READ CHAPTER 44 Dental Liners, Bases and Bonding Systems (p.750-765)
Key Terms: Desiccate, Etchant (Etch), Eugenol, Obliterate, Sedative, Smear Layer
Recall Questions: 1, 2, 3, 9, 12, 13, 14, and 15

READ CHAPTER 45 Dental Cements (p.766-778)
Key Terms: Exothermic Reaction, Luting, Provisional, Retard, Spatulate
Recall Questions: 2, 3, 4, 5, 8, 9 and 10

READ CHAPTER 46 Impression Materials (p.779-799)
Key Terms: Alginate, Base, Catalyst, Centric, Extrude, Occlusal Registration, Viscosity
Recall Questions: 1, 2, 3, 4, 5, 6, 7, 9, 17, 19, 20 and 23

READ CHAPTER 47 Laboratory Materials and Procedures (p.800-820)
No Key Terms
No Recall Questions

READ CHAPTER 50 Fixed Prosthodontics (p.854-873)
Key Terms: Abutment, Bevel, Cast Post, Fixed Bridge, Full Crown, Gingival Retraction, Inlay, Onlay, Porcelain Fused to Metal (PFM), Pontic, Shade Guide, Unit, Veneer
Recall Questions: 1, 3, 4, 8, 9, 10, 12, 13, 16, 17 and 19

READ CHAPTER 51 Provisional Coverage (p.874-883)
Key Terms: Custom Provisional, Polycarbonate, Pre-Formed, Provisional
Recall Questions: 1 through 10

READ CHAPTER 52 Removable Prosthodontics (p.884-899)
Key Terms: Edentulous, Framework, Full Denture, Mastication, Partial Denture (RPD), Reline, Tori, Tuberosities
Recall Questions: 1, 3, 6, 16 and 19

READ CHAPTER 53 Dental Implants (p.900-909)
No Key Terms
No Recall Questions

READ CHAPTER 54 Endodontics (p.910-926)
No Key Terms
No Recall Questions

READ CHAPTER 56 Oral Maxillofacial Surgery (p.953-975)
No Key Terms
No Recall Questions

BE PREPARED
FOR NEXT WEEK’S TEST:
- Key terms and know your recall questions
- Restorative materials, know resins, bases, liners and cements
- Impression materials
- Knowledge of composite, crown and bridge steps
- X-ray mount diagram
- Know your instruments and functions along with your knowledge of a slow speed handpiece and highspeed handpiece
- Review restorative and perio charting
- Good things come to those who study

Subject to change
CEMENTS, LINERS AND BASES

Permanent Cements
- Zinc Phosphate Cement, Flecks: exothermic, gives off heat
- Glass Ionomer Cement, Fuji or Ketac: self-cured and light-cured, mixed on paper pad, kit has measuring devices
- Zinc Oxide, Eugenol (ZOE): powder and liquid mixed on paper, comes with a measuring “pipette”

Temporary Cementation
- Temp Bond: usually comes in two tubes, equal lengths, mixed on paper pad
- Zone: same as temp bond except no Eugenol as it does not react well with some acrylics

Using cements, mixed as base material
- Bases: protect pulp, before placing the restoration. Mixed like cementation, except thicker
- Insulating Base, Flecks: placed in a deep cavity preparations to protect against thermal shock, sudden temperature changes in tooth
- Sedative Bases, Zinc Oxide - Eugenol: helps soothe a pulp that has been injured by decay or irritated during the process of removing decay
- Temporary Restoration, IRM: may be used for temporary restorations that are meant to last for a short-term
- Cavity Liners, DYCAL: used to provide a barrier between the pulpal tissue and chemical irritation caused by cements and restorative materials. Comes in 2 tubes, equal amounts, mixed on paper pad

NOTES
LIST THE MOST COMMONLY USED

CEMENTS (LUTING AGENT)
- Flecks
- Zone
- Vitrebond - Glass Ionomer
- Ketac
- Rely-X
- Durelon
- Clearfil

CAVITY LINERS
- Dycal
- Vitrebond - Glass Ionomer
- Ketac
- Life
- Lime Light
- Preline
- Temp Canal
- Time Line

TEMP FILLING MATERIAL
- IRM
- Cavit
- Zoe
- Duotemp
- Tempit
- Fermit
- Teremex
- Coltosol
- First Fill

NOTES
ALGINATE IMPRESSION - CLINIC TIPS

- Fluff powder before measuring
- Do not pack Alginate into measuring scoop level
- Use cool water, especially at first
- Spatulate using the figure-8 method
- Smooth and creamy, no air bubbles
- Load max. tray from the backside
- Load mand. tray from the lingual, right side, then the left side
- Avoid causing air bubbles with loading
- Level off excess Alginate with a spatula
- Wet finger to smooth surface, horseshoe
- Smear Occlusal surfaces of teeth with Alginate
- Insert tray in patients mouth diagonally
- Seat posterior to anterior
- Push tray onto teeth evenly
- Max., anterior of tray up and under lip/nose, pull lip
- Mand., push down evenly, thumbs under chin, first fingers, mid-tray, squeeze, pinch
- Hold without movement
- Remove by breaking suction with index finger alongside tray edge, pull on handle with opposite hand
- Remove diagonally

Each impression MUST:

- Be centered over both the lateral and central incisors
- Not be overseated, this means pushed down to far, which would expose the tray
- Have sharp anatomic detail of the full hard palate for the maxillary arch
- Show Vestibular areas for both arches
- Have both arches
- Have sharp anatomic detail of all teeth present in the arch and soft tissue areas
- Have Maxillary tuberosity, retro-molar pad
- Not have air bubbles or holes

IMPRESSION TRAY SIZING FOR NORTHSHORE

sizing may differ at other offices

<table>
<thead>
<tr>
<th>Maxillary</th>
<th>Mandibular</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 large</td>
<td>2 large</td>
</tr>
<tr>
<td>3 medium</td>
<td>4 medium</td>
</tr>
<tr>
<td>5 small</td>
<td>6 small</td>
</tr>
</tbody>
</table>
IMPRESSION REVIEW

Maxillary

1. Air pockets on tooth and gingival surfaces.
   Possible Causes:
   - Water remaining in the impression during the pour-up
   - Air pockets in the plaster mix itself due to it being too thick or too thin
   - Over or under vibrating the plasters mix during the pour-up procedure

2. Overhang on the distal of the 2nd molar.
   Possible Causes:
   - The tray used was too short
   - Plaster had filled a void in the impression

3. Small amounts of excessive plaster on the teeth and gingival tissue.
   Possible Causes:
   - Small voids in the impression itself
   - Excessive water remaining in the impression itself

4. Overhang blocking tooth or gingival surfaces.
   Possible Causes:
   - Base material flowed over the edge of the tray
   - Inadequate vestibular roll on impression

Mandibular

1. Air pockets on tooth and gingival surfaces.
   Possible Causes:
   - Water remaining in the impression during the pour-up
   - Air pockets in the plaster mix itself due to it being too thick or too thin
   - Over or under vibrating the plasters mix during the pour-up procedure

2. Inadequate impression of the retro-molar pad.
   Possible Causes:
   - The impression tray used was too short
   - Excessive water remaining in the impression during the pour-up procedure

3. Small amounts of excessive plaster on the teeth and gingival tissue.
   Possible Causes:
   - Small voids in the impression itself
   - Excessive water remaining in the impression itself

4. Broken Mandibular model.
   Possible Causes:
   - A tray that was locked onto the model due to an excess of stone flowing over the edge of the tray because the mixture is too thin
   - Excessive pressure when using the lab knife to separate the tray from the model

5. Overhang blocking tooth or gingival surfaces.
   Possible Causes:
   - Base material flowed over the edge of the tray
RECOMMENDATIONS

1. When taking the impression, be sure to try the tray in patients mouth before mixing any material checking to confirm the there is adequate space behind the last tooth of the arch so that he distal surface can be clearly seen when the model is poured up.

2. Fill any voids in the impression with either more Alginate or play dough prior to pouring up the model to avoid small amounts of excess on study models. If there are still some small spots of excess plaster or stone, they can usually be removed gently with the tip of an instrument.

3. Before starting to pour-up the impression, make sure that you blow the excess water from the impression with an air/water syringe.

4. When seating the tray in the patient’s mouth, be sure to have the patient make an “ohhhh” sound and motion with their mouth so you have an adequate vestibular roll on the impression. IF the patient is unable to make this sound and movement, get the same result by gently pulling the patient’s lips around the excessive impression material. If you still do not have an adequate vestibular roll to prevent an overhang, you can create an artificial ledge by adding a line of play dough or rope wax to keep back any excess plaster or stone being used to create a base for the model.

5. When mixing the plaster to pour up the impression, be careful that the initial mix is not so thick that it cannot be “walked” around the impression and not so thin that it is visibly watery.

6. Once the model has been poured up, you can use a spatula to smooth off the top of the base as well as remove any excess material from the sides of the tray. A paper towel wrapped carefully around the edges will also help keep the material in places as well as making sure the mix for the base is not overly thin.

NOTES
IMPRESSION TRAY SIZING AT NORTHSHORE DENTAL ASSISTING ACADEMY

This information can differ depending on the office

Maxillary
1 Large
3 Medium
5 Small

Mandibular
2 Large
4 Medium
6 Small
OrthoCAD™ Digital Study Model
Reviewing Your OrthoCAD™ Impressions

Figure 15A

KEY

- Alginite rolled over the edge of the tray, adding strength for retention.
- Proper impression depths. Impression shows all gingival tissue and margins.
- Midlines are represented in the impression.
- Muscle definition in the impression.
- Molars are complete.
OrthoCAD™ Digital Study Model System
Avoiding Common Impression Mistakes

<table>
<thead>
<tr>
<th>Defect</th>
<th>Description</th>
<th>How to Avoid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teeth Hit Tray</td>
<td>The impression is taken too deep and contacts the tray. May cause inaccurate representation of incisal tips.</td>
<td>Size the tray to fit the patient’s mouth. Use enough impression material to adequately fill the tray. Seat the tray deep enough to include teeth and gum tissue. Do not allow patient to “bite” into the tray.</td>
</tr>
<tr>
<td>Retention</td>
<td>Impression tray does not retain the material in its original structure. Material looks as if it is peeling away from the tray.</td>
<td>Use impression trays with as many retention holes as possible. Let the impression material flow slightly over the sides of the impression trays.</td>
</tr>
<tr>
<td>Impression Not Taken Deep Enough</td>
<td>The impression tray is not seated deep enough into the patient’s mouth or the tray itself is not deep enough. This often causes a lack of gingival margin and tissue replication.</td>
<td>Fully seat the impression tray into the mouth without hitting the bottom of the tray. Consider using a deeper tray for these situations.</td>
</tr>
<tr>
<td>Bubbles</td>
<td>Improper mixing of impression material creates voids and leads to inaccurate representation of the dentition.</td>
<td>Follow manufacturer’s directions when preparing impression material to ensure there are no air pockets or “bubbles” in the mixture.</td>
</tr>
<tr>
<td>Impression is Dried Out</td>
<td>Impression material lacks the necessary moisture to maintain its structure and viscosity. This may cause distortion in teeth anatomy, shape, and size.</td>
<td>Wrap impression in paper towels and add water into the provided ziplock bags. (In winter months add a couple drops of alcohol to the ziplock bags as well.)</td>
</tr>
<tr>
<td>Missing Distal of the Molars</td>
<td>Distal areas of the molars are missing from the impression.</td>
<td>Ensure the correct tray size is used for the patient and make sure the tray has enough alginate to cover the full dentition.</td>
</tr>
<tr>
<td>Tray too Large</td>
<td>The impression tray selected for the patient is too large. Missing distals of the molars are a common result.</td>
<td>Check the size of the tray with the patient prior to the actual impression procedure.</td>
</tr>
<tr>
<td>Tray Not Large Enough</td>
<td>The impression tray selected for the patient is too small.</td>
<td>Check the size of the tray with the patient prior to the actual impression procedure.</td>
</tr>
</tbody>
</table>

Figure 16A
PROVISIONAL TOOTH COVERAGE: STEPS OF FABRICATING A TEMPORARY CROWN

1. Make a template with either one of the following materials:
   Quadrant tray with Alginate.
   No tray, just use blue mousse which is a bite registration material extruded directly onto the patient’s mouth.

2. Try the template in the patient’s mouth to feel how it fits.

3. Vaseline the template or Vaseline the prepped tooth will aid in preventing the temporary from sticking to the temporary material and the prepped tooth.

4. Place the tip onto the extruding gum.

5. Extrude a small amount of the temporary crown material onto a napkin or a 2x2.

6. Place the tip into the template and squeeze the handle of the gun, this way the materials flows properly into the template. You will fill the template three-fourths full with temporary crown material.

7. Place the template over the prepped tooth on the patient and let it set for 90 seconds.

8. Gently lift the template off the tooth.

9. Remove the provisional (temporary) crown from the template.

10. Trim the provisional by marking your margins using a pencil, the you trim by using either a finishing disc or a lab bur.

11. Evaluate and adjust the margins, contact points and occlusion.

12. Seat the provisional with temporary cement three-fourths full, have the patient slowly bite down on a cotton roll.

13. Remove any excess temporary cement with an explorer. Use knotted floss to remove any cement Interproximal.


NOTES
A fixed bridge can range in size from three units (teeth) up to, and including, an entire arch. Fixed bridges can be fabricated by the dental laboratory from:
- Gold
- Porcelain fused to metal
- Porcelain

**CONVENTIONAL FIXED BRIDGE**

A convention fixed bridge is an assembly made up of two or more crowns cast in combination with the missing teeth. The teeth supporting the bridge on either end receive the crowns on the bridge and are referred to as abutments. The missing teeth replaced by the bridge are called the pontics. The abutment crowns are connected to the pontic(s) and the bridge is a cast one-piece unit.

Figure 15A shows a three-unit conventional fixed bridge consisting of two abutment crowns and one pontic. The abutment teeth are prepared using the same technique used for preparation of a single crown. Abutment teeth provide the anchorage (support) to hold the bridge in the mouth. The pontic (missing tooth) is held in place by the crowns on the two adjacent abutment teeth, since the pontic and abutment crowns are cast and supplied as a one-piece unit by the dental laboratory.
CROWN PREPARATION AND PROCEDURE SET-UP

The exact instruments used may vary from dentist to dentist, but a crown preparation procedure set-up will include the following:

- Dental explorer
- Cotton pliers
- Mouth mirror
- Syringe loaded with a needle and local anesthetic
- Gingival retraction cord
- Impression material
- Impression tray(s)
- Mixing pad and spatula
- Cotton rolls or Dri-Angles®
- Temporary crown materials
- Temporary cement
- Gauze
- Articulating paper
- Dental floss

Laboratory-fabricated restorations can be custom made in different forms. Figure 16A shows the differences:

- An inlay is placed as a conservative and minimal restoration, for example, if one or two tooth surfaces need to be restored. There is little damage to the tooth from decay to compromise its strength.
- An Onlay is placed when protection (coverage) if one or more cusps is necessary. The Onlay helps to strengthen the remaining tooth structure.
- A crown is placed when protection of the entire clinical crown of the tooth is needed due to extensive damage to the tooth structure from decay or breakage. Patients will often refer to crowns as “caps”.

![Inlay, Onlay, Crown](Image)
RESTORATIVE DENTISTRY - CROWN AND BRIDGE RESTORATIONS

Cast Restorations: known as crown and bridge restorations, designed to restore damaged teeth and replace missing teeth.

Types of Cast Restorations:
- Inlay: covers inside part of the Occlusal and proximal surfaces, no cusps involved.
- Onlay: covers all or most of the Occlusal and proximal surfaces, one or more cusps involved.
- Crown: also know as full crown. It completely covers the anatomic crown of individual teeth to restore to its original contour and function.
- Porcelain Jacket: very thin shell covered by layers of porcelain to math the shape and shading of a natural tooth. Used on anterior teeth and are esthetically pleasing, however, they lack the strength for use on posterior teeth.
- Fixed Bridges: a cast restoration that replaces one or more missing adjacent teeth in the same arch. It is referred to as “fixed” because it is cemented in place and cannot be removed from the teeth or mouth.
- Veneers: thin layer of tooth-colored material that is bonded or cement to the prepared too surface, usually used to improve appearance of facial or anterior teeth.

Fixed Bridges are Described by Three Components:
- Abutments: natural teeth that server to support the replacement tooth or teeth, located usually at either end of the bridge.
- Pontics: the artificial tooth that replaces the missing tooth. There is one Pontic for each missing tooth.
- Units: the number of pontics and abutments. For example, a three unit bridge consists of two abutments and one Pontic.
DENTAL IMPLANTS

What are dental implants?
An implant is a hollow titanium screw, surgically placed into the jaw bone, that a tooth or multiple teeth can be built upon.

How do they work?
The implant is not recognized as foreign by the body and will be untreated into the bone (the bone will grow into it). Once integrated, the implants is solid as bone and can support a tooth.

How longs does that take?
For a Maxillary arch, 6 months of surgical healing. Mandibular arch, 3 months of surgical healing. One to four weeks of healing after a soft-tissue uncovery.

Who can get them?
Patients for whom rehabilitation will confer long term benefit to the patients and will produce superior result to other alternative treatments such as bridges an dentures.

Who should NOT get them?
Patients compromised by elective surgery or infections such as heart failure, mitral stenosis, uncontrolled diabetes, blood dyscrasias, etc. Someone that cannot maintain high standards of oral hygiene. Patients with uncertain bone integration (recent irradiation of the jaws). Heavy smokers, decreased resistance to infection and diminished oral healing.

How much do they cost?
Surgical placement varies, depends on bone grafting, soft tissue grafting, sinus lifting, etc.

Abutment:

Crown:

IMPLANT PARTS

Implant Fixture: the part of the implant that is surgically place in to the jaw bone.

Healing Cap: a cap placed on the implant to protect the top of the implant after it has been uncovered (exposed through the gingival tissue). The healing cap helps shape the gum tissue while it is healing, before the abutment and crown are placed.

Implant Abutment: the part of the implant that connects the fixture to the crown (usually held in place with a torque tightened screw).

Loading: the term used when an abutment and crown (tooth) are placed on the implant fixture.

Immediate Loading: when an abutment and crown (tooth) are placed on the implant fixture on the same day the fixture is placed (surgery day). Pros and cons are the relation of vital structures.
UNDERSTANDING ORAL SURGERY

Oral and Maxillofacial Surgery: diagnosis and surgical treatment diseases, injuries and defects of the oral and Maxillofacial regions.

Specialized Needs:
- Patient record, current medical history, radiographs, pain control methods to be used.
- Signed consent indicating the patient understand the procedure and is aware of possible complications.

Oral Surgery Instrumentation: instruments are designed to separate the tooth from the socket, retraction, loosen, elevate the tooth from the socket. They must be heat sterilized.

COMMONLY USED INSTRUMENTS

Straight Elevators: primary use its to loosen and lift the tooth from the socket. Common elevators are the straight, apex and cryer. Each comes in small and large referring to the tip of the instrument.

Extraction Forceps: used to rock the tooth so the tooth can be removed from the alveolar bone, after they have been loosened with the elevator. Many shapes and sizes designed to grasp teeth with different crown shapes, root configurations and locations in the mouth.

Universal Forceps: Maxillary, 150. Mandibular, 151.

Surgical Curette: double-ended scooped-shaped. Used to debride extraction socket.

Rongeur: used to trim sharp projections in the alveolar bone, common used after multiple extractions.

Root Tip Picks: used to retrieve the tip of a root that has fractured off in the socket.

Bone Files: has large cutting grooves, used to smooth the surface of the bone after the rongeur has been used.

Scalpel/Bard Parker: surgical blade attach a handle is used to make precise incisions into soft-tissue.

Hemostat: has beaks (both curved and straight) with serrations and a locking mechanism on the handle that makes it useful for grasping and holding an object or tissue.

Needle Holder: resembles hemostat, but has a smaller straight (only beaks, locking mechanism, holds suture needle firmly.

Suture Scissors: heavier, straight or curved blades used to cut sutures.

Periosteal Elevators: used to reflect tissue from the bone.

Retractors: usually know as “Minnesota Retractor” used to retract cheeks and soft-tissue.

Tissue Forceps: resemble tweezers, they have serrated tips to grasp tissue.

Sutures: used to close the surgical site, usually silk. Common size is 4/0, 18 inches long.

Surgical Suction Tip: small in diameter, long, usually curved, both disposable and autoclavable.

Surgical Scissors: fine, straight or curved blades, used to cut tissue.
SURGICAL TERMINOLOGY

Impacted Tooth: one that had not erupted normally due to coverage by the bone and/or tissue.

Bony Impaction: a tooth whose eruption is blocked by both the bone and the tissue.

Soft Tissue Impaction: a tooth whose eruption is blocked only by gingival tissue.

Alveolar Bone: the part of the jaw bone in which the roots of the teeth are embedded.

Alveolar Socket: the cavity left in the alveolar bone where the roots of the tooth was held in position.

Edentulous: having lost all natural teeth.

Alveoloplasty: surgically contouring the remaining bone and soft tissue to properly contour the edentulous ridge.

Impacted Tooth: one that had not erupted normally due to coverage by bone and/or tissue.

Bony Impaction: a tooth whose eruption is blocked by both bone and tissue.

Soft Tissue Impaction: a tooth whose eruption is blocked only by gingival tissue.

Dry Socket (Alveolitis): a very painful condition that usually occurs 2 to 4 days after the removal of a tooth. Possible causes can be inadequate blood supply, infection, trauma, or dislodging a clot.

Hemostatic: pertaining to the control of bleeding.

Hemodent: a product commonly used to stop minor bleeding.

Surgicell: a product of mesh like material placed on a wound to stop minor bleeding.

Silver Nitrate Sticks: matchstick-like in appearance, dabbed onto wound for minor bleeding.

NOTES
CONTROL OF BLEEDING

Immediately after an extraction, the Doctor you assist will place a 2x2 gauze pad folded over the socket, (extraction site), to control bleeding and to promote a clot formation for the healing process. The pack must stay in place to control the bleeding. The assistant will give the a patient a list of postoperative, (after surgery), instructions:

- Keep the pack in place for at least another 30 minutes. If the pack is removed to soon, it could disturb the clot formation and may increase bleeding
- If the bleeding continues and does not stop, call the dental office
- Do not disturb the clot with your tongue or by rinsing your mouth vigorously
- Restrict strenuous work or physical activity for that day.

CONTROL OF SWELLING

After extensive surgery, expected swelling can be controlled with cold packs and the following Post-Op instructions:

- If recommended by the Dentist, take ibuprofen before and after surgery to help prevent and control swelling
- During the first 24 hours, place a cold pack on a 20 minute on/off cycle
- After the first 24 hours, apply external heat to the area of the face to enhance circulation in the tissues and to promote healing
- After the first 24 hours, being gently rising your mouth with a warm saline solution (salt water) every 2 hours to promote healing

Once a tooth has been extracted, healing begins immediately, with the blood forming a clot. The clot is important because it protects the wound and will later replaced by granulation tissue and ultimately bone failure of the healing process can result in Alveolitis, (dry socket).

NOTES
CROWN PREP AND/OR BRIDGE STEPS AND INSTRUMENTS
(The Cord Packing instrument is used during this procedure, there are also two ways to take the final impression)

NOTE: Always check the patient health history

Procedure

1. Assistant will hand to the Doctor.
2A. Assistant applies topical.
2B. Doctor will anesthetize.

3. Assistant will pick the shade.
4. Assistant will make a template before the Doctor preps the tooth.
5. Assistant places rubber dam.
6A. Doctor will prep the tooth.
6B. Doctor will evaluate for buildups, pins or posts.
7. Doctor or assistant will remove rubber dam.
8. Doctor or assistant will place retraction cord around prepped tooth. Wait approximately 5 to 10 minutes for the cord to retract the tissue from the tooth.
9. Doctor will remove the retraction cord.

All in One Final Impression Procedure

10. Assistant will hand the Doctor light body impression material. Doctor will place light body impression material around the heavy body impression material area of the prepped tooth. The assistant will load both sides of the triple tray with heavy body impression material and then instruct the patient to bite down for approximately 5 minutes.
11. Assistant will remove the impression for the Doctor to evaluate. Assistant will then prepare the Impression for the lab to pick up.
12. Assistant will fabricate a temporary crown.
13. Assistant or the Doctor will adjust the occlusion if necessary.
14. Assistant will seat the temporary crown with temporary cement.

*Please note that there is another way to do a final impression and that is a 3-step procedure (NOTE: you will not be tested on these steps this is just for you to understand that there are a couple of different ways to get the same result):

Assistant takes separate impression of the opposing arch. Assistant takes bite registration.

Assistant will hand the Doctor light body impression material. Doctor will place the light body impression material around the area of the prepped tooth. The assistant will load a full mouth tray with heavy body impression material and hand to Dr. to place into the patients mouth then either the Doctor or the Assistant will hold the impression in the patients mouth for approximately 4 minutes.

Post-Op Instructions:
- Be careful while you are numb
- Avoid food and drink while you are numb
- Pull out to the side while flossing
- Avoid sticky or crunchy foods while healing

NOTE: Write chart notes