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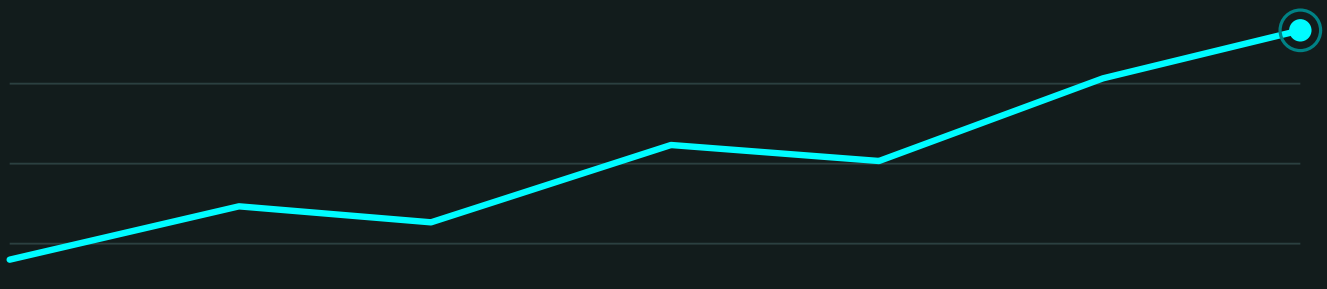
FIELD GUIDE NO. 05 · 2026 EDITION

The Dental Group Occupancy Playbook

What it takes to keep chairs full across a multi-office dental group: the utilization math, the recall engine sitting inside your own charts, and the marketing system that captures patients the DSOs are spending millions to reach. Written for owners of independent, multi-location dental groups.

SCORING OFFICES BY HEADROOM · THE RECALL GOLDMINE · BOOKED, KEPT, COLLECTED



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ABOUT THIS FIELD GUIDE

Written for the owners who built the group

This guide is written for a specific operator: the dentist-owner who built the largest independent group in their corner of the metro. Multiple offices, dozens of doctors and hygienists, specialists under one roof, an in-house savings plan for the uninsured, a five-figure review base, and a brand-new office with eleven operatories that has to fill. Every office is the same practice. Every schedule tells a different story.

We use the word occupancy on purpose. A dental group sells chair time, inventory that expires at the top of every hour while rent, payroll, and equipment bill you either way. The ADA's own survey data says the quiet part out loud: 81.3% of dentists cite no-shows and cancellations as the primary reason schedules never reach full capacity.[1]

One promise about the numbers

Every statistic here comes from a named third-party source: ADA survey data, Dental Economics, published recall and phone benchmarks, and peer research on lead response and reviews, each with a numbered citation listed at the back. Where we model a scenario, we label it an illustrative model in plain sight. If a number cannot survive being asked about on a call, it does not belong in a document with our name on it.

What's inside

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CHAPTER 01

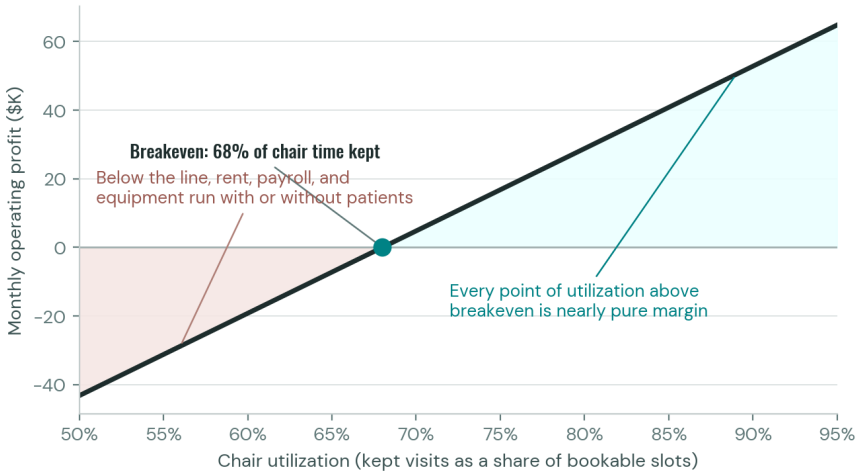
The chair is the building

01

A dental office is a fixed-cost machine with a drill: premium retail rent, clinical payroll, six-figure equipment, lab and insurance overhead, all committed before the first patient of the month sits down. Real estate calls the threshold the breakeven occupancy ratio;[22] in a dental group the unit is the operatory-hour, and the metric is chair utilization: kept visits as a share of the slots your providers and rooms offer.

The math, in one worked example

Take an illustrative six-operatory office offering 1,200 appointment slots a month at $250 blended production per visit,[11] with roughly 20% variable cost, and fixed costs set so breakeven lands at 68% utilization.



Monthly operating profit vs. chair utilization for a modeled six-operatory office. Illustrative model: 1,200 slots, $250 per kept visit, ~20% variable cost, breakeven at 68%.

Production-per-visit benchmark per practice growth data. Sources 11, 22.

In this model one point of utilization is twelve kept visits a month, worth roughly $29,000 a year, and a dentist-hour of production runs $475 to $575.[4] Multiply by six or eight offices and the gap between the group's best schedule and its worst is a seven-figure line item hiding in plain sight. Operations protects the chairs. Only demand fills them.

UPRYT POV

Most groups manage the cost side relentlessly: supplies, labs, staffing ratios. The demand side gets whoever answers the phone between patients. Costs have a floor. Utilization has headroom, and the headroom is where the margin lives.

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CHAPTER 02

The multi-office trap

02

The pattern repeats in almost every group. The flagship office is booked out and carries the P&L. The newest office, the one with eleven operatories and the 3D imaging, has holes in every column of the schedule. Same doctors rotating through, same standards, same brand on the door. So why does the census diverge by office?

When the clinical product is consistent and the schedules are not, the variable left standing is demand capture, and at the office level that is a marketing output: map rank in that neighborhood, reviews for that location, answer rate on that phone line, referral relationships in that community. One reputation in the operatory, a separate battle on every map pin.

How the fragmentation happens

The website came from a dental template vendor years ago. Ads run through a shop that reports clicks. Reviews happen when the front desk remembers. Each office fights alone. The discipline gap is measurable: 94% of high-performing multi-location brands run a dedicated local strategy per location versus about 60% of average performers,[20] location-specific pages convert up to 50% better than one brand homepage,[19] and 76% of near-me searchers visit a business within 24 hours.[18] The demand is there, suburb by suburb. What varies is who captures it.

94% vs 60%
high performers vs. average with a dedicated local strategy [20]

+50%
conversion lift, office pages vs. one brand homepage [19]

76%
of near-me searchers visit within 24 hours [18]

The independent's edge over the DSO

Corporate dentistry outspends you on brand. It rarely outruns you locally: DSO locations often post lower recall rates than independent practices, because higher staff turnover breaks the relationship continuity recall depends on.[10] Your forty years in the community, your five-figure review base, and your specialists under one roof are exactly the assets a location-level marketing system compounds and a fragmented one wastes.

UPRYT POV

One firm in the stack usually figured out long ago that a fragmented client never leaves. Making yourself hard to replace is a skill. It is not the same skill as filling chairs.

CHAPTER 03

How patients choose a dentist now

03

Dentistry is a reviews business now. 97% of consumers read reviews before choosing a local business,[16] and a group that has spent decades earning a five-figure review count is sitting on a moat most competitors cannot buy. The catch: patients read reviews per office, on the profile for the address they will actually drive to, and a group-level number does not transfer to a new office with eleven empty operatories.

The discovery layer moved again

Consumers using AI tools for local recommendations jumped from 6% to 45% in a single year,[17] and those assistants weigh the same structured data, consistent facts, and review signals your human patients do. Add the table stakes: 46% of Google searches carry local intent,[18] 89% of patients want to schedule anytime from a phone or computer, and 61% would consider switching providers for a digital front door.[21] The practice that can be found, trusted, and booked at 10pm wins the family that moved in last month.

And the family is the unit

General dentistry's quiet advantage is that one good first visit converts a household. The spouse, the kids, the ortho consult, the implant case years later: first-year production per new patient runs $850 to $1,300, and lifetime value runs $8,000 to $10,000 or more,[7] before counting the relatives who follow. Every marketing number in this guide should be read against that lifetime figure, not against the first cleaning.

UPRYT POV

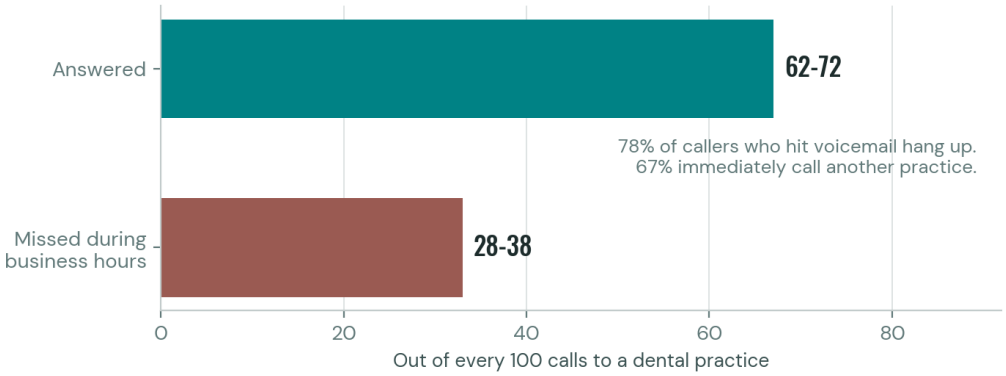
The DSO next door is buying attention. You already own trust. The system's job is to make that trust visible, office by office, on every surface where a new family is choosing.

CHAPTER 04

The quiet leak

04

Now the uncomfortable audit. Across multiple studies, dental practices miss 28% to 38% of incoming calls during business hours,[5] and the callers do not wait: 78% of patients who reach voicemail hang up without leaving a message, and 67% immediately call another practice.[6] At $850 to $1,300 of first-year production per new patient,[7] a busy Monday morning of unanswered rings is real money choosing your competitor.



The front-door leak: what happens to 100 inbound calls at a typical dental practice.

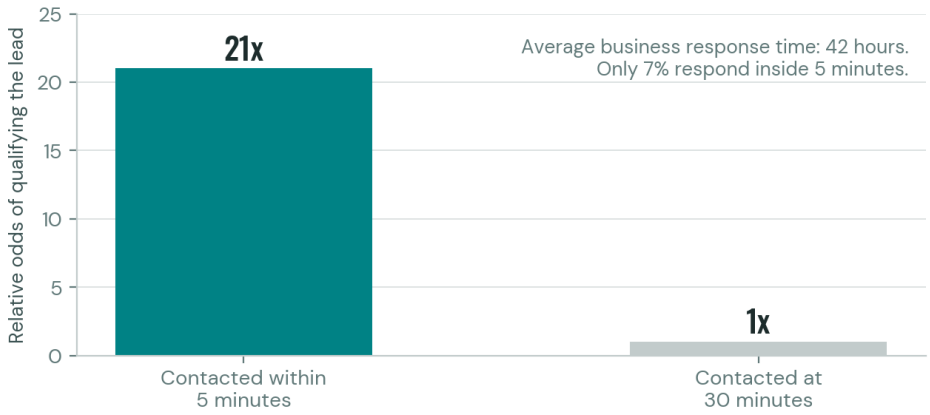
Sources 5, 6. Multi-study call-tracking data.

The chairs leak too

The average dental no-show rate runs 15% to 20%, one in six scheduled appointments,[3] at $200 to $400 of lost production per empty slot,[4] which is how the average practice gives up $105,000 or more a year.[1] The spread is the story: the top tenth of practices holds no-shows near 1%,[1] which means this is a systems problem, not a patient problem.

Speed decides who gets the new patient

For web inquiries the window is minutes: contacting a lead within 5 minutes makes you 21 times more likely to qualify it than waiting 30,[23] 78% of buyers choose whoever responded first,[25] and the average business takes 42 hours.[24] Between the phones, the no-shows, and the response speed, most groups can add meaningful utilization without buying a single new click. Plug the leaks first; every acquisition dollar works harder afterward.



Relative odds of qualifying a new-patient inquiry by response time.

Sources 23, 24, 25. MIT/InsideSales lead response research; HBR response study; industry response-time surveys.

UPRYT POV

Call your own busiest office on a Monday at 8am. Submit a lead to your own website on a Saturday. Time both. Whatever the stopwatch says is your real marketing budget leak, and it is fixable in weeks.

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CHAPTER 05

The gold already in your charts

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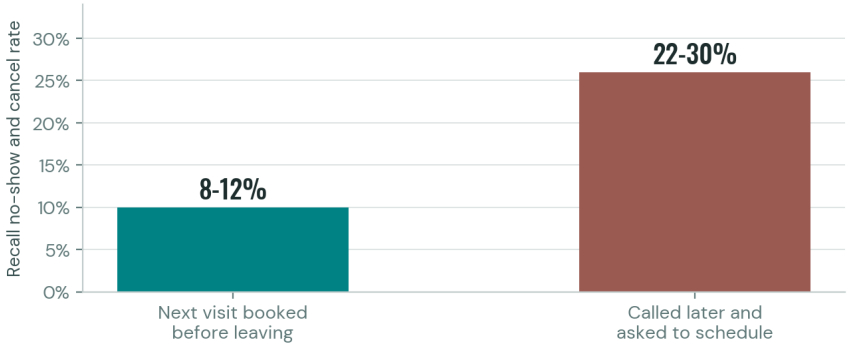
Before a group spends another dollar acquiring strangers, it should mine the patients it already won. The industry-average hygiene recall rate sits at 60% to 70%,[9] the average practice loses 15% to 20% of its patient base to attrition every year,[10] and more than 40% of diagnosed treatment plans nationally go uncompleted.[12] One vendor analysis puts the unscheduled treatment sitting in the average practice's own software at $1 million or more; treat that figure as directional, and the direction is unmistakable.[13]

The booking moment is the whole game

Only about half of practices book the next hygiene visit before the patient leaves; top performers hit 70% or better.[9] The payoff compounds twice: pre-scheduled patients return at 80% to 90% versus 35% to 45% for patients who leave unbooked,[10] and when they do return, they show up.



Recall no-show and cancellation rate, by when the next visit was booked.

Source 9. Practice management benchmarking data.

Run reactivation as a standing system

Lapsed patients, overdue perio maintenance, and unscheduled restorative work are the cheapest kept visits a group can buy: the chart is on file and the outreach costs a text sequence instead of a click budget. Run a weekly reactivation number per office, worked like a pipeline; structured recall systems retain 85%+ of active patients versus 60-70% without.[11]

UPRYT POV

Marketing plans start with strangers because strangers are what vendors can sell you. Your own charts are the highest-margin demand channel the group owns, and nobody is invoicing you for it yet.

CHAPTER 06

Scoring offices by headroom

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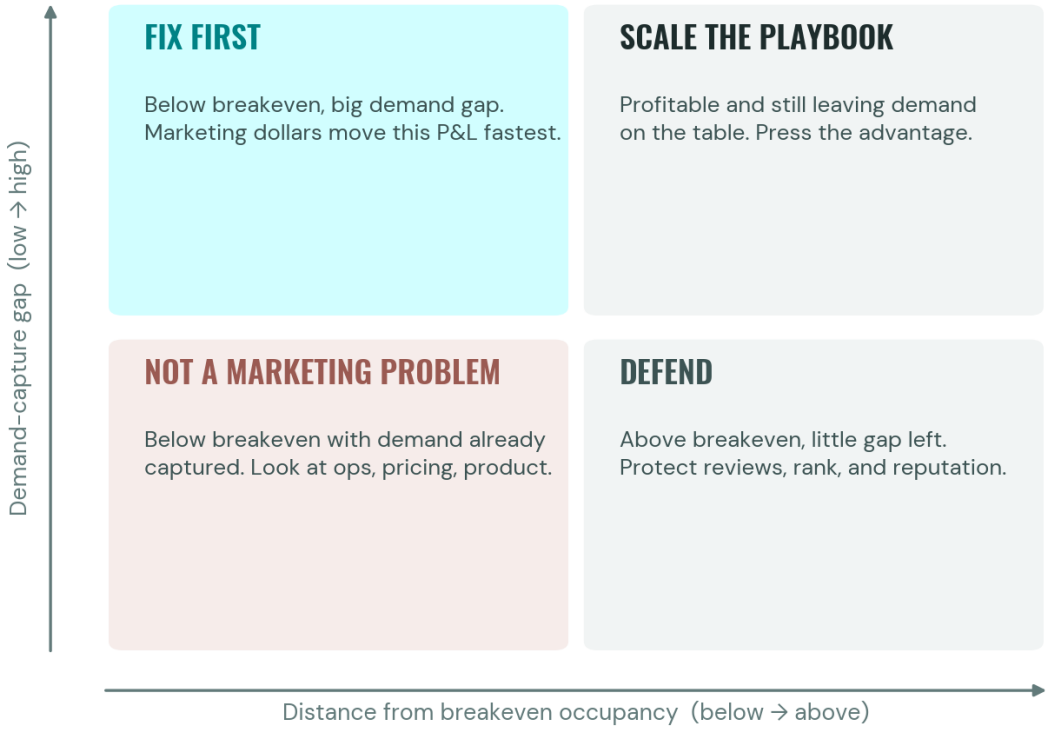
Marketing budgets in dental groups get allocated evenly, because it feels fair, or loudly, toward whichever office manager escalates best. Headroom scoring replaces both with two questions per office: how far is it from breakeven utilization, and how much demand is it failing to capture?



The headroom matrix. Plot every office by distance from breakeven utilization and by unclaimed demand in its trade area.

How to run it

Signal	Where it comes from	What it tells you
Distance from breakeven	Office P&L: fixed costs, contribution per kept visit, current utilization	Urgency. Below the line, every month compounds the problem.
Local rank gap	Map pack position vs. top 3 competitors on money keywords	Visibility; 76% of near-me searches become a visit within a day [18]
Review gap	Rating and volume vs. the local leader, per office	Credibility; 97% of patients read reviews first [16]
Answer rate and speed	Share of calls answered; minutes to first response on web leads	Conversion; 28–38% of dental calls go unanswered [5]
Hygiene reappointment rate	Share of patients leaving with the next visit booked, per office	Retention engine; average ~50%, top performers 70%+ [9]
Unscheduled treatment value	Diagnosed, unscheduled dollars sitting in the PMS, per office	Recoverable revenue; 40%+ of treatment plans go uncompleted [12]

The matrix also protects you from the classic mistake: pouring ad spend into an office whose problem was never demand. An office below breakeven that already captures its trade area has a payer-mix, capacity, or reputation-repair problem, and more marketing will only document it faster.

UPRYT POV

We run this scoring in week one of every engagement and put the grid in front of the whole leadership team, office managers included. Half the value is the budget logic. The other half is that the managers stop arguing with each other and start arguing with the grid.

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CHAPTER 07

Booked, kept, collected

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A filled chair only counts when the money lands. Dental has a third gate the other local industries mostly skip: insurance. The benchmark for a well-run office is a 98% collection rate on adjusted production,[12] and every point below it is finished clinical work the group performed for free. So the reporting chain in dentistry has to run one link longer: demand captured, appointment booked, visit kept, production collected.

The metrics that survive contact with the P&L

Weekly, per office, per provider: chair utilization against breakeven, cost per booked and kept new patient by channel, answer rate and response speed, hygiene reappointment rate, review velocity, unscheduled treatment value, and collection rate with 90-day insurance aging. If a number cannot be traced to a filled chair or a collected dollar, it goes in an appendix, not a headline.

The software wave is real, and it is aimed at exactly these leaks

A new class of dental tools has emerged that pairs software with specialist humans, and the good ones attack the gates in this guide directly. Revenue cycle platforms like DayDream Dental run the collections gate end to end: insurance verified 5 to 7 days ahead of the schedule, claims worked every 7 days until paid, payments posted within 24 hours, and 90-plus-day insurance aging driven toward zero, with a stated goal of collecting 100% of what the practice is owed.[15] AI phone platforms attack the 28-38% missed-call leak with 24/7 answering, and modern reminder systems attack the no-show gap. Evaluate any of them against your own numbers, but the principle stands: every leak in this guide now has purpose-built tooling, and the groups that wire demand, retention, and collections into one system compound while the rest keep buying clicks to refill a leaky bucket.

UPRYT POV

Our lane is demand and the weekly readout; tools like these close the keeps and the collections. The winning stack is boring on purpose: one demand system, one retention engine, one revenue cycle, one page a week that shows all three.

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CHAPTER 08

The new-office calendar

08

Most groups start marketing a new office the week the build-out finishes. The revenue clock has earlier gates: payer credentialing for every provider at the new location runs 90 to 120 days on average, and complex cases run 180 or more,[26] while search engines and AI assistants need weeks to trust a new address. One calendar, starting at lease-signed, runs credentialing and demand in parallel.

Window	What ships	Why it cannot wait
Day -150 (lease signed)	Payer enrollment filed for every provider. Office page live with a founders list. Google Business Profile created, verification started. Tracking numbers provisioned.	Credentialing averages 90 to 120 days;[26] starting at -150 protects day-one billing.
Day -120 to -60	Provider bios, photography, and treatment content shipped. Citations locked. In-house savings plan presale opens to the founders list. Community and school outreach begins.	A presold membership base converts opening week from an experiment into a schedule, exactly the play an in-house plan makes possible.
Day -60 to -21	Online booking live. Paid local campaigns on. Phone and 5-minute web response rehearsed with real test leads, lunch hours and evenings included.	Inquiries answered inside 5 minutes qualify at 21x the rate of slow ones;[23] the habit must exist before the volume does.
Day -21 to open	Founders list converted to booked first visits, family blocks encouraged. Opening month built to meaningful utilization. Review engine armed for the first kept visits.	An office that opens at real utilization resets the whole ramp, and early reviews compound from day one.
First 90 days	Weekly one-page readout: utilization, kept visits, reappointment rate, cost per booked and kept, answer rate, review velocity, collections. Reactivation pointed at the dayparts that reveal themselves.	The first quarter sets the office's rank, review base, and habit loops every later quarter inherits.

The calendar is boring on purpose. New offices fail from sequencing, not from a lack of ideas: the payer application that sat, the profile that was not verified, the ads pointed at a page that was not live. A written calendar converts the opening from an event into a system, the only version that repeats at office 8 and office 18.

UPRYT POV

We treat a signed lease as the starting gun for credentialing and demand together. If either starts at the ribbon cutting, the ribbon is cutting into the first year's P&L.

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CHAPTER 09

The owner's diagnostic

09

Ten questions to put to your current marketing setup, whether it is in-house, outsourced, or a pile of both. Score one point for every confident yes.

01 Do you know each office's breakeven utilization?
Not the group's. Each office's. If finance cannot produce it, Chapter 1 can.

02 Can your marketing team name kept-visit utilization by office?
If the people spending the demand budget do not know the demand number, they are optimizing something else.

03 Do you know your answer rate, and have you tested it?
28–38% of dental calls go unanswered.[5] Call your busiest office on a Monday at 8am.

04 Is a human responding to web inquiries inside 5 minutes?
The 21x window.[23] Submit a lead to your own site on a Saturday.

05 Do you know your hygiene reappointment rate, by office, by provider?
Average practices pre-book about half; top performers 70%+.[9]

06 Do you know the unscheduled treatment value sitting in each office's PMS?
More than 40% of diagnosed plans go uncompleted nationally.[12] It is the cheapest revenue you have.

07 Does every office have its own pages, profile, and review engine?
97% of patients read reviews,[16] and they read the profile for the address they will drive to.

08 Do you know cost per booked and kept new patient, by channel, by office?
It is the only acquisition number that survives contact with the P&L.

09 Does reporting run all the way to collected?
The 98% collection benchmark[12] is where a filled chair becomes actual revenue.

10 Could you fire any single vendor without losing your own accounts?
If someone else owns the domain, the ad accounts, or the profiles, you have a landlord, not a partner.

Scoring: 8 to 10, your system is ahead of most of the market; press the advantage. 5 to 7, the leaks are findable and probably concentrated in two or three questions above. 4 or below, the good news is that nothing here requires more budget to fix. It requires an owner.

THE NEXT STEP

Ready when you are. No rush on our end.

Everything in this guide works whether or not we ever meet. Run the breakeven math, score your offices, call your own front desk on a Monday morning, pull the unscheduled treatment report, and put the diagnostic in front of whoever runs your marketing today. If the answers come back clean, you have built something most groups never do, and you should keep doing exactly what you are doing.

If they do not, that is usually not a people problem. It is a fragmentation problem, and it is fixable.

WHERE UPRYT FITS

UPRYT is the embedded growth team for multi-location operators, dental groups included. We replace the pile of vendors with one team that plugs in like in-house, owns the schedule with you, and runs everything in this playbook as a system: the headroom scoring, the recall and reactivation engine, the 5-minute response machine, the review engine per office, the new-office calendar, and the weekly one-page readout that runs booked, kept, collected. When you grow, we do not tax it. Your spend going up does not make us cost more, and a new office does not restart the relationship.

THE FIRST STEP IS FREE. We audit what you are running today, office by office, against every benchmark in this guide, and hand you the findings. Keep them either way. **upryt.io/audit**

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