone.

Patient Discussion:

It is imperative that your patient is thoroughly informed of the procedures to be performed on them at The Center. It is very important that your patient realizes that although you are a licensed dentist, you will be in a training situation and applying newly learned techniques. Your patient will also need to realize that photography is a key component of this course and every phase will be documented. Please make certain the patient consent form is completed and explained before being signed by your patient.

License Information:

We are required to obtain a certification of licensure, sometimes referred to as verification of license. This must be requested from your state board and mailed directly to The Center. Please note this is not to be confused with your certified license as those are only sent to you and should stay at your practice. We will keep your license on file and update it online for you for future live patient courses you attend—provided your state has this feature available. If you are out of state, you **MUST** obtain a temporary license. This is an online process and typically takes 4-6 weeks, the process can be started at <http://www.dental.ohio.gov/Licensure/Dentist.aspx#5562-limited-continuing-education-license>

If you have any questions please contact sarah.prkusic@dentalceramicsusa.com.

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Important Information Checklist

Enclosed in this packet is a variety of forms which need to be filled out completely prior to the course date. These documents will help us approve your patient's case. Please email them to sarah.prkusic@dentalceramicsusa.com.

These documents are legally required and used to award CE's based on the time spent preparing your patient for this course.

- Student Registration Form
- Agreement for the Dentist Participant
- Release of Liability
- Course Patient Registration & Medical History
- Patient Consent for Treatment
- Patient Agreement and Release Form
- Doctor & Team Member Photo Consent & Release Form
- Patient Photo Consent & Release
- Periodontal Evaluation
- Pre-course Questionnaire (Dentist, Team)
- Have an original certification of licensure.

For case approval, you must send the following three months prior to the course:

- Upper and lower models (mounted) and case approval worksheet mailed to:
The Center at Dental Ceramics: 3404 Brecksville Rd, Richfield, OH 44286
- Radiographs and photos in digital format emailed to: sarah.prkusic@dentalceramicsusa.com.
- If you are sending a digital scan, directions are as follows:
 - If you have an iTero scanner, you would search Dental Ceramics (make sure it is the one in Ohio,) and enter our account number: 2293.
 - If you have meditlink, 3 shape, CSconnect or Sirona, email to tech@dentalceramicsusa.com.
 - Stls files can be sent to sarah.prkusic@dentalceramicsusa.com. If it states file is too big, we can use a WeTransfer link or a dropbox link.
- NOTE: When sending files, please state the file is for your Aesthetic Excellence Course patient so we know how to schedule your case.

In the absence of the above requirements, The Center cannot undertake the approval of a case.

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Dentist Participant Registration Form

Dentist Name: _____ Practice Name: _____

First Team Member Name: _____

Second Team Member Name: _____

Additional Team Member Name: _____

Who Referred You to The Center? _____

Daytime Phone: _____ AGD # _____

Email: _____ License #: _____

Educational Background

Dental School: _____ Degree: _____ Year: _____

Graduate Residency: _____ Do you teach? _____

If so, where? _____

How many years have you practiced dentistry? _____

Do you consider yourself:

- Beginning esthetic dentist Experienced esthetic dentist
 Intermediate esthetic dentist Highly experienced esthetic dentist

Do you operate: Right Handed Left Handed **Glove Size:** _____

What Procedures do you prefer doing the least and why?

What is the main reason you are attending this program?

What do you hope to get out of the program?

What are your main concerns about cosmetic dentistry?

How many of the following procedures do you do a month?

Porcelain Veneers _____ Direct Resin Restorations _____ PFM's _____

All Porcelain Crowns _____ Indirect Resin Restorations _____

Amalgam Fillings _____ Gold Inlays/Onlays _____

Non-Metallic Bridge _____ Direct Resin Veneers _____

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241

www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Agreement for the Dentist Participant

I, _____, am a participant in a continuing dental education program, Aesthetic Excellence, at The Center at Dental Ceramics ___/___/20___.

Pursuant to class curriculum, I willingly agree to participate in a clinical situation at The Center at Dental Ceramics. I understand and agree that I will be required to conform to the Center's policies and procedures during the time I spend in the clinic. I understand and agree to take direction from the clinic faculty and his/her designees.

I hereby verify and confirm that _____ is my patient of record. I also agree that I am responsible for all the follow-up remedial care on my patient for this course.

My current liability insurance coverage is with:

Name of Insurance Company: _____

(_____) I have included a copy of my current Malpractice Medical Insurance Declaration page
(initials)

Participating Doctor's Signature: _____

Printed Name: _____

Date: _____

(_____) I have request a certification of licensure from my state board on ___/___/20___.
(initials)

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Release of Liability Agreement

I am participating in Aesthetic Excellence on ___/___/20___ until ___/___/20___ at The Center at Dental Ceramics.

In consideration of the opportunity to participate in this program, I hereby release The Center at Dental Ceramics, their directors, employees, and agents from any claim, damage of liability for or arising out of an injury or death which could result from my own actions or omissions or the actions or omissions of any employee or agent of The Center at Dental Ceramics.

(Print Name of Dentist Participant)

(Signature of Dentist Participant)

___/___/20___

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Course Patient Registration & Medical History

Patient Name: _____
 I prefer to be called (nickname): _____
 D.O.B.: _____ Age: _____ Gender: M F
 Home Address: _____

 Phone #: _____
 Emergency Contact:
 Name: _____ Phone #: _____
 Relationship: _____

MEDICAL HISTORY

Do you have any of the following? Y/N

<input type="checkbox"/> Angina	<input type="checkbox"/> Blood pressure problem
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Heart valve problems
<input type="checkbox"/> Taking Heart Meds	<input type="checkbox"/> Take a pre-medication
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Sleep Apnea/OSA
<input type="checkbox"/> Taking Coumadin or	<input type="checkbox"/> Abnormal bleeding
<input type="checkbox"/> Anticoagulants	<input type="checkbox"/> Asthma
<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Joint replacements
<input type="checkbox"/> Taking other prescribed or (total hip, knee, pins, or implants)	

OTC medication not listed above:

For Women:

Taking birth control pills Pregnant?

Are you allergic to or have reacted adversely to any of the following?

Local anesthetic
 Penicillin or other antibiotics
 Aspirin, Acetaminophen or Ibuprofen
 Latex
 Sulfa drugs
 Codeine or other narcotics
 Metals
 Other not listed

Other concerns we should be aware of:

Diabetes
 Cancer/tumor
 Seizures/Epilepsy
 Fainting spells /light-headedness
 Smoke or chew tobacco
 STD
 Oral lesions
 Other not listed

- 1.) How would you describe the condition of your teeth and gums?
- 2.) Are you currently in pain or discomfort with your teeth or gums? Explain.
- 3.) How often do you brush your teeth?
- 4.) How often do you floss your teeth?
- 5.) Do your gums bleed when you brush? When you floss?
- 6.) Have you ever experienced pain in your jaw joint?
- 7.) Do you snore? Have you been diagnosed with sleep apnea?

I understand the information I have provided is true and correct to the best of my knowledge, and that it will be held in the strictest confidence. It is my responsibility to inform my dentist and The Center at Dental Ceramics of any changes in my medical history status. I hereby give my informed consent for treatment and authorize the release of this information for insurance claim purposes. I authorize photographs of my care and treatment, which may be used for educational viewing by other healthcare professionals, team members or patients and marketing in the media. I have read, understand, and agree with the accompanying "Patient Release Form" for this continuing education course. I acknowledge and understand I am responsible for payment.

Patient Signature: _____

Witness: _____

Treating Doctor (print) _____

Treating Doctor (signature) _____

Date: _____

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
 www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Patient Consent for Treatment

Patient name: _____

Date of birth: _____

Ohio State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Dr. _____ can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form will acknowledge your consent to treatment recommended by Dr. _____ and his/her team.

I request and authorize Dr. _____ or his/her associates or team to perform the following treatment upon me: _____

This has been recommended to me by Dr. _____ in order to diagnose and/or treat the following condition: _____

While this procedure is often an effective test or treatment, not all dental or oral diseases or problems can be diagnosed or treated with this test or treatment. Each person is unique and presents a different set of circumstances. Some of these circumstances are not revealed until during the procedure itself or after. During the course of treatment, unknown or unforeseen conditions may be revealed that necessitate a modification of the proposed treatment. Your dentist will exercise his/her professional judgment to perform a conservative preparation of your teeth, and make other necessary decisions regarding the manner and method of any procedures as he/she and his/her team deem appropriate to achieve the desired results. Dental procedures described above have a very high degree of success in dental practice. Human tissues, however, react differently to dental treatment depending on a variety of factors. Each individual case is different and the exact results for each specific case is difficult, if not impossible, to guarantee specific results. There are many variables that affect how long restorations or whitening can be expected to last including general health, maintenance of good oral hygiene, regular dental checkups, etc. Therefore, no guarantees can be made or assumed regarding the longevity of restorations or whitening. I consent to the administration of anesthesia or other medications before, during or after the procedure by qualified medical personnel. I understand that all anesthetics involve the rare potential of risks or complications such as damage to vital organs like the brain, heart lungs, liver and kidneys; paralysis; cardiac arrest; and/or death from both known and unknown causes. I have chosen to undergo this procedure in a continuing education, hands-on environment with a qualified dentist after considering the alternative forms of diagnosis and/or treatment for my conditions including non-treatment or other procedures or tests. Each of these alternative forms of diagnosis or treatment has its own potential benefits, risks and complications of which I have been made aware. I understand that there are potential risks, complications and side effects associated with any dental procedure. Although it is impossible to list every potential risk, complication and side effect, I have been informed of some of the possible risks, complications and side effects of this procedure. These could include but may not be limited to the following:

Root canal, possible unexpected tooth loss

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Patient Consent for Treatment (cont.)

Most of these risks, complications and side effects are not serious or do not happen frequently. But although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by Dr. _____ or qualified team members performing the procedure. Although most procedures have good results, I acknowledge that no guarantee has been made to me about the results of this procedure or the occurrence of any risks, complications and/or side effects.

These potential risks and complications could result in the need to repeat the procedure; additional dental, medical or surgical treatment or procedures; hospitalization; blood transfusions; or, very rarely, permanent disability or death. I recognize that during the course of treatment, unforeseeable conditions may require additional treatment or procedures. I request and authorize Dr. _____ and other qualified medical personnel to perform such treatment or procedures as required.

I certify that I have read or had read to me the contents of this form. I have read or had read to me and will follow any patient instructions related to this procedure. I understand the potential risks, complications and side effects involved with any dental treatment or procedure and have decided to proceed with this procedure after considering the possibility of both known and unknown risks, complications, side effects and alternatives to the procedure. I also understand that I have the right to discontinue treatment at any time and have the obligation to inform Dr. _____ immediately of my decision to do so. I declare that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Patient Name: _____

Patient Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Patient Agreement & Release Form

I hereby apply for selection as a patient for dental service to be performed for and upon me by participating dentist(s) in the continuing education course to be held at The Center at Dental Ceramics (herein called The Center) in Richfield, Ohio. In consideration, I hereby waive, release and discharge the following from any and all claims for pain, injuries, damages, or otherwise of whatsoever nature which I might claim or assert by virtue of performance for and upon me of such dental services by the participants themselves and The Center and its faculty and staff. I further recognize that the participating dentist(s), who will perform services for and upon me during the course, will do so as independent professional(s), and they will not be performing such services in any way as agents or employees, or for any benefit of The Center or any employee thereof. It is my understanding that follow-up/remedial care will be rendered by my assigned participant/practitioner and that I may discontinue treatment at any time with the obligation of informing my assigned participant/practitioner immediately of my decision to do so.

Having read the above, I verify that I understand the information contained therein, and I grant authority to the continuing education course participants to perform those procedures and treatments deemed necessary for me, _____, (patient name) while I am a patient here and I further authorize The Center personnel to use material, including visual aids, pertaining to this case for teaching and printing publications. I also authorize photographs to be taken of me for educational purposes and understand that my identity will be protected in accordance with HIPAA regulations. These photographs may be used in teaching, lectures, and marketing in various media.

Print Name of Dentist

Signature of Dentist

Date

Print Name of Patient

Signature of Patient

Date

Print Name of Witness

Signature of Witness

Date

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Doctor Photo Consent & Release Form

As a participant in the **Aesthetic Excellence** course, I authorize agents of The Center at Dental Ceramics to take photographs & videos of my/our participation in the course.

I/We also hereby authorize The Center at Dental Ceramics to use my/our photography/videos and/or likeness for educational purposes in teaching lectures and in various marketing media in perpetuity for promoting The Center at Dental Ceramics and its courses.

Print Name of Dentist Participant

Date

Signature of Dentist Participant

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Team Member Photo Consent & Release Form

As a participant in the **Aesthetic Excellence** course, I authorize agents of The Center at Dental Ceramics to take photographs/videos of my/our participation in the course.

I/We also hereby authorize The Center at Dental Ceramics to use my/our photograph/videos and/or likeness for educational purposes in teaching lectures and in various marketing media in perpetuity for promoting The Center at Dental Ceramics and its courses.

Print Name of Team Member

Date

Signature of Team Member

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Patient Photo Consent & Release Form

As a participant in the **Aesthetic Excellence** course, I authorize agents of The Center at Dental Ceramics to take photographs/videos of my/our participation in the course.

I/We also hereby authorize The Center at Dental Ceramics to use my/our photograph/videos and/or likeness for educational purposes in teaching lectures and in various marketing media in perpetuity for promoting The Center at Dental Ceramics and its courses.

Print Name of Patient

Date

Signature of Patient

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Pre-Course Dentist Questionnaire

In ongoing efforts to uphold our mission of enabling the restorative dentist and his/her team to achieve higher levels of success and satisfaction in clinical practice, please complete the following questionnaire and email it to

While this questionnaire can remain anonymous, you have the option to include your name. Thank you in advance for your insights!

Your Name: _____

1.) What objectives do **you** hope to accomplish by attending this course?

2.) How often do you attend continuing education courses per year? _____ times per year
How many out-of-state? _____ How many online? _____

3.) Have you attended courses at The Center at Dental Ceramics before? ____Y ____N
---> If yes, what course(s)?

4.) How often does your practice send team members to attend continuing courses per year?
____times for the team ____Do not know

5.) What influences **you** the most when choosing courses for yourself?
____location ____subject ____speaker ____cost ____# of credits
____other (please describe)

5.) What influences **your practice** the most when choosing courses for yourself?
____location ____subject ____speaker ____cost ____# of credits
____other (please describe)

6.) What future course topics would interest you? Please describe:_____

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Pre-Course Team Questionnaire

In ongoing efforts to uphold our mission of enabling the restorative dentist and his/her team to achieve higher levels of success and satisfaction in clinical practice, please complete the following questionnaire and fax it or email it back at least 7 days before the program. While this questionnaire can remain anonymous, you have the option to include your name. Thank you in advance for your insights!

Your Name: _____

1.) What objectives do **you** hope to accomplish by attending this course?

2.) What attracted you the most to attend this course?

3.) How often do you attend continuing education courses per year? _____ times per year
How many out-of-state? _____ How many online? _____

4.) Have you attended courses at The Center at Dental Ceramics before? ____Y ____N
---> If yes, what course(s)? _____

5.) How often does your clinical and administrative team attend continuing education courses per year?
____times for clinical team ____times for administrative team

6.) What influences **you** the most when choosing courses for yourself?
____location ____subject ____speaker ____cost ____# of credits
____other (please describe) _____

7.) What challenges are you currently facing in your practice right now?

____ Low treatment acceptance	____ Unsuccessful marketing efforts
____ High accounts receivable	____ Laboratory issues
____ Team turnover/low morale	____ Lack of new patients
____ Insurance issues	____ None
____ Other (please describe:) _____	

8.) Does your dentist ask for a summary of your CE experiences when attending courses out of the office?
____Y ____N ____Never asks

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



All lab work will be done at Dental Ceramics Inc. as they are most familiar with the course and have handled all of The Center's cases over the years.

The tuition is \$12,500 with lab fees included up to 14 units. Course fees are due upon registration. Course fees cover the cost to bring one team member. Additional team members are welcome for \$250 per person for both sessions.

Payment can be accepted in a maximum of 3 installments, unless otherwise arranged with The Center. A third of the course fee is required prior to accepting case materials and documentation. Please see our Cancellation Policy on page 23 of this packet for more details.



Prep Session Day One

8:00 am-8:30 am	Registration & Breakfast	
8:30 am-10:00 am	Welcome Introduction	Dr. Spoor
	Lecture	
10:00 am	15 minute break	
10:15 am-12:00 pm	Lecture	Dr. Spoor
12:00 pm-1:00 pm	Lunch	
1:00 pm-1:45 pm	Hands-on Photography	
1:45 pm-3:15 pm	Mock-up Discussion	
3:15 pm	15 minute break	
3:30 pm-4:00 pm	Instructor Introductions	
	Prep Design Lecture	Dr. Harding
4:00 pm-5:00 pm	Case Design Review	

Prep Session Day Two

7:30 am-8:00 am	Breakfast	
8:00 am-9:30 am	Introduction to the Prep	Dr. Spoor
	Lecture	
9:30 am	15 minute break	
9:45 am-11:00 am	Lecture	Dr. Spoor
10:30 am	Group 1 Patient Arrival	
11:00 am-11:30am	Lunch	
11:30 am-4:30 pm	Clinical Session	
4:30 pm-5:30 pm	Wrap-up Discussion	
5:30 pm	Drinks & Appetizers	

Prep Session Day Three

7:30 am-8:00 am	Breakfast	
7:30 am	Group 2 Patient Arrival	
8:00 am-8:30 am	Group Discussion	
8:30 am-12:30 pm	Clinical Session	
12:30 pm-1:00 pm	Lunch	
1:00 pm-2:30 pm	Discussion	
2:30 pm-5:00 pm	Wrap-up Discussion	Dr. Digiannantonio Dr. Doolin Dr. Castellarin

Please Note: the schedule will be emailed to each participant in advance for each course. The above schedule is subject to change.

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Proposed Schedule & Cancellation Policy

Seat Session Day One

7:30 am-8:00 am	Breakfast & Registration
8:00 am-12:00 pm	Lecture
10:30 am	Group 1 Patient Arrival
11:30 am-12:00 pm	Lunch
12:00 pm-4:30 pm	Deliver Final Restorations
4:30 pm-4:45 pm	Final Photography
4:45 pm-5:30 pm	Wrap-up Discussion

Dr. Spoor

Seat Session Day Two

7:30 am-8:00 am	Breakfast
7:30 am	Group 2 Patient Arrival
8:30 am- 12:30 pm	Deliver Final Restorations
12:30 pm-1:00 pm	Lunch
1:00 pm-2:00 pm	Case Wrap-up & Final Photography
2:00 pm-5:00 pm	Panel Discussion: Review cases & photos
5:00 pm	Celebratory Champagne Toast
6:00 pm	Award Ceremony Drinks & Dinner

Please Note: the schedule will be emailed to each participant in advance for each course. The above schedule is subject to change.

Cancellation Policy:

Payment is expected with registration unless otherwise arranged with The Center. Payments may be accepted in a maximum of thirds. A minimum of 1/3 the tuition cost is required prior to case approval. If cancellation is received less than 65 days prior to the course, 100% of the paid deposit is forfeited. If cancellation is received less than 30 days prior to the course, 100% of payments towards tuition is forfeited. Financing is available for qualified participants. The Center at Dental Ceramics recognizes that times may arise when dentists may not be able to participate in courses due to unforeseen situations. Tuition deposits may be transferable and substitutes permitted in the event of cancellation/postponement of dentist participation with prior approval from The Center at Dental Ceramics. The Center at Dental Ceramics reserves the right to alter and/or cancel any course/program at its discretion. Any tuition received for a cancelled course will be refunded or applied to a future program. Please call us with any questions. 330.523.5240.

Communication. Personalization. Confidence.

3404 Brecksville Road | Richfield, Ohio 44286 | P: 330 - 523 - 5240 | F: 330-523-5241
www.dentalceramicsusa.com | frontoffice@dentalceramicsusa.com



Airports

Cleveland-Hopkins International (CLE)

About 22 miles from The Center

5300 Riverside Drive

Cleveland, OH 44135

(216-265-8675)

www.clevelandairport.com

Akron-Canton Airport (CAK)

About 30 miles from The Center

5400 Lauby Road NW

North Canton, OH 44720

(888-434-2359)

www.akroncantonairport.com

Hotels

Hilton Akron/Fairlawn (**recommended**)

3180 W. Market Street

Akron, OH 44333

(330-867-5000)

Use corporate code: 3082986 when calling to reserve!

We will also provide a booking link prior to the course for the discount via email.

Car Rental Agencies

Alamo 844-806-3353

Enterprise- 330-926-2300

Avis 330-665-2525

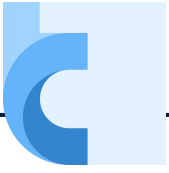
Budget 330-668-9603

Taxi Services

United Cab Company Cleveland 216-398-9000

Akron-Canton Txi 330-808-2159

Uber & Lyft



What is the weather like in Northeast Ohio?

In the winter, it tends to be cold and snowy with temperatures averaging around 17-43F. In the spring, the weather is chilly and typically rainy with temperatures between 40-70F. Summers are hot with temperatures ranging from 60-90F. In the fall, it cools down with days averaging 45-70F. The weather in Ohio can change very quickly so make sure to check the forecast before arrival.

What should I wear when I come to The Center?

Business casual. It also may be a bit cold, so a light sweater might be desired. When treating a patient, wear what you typically would wear in your office as long as it fits the OSHA/CDC guidelines and regulations.

Is food served at The Center?

Each day there will be a continental breakfast served and lunch is provided in the afternoon. Dinner is on your own unless specified by The Center. There are a variety of restaurants in the area that we can recommend.

Do I need to attend both days, if I'm only prepping/seating on one of the days?

Yes! All doctors are required to attend the entirety of both sessions of Aesthetic Excellence. Your patient and assistant is only required to attend their pre-assigned day. In order to receive all of your credits, the doctor must attend all days.