BUILD A DENTAL PRACTICE THAT GROWS WITHOUT YOU

THE SIX SYSTEMS THAT CONVERT AND KEEP PATIENTS

DSD
Digital Smile Design

Why you're reading this

Most practices don't have a growth problem.
They have a dependency problem.

Somewhere in your practice there is a person who holds things together. They remember the follow-up, they notice the overnight enquiry, they chase the review and the recall. When they're in, things move. When they're busy, things wait. When they leave, a good part of how your practice works walks out with them.
That person is usually excellent. That's the trap.

If a task only happens because a specific person remembers to do it, you don't have a system. You have a person holding everything together.

The better that person is, the more invisible the risk, because the output looks fine right up until the day it isn't.

This guide removes the dependency. Not by hiring a better hero, but by building systems a person can be removed from. There are two engines and six systems, and most of your lost revenue is hiding in the same two or three places it hides in every practice we look at.

How to use this guide: read the architecture on the next page, then the six system breakdowns. At the back you'll find a 24-question diagnostic. Score yourself and fix them one at a time.

Two engines, six systems

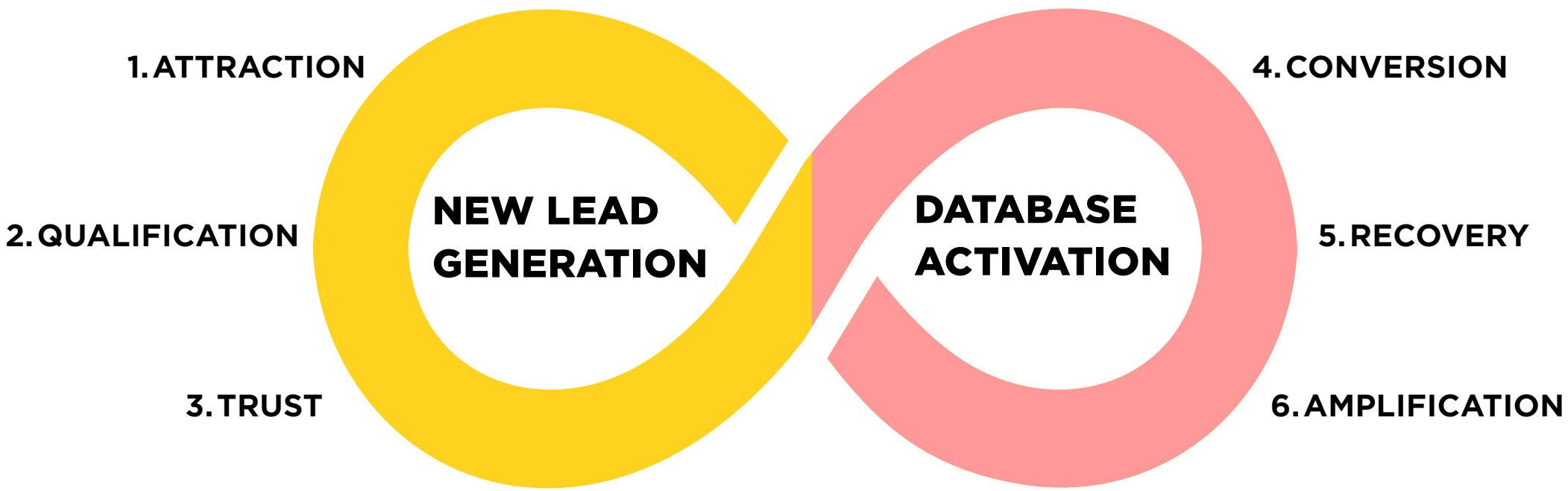
Everything that turns a stranger into a booked, treated, returning patient sits inside six systems, grouped into two engines.

Engine ONE: new lead generation
Takes someone who has never heard of you and brings them to a consult ready to talk.

- System 1: Attraction
- System 2: Qualification
- System 3: Trust

Engine TWO: database activation
Takes the patients you already have contact with and turns them into treatment and referrals.

- System 4: Conversion
- System 5: Recovery
- System 6: Amplification



SYSTEM 1. ATTRACTION

Ask a room of owners their number one problem and around nine in ten say leads. It's the wrong answer, and believing it is expensive.

Attraction is the easiest it has ever been. What you do afterwards is the hard part.

Pour more leads into a practice that can't follow them up and you don't get more patients. You get a frustration cycle: the agency believes it delivered, the practice sees no new patients, both blame each other, and the budget keeps burning.

The fix

- Get attraction working just enough to feed the engine, then stop obsessing over it.
- Never run paid media without systems two to six already live. Paid behaves like a drug: stop paying and the attention stops.
- Balance your sources toward the ones that compound (reviews and referrals from System 6) rather than the ones you rent.

System vs team: the system tracks source and volume and runs the always-on inputs; the team decides budget balance and owns the compounding sources.

SYSTEM 2.
QUALIFICATION

Same enquiry, quarter past nine at night, three practices. Practice A does nothing till morning. Practice B fires an autoresponder. Practice C responds in sixty seconds with a real conversation. You already know who wins.

$265,000 a year, lost not to bad clinical work, just to silence. (In a $3M practice.)

Around 78% of patients go with whoever responds first. The North American average response time is about 47 hours. Respond in sixty seconds against that and you're barely competing.

The fix

- An AI-first response inside sixty seconds, every hour of every day, around 80% human-enhanced so it reads like a person and never sleeps.
- Sort every lead hot, medium, or cold, and work hot first.
- Run an eight-stage pipeline so no lead is lost between one person's inbox and another's.

System vs team: the system handles the 60-second response, triage, and pipeline tracking; the team takes hot leads and adds the human judgement that closes them.

SYSTEM 3.

TRUST

The gap between booking and consult is where trust is built or lost, and most practices leave it completely silent. Silence has a measurable cost: no-shows.

No-shows climb from around 2% same-day to roughly a third by fifteen days out.

A no-show isn't a lost appointment fee. It's the lost treatment, the lifetime value, and potentially up to twelve months of revenue that never starts.

The fix: communication zero. A planned sequence of eight emails over about twelve days, before they ever sit in the chair. Each email does one job:

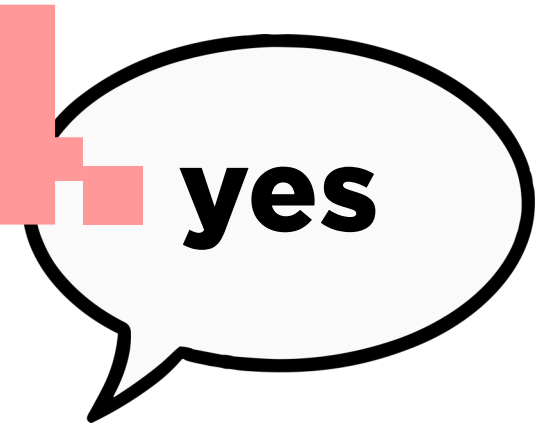
- Introduce the doctor
- Share the practice's story and values
- Show social proof
- Answer the common questions
- Deal with insurance
- Sort the logistics
- Set expectations for the visit

Timing adapts: sooner consult, fewer and compressed. Twelve days of silence, or twelve days of trust. You're choosing one or the other whether you mean to or not.

Two details that punch above their weight: the most anxiety-reducing thing you can tell a patient before a comprehensive consult is that no treatment will happen at this visit. And asking permission at booking makes eight emails feel expected, not like spam.

System vs team: the system sends the sequence on adaptive timing; the team adds personal touches and answers anything it raises.

SYSTEM 4. CONVERSION



Around 60% of comprehensive consults end with some version of "I'll think about it." Most practices hear a polite no and move on. It's the most expensive misread in the building.

It's not a no. And it's not one objection. It's actually six.

- Financial (~45% of unspecified deferrals): the plan is wanted, the money is the blocker.
- Spouse or partner (~25%): they genuinely need to talk to someone at home.
- Fear: the treatment, the chair, the unknown.
- Second opinion or shopping: they want to compare.
- Urgency: it isn't a priority yet.
- Genuine no: real and settled, and the smallest group of the six.

About 40% say yes on the day. The other 60% defer.
That's $1.5 million in deferred plans annually, just sitting there (in a $2-3M practice running 400-500 consults a year.)

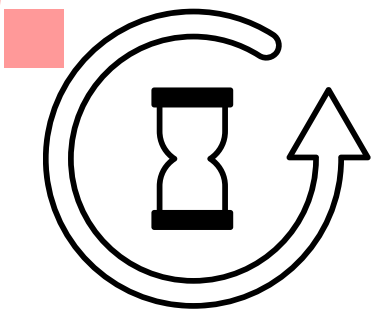
Systematic follow-up recovers around 30 to 40% of that backlog. Not through pressure, through patience and the right message to the right barrier.

The fix

- Find out which of the six barriers it is rather than guessing: record and transcribe the consult, and have the team ask directly.
- Run a contextual 30-day follow-up in three phases, drawing on a library of around 49 templates sorted by barrier. The team classifies the barrier and makes two calls; the system runs the rest.
- If the barrier is fear, do not create urgency. It backfires every time. The fear branch gets empathy, testimonials, reassurance, and time.

Two messages do most of the closing: the first one after they leave, and the final breakup message. The breakup message works by releasing low-grade guilt (it's fine if the timing isn't right, we'll be here). Around 50% of people who get it go ahead. Permission, not pressure.
System vs team: the system runs the three-phase sequence by barrier type; the team classifies the barrier and makes two calls.

SYSTEM 5.
RECOVERY



Some patients won't convert inside the 30-day window. The instinct is to write them off. That's the mistake.

$5 to $15 to reactivate someone you already have. $150 to $300 to acquire a new lead.

Most patients who deferred never do the treatment with anyone; it just wasn't a priority. Their life hadn't changed yet. Recovery's job isn't to close them. It's to keep the door open so that when life does change, you're the practice they come back to. The danger is silence: lose contact for around 18 months and they're gone for good.

The fix:

- Rest about 30 days after the follow-up ends
- A seven-day sequence at day 60
- Again at day 120
- Four waves total, with the incentive rising the longer it runs
- Seasonal reasons layered on top: insurance reset, tax-refund season, birthday, new year

When someone responds, they're not "closed." They re-enter qualification as a live lead, with the team picking up the alert with full context. A simple email newsletter is one of the best recovery tools there is, because everyone on it already raised their hand once.

System vs team: the system fires the cadence, the seasonal campaigns, and the alerts; the team responds with full context and re-qualifies.

SYSTEM 6.
AMPLIFICATION

83% of happy patients intend to refer you. Only 29% actually do.

Around 68% intend to leave a review; only about 7% do. That gap isn't a motivation problem, the goodwill is already there. It's an infrastructure problem. The practice never built the ask, so the intention quietly evaporates.
Build the ask as a standing system triggered by a happy signal. There are two compliant ways to run it.

- Approach A, proactive: send an NPS-style question to everyone, then a review link to everyone, regardless of score. Roughly 8 to 10 reviews a month and a genuine moat over time. Fragile under 50 total reviews, because one bad review takes a 4.9 to a 4.2 when your base is thin.
- Approach B, reactive: use NPS for insight, then ask for a public review only from patients who volunteer they had a great experience. Slower, but safer when your count is low.

What you cannot do is gate. Sending NPS to everyone and the review link only to high scorers is review gating: non-compliant and, in many places, illegal. Adjust your response tone by score, not who gets asked. A low score gets a soft, private follow-up; a high score gets gently pointed to a public review.

This is the system that closes the flywheel. The reviews and referrals it produces feed straight back into attraction. That's the loop. That's why it runs without a hero.
System vs team: the system triggers the ask on a happy signal and routes by score; the team moves a card and handles low scores personally.

WHO RUNS IT?

A system needs an owner, and ‘everyone’ is not an owner. These are seats, not necessarily separate people; in a smaller practice one person can wear two hats. What matters is that every seat is named and accountable.

- System owner (usually the office manager): owns the architecture, the cadences, and the seasonal calendar. The seat that makes the practice run without you.
- Lead responder: owns qualification. Sixty-second response, qualify, triage, hand over with context.
- Case coordinator (treatment coordinator): owns conversion and responds to recovery alerts.
- Clinical voice: the clinician whose authority shows up in the trust and conversion content.
- Marketing coordinator (optional): owns attraction inputs and the newsletter.

The one seat you must never collapse: lead responder and case coordinator are two different jobs.

The lead responder reacts fast to brand-new enquiries all day. The case coordinator runs patient, multi-week follow-up on deferred plans. Put them in one person and one always gets dropped, usually the slow, patient one, which is exactly the one sitting on $1.5 million.

SYSTEM VS TEAM

For each system, the honest split between what runs on its own and what still needs a person. The principle: automate the remembering, keep the judgement and the relationship human.

SYSTEM	What the system handles	What the team does
Attraction	Tracks source and volume, runs always-on inputs	Decides budget balance, owns compounding sources
Qualification	60-second first response, triage, pipeline tracking	Takes hot leads, adds human judgement to the close
Trust	Sends communication zero on adaptive timing	Personal touches, answers anything it raises
Conversion	Runs the 30-day, 3-phase sequence by barrier	Classifies the barrier, makes two calls
Recovery	Fires the four-wave cadence, seasonal campaigns, alerts	Responds to alerts with full context, re-qualifies
Amplification	Triggers the ask on a happy signal, routes by score	Moves the card, handles low scores personally

THE NEXT STEP

Now you know what good looks like across all six systems, score yourself against them.

Take the Case Acceptance Diagnostic, a 24-question self diagnosis that takes less than 4 minutes to complete.

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