Ronald L. Gallerano, D.D.S., M.S.D., P.A.

DIPLOMATE OF
THE AMERICAN BOARD OF ORTHODONTICS

P.O. Box 1145
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INTRODUCTORY INFORMATION

Welcome to our office! We are honored that you have chosen us to provide your orthodontic care and we look forward to serving you. It is our desire to address your concerns about your bite problem (or "malocclusion") during this first visit, which we call the **examination.** This appointment will last approximately 1 hour.

Malocclusion simply means *"crooked teeth."* Orthodontics is the treatment of malocclusion to achieve at least one and usually two goals:

1. Correction of the bite to improve the fit of the teeth, facilitate cleaning the teeth, chewing, digestion, and your general health.

2. Improvement of facial appearance — a more attractive smile and often an improvement in facial contour.

Some of the problems which can be helped with Orthodontics include spacing or crowding of the front teeth, protruding teeth, tilting of teeth into spaces created by tooth loss, and straightening teeth that, for any reason, have assumed abnormal positions in the mouth. Problems such as chronic headaches, soreness of the jaws and neck muscles, and nightly grinding of teeth may possibly be related to malocclusion though not always.

No one is ever too old to begin orthodontic treatment! In general, tooth position can be improved at any age, even though there is a tendency to associate orthodontics with children. However, if your gums and the bone supporting your teeth are healthy and normal, then *age is not a factor.* When not healthy, the condition may be overcome by initial preparatory therapy.

The detailed information that you have provided in the Medical and Dental History, the X-ray that will be taken (or provided), and the observations that Dr. Gallerano will note during the examination will allow for a *general diagnosis.* After he has completed the examination, he will address your concerns and answer the following questions:

[1] Is there an orthodontic problem?
[2] If so, in general, what is it?
[3] Can it be corrected?
[4] When should it be corrected?
[5] How long will it take to correct?
[6] How much will have to be invested to correct the malocclusion?

The next step is to accumulate the data necessary for Dr. Gallerano to provide an accurate diagnosis and develop a precise program *("Treatment Plan")* that will correct your malocclusion. This *"step"* is termed the "diagnostic records" and is outlined on the next page.

More Information At:
SForthoTX.com

CONTINUED ON REVERSE

DIAGNOSTIC RECORDS

Each patient's malocclusion presents a unique problem, which requires *individualized* diagnosis and a treatment plan which is specific and directed to that particular problem, or combination of problems. The complete diagnosis will be based on records compiled from several sources.

A photographic study of your face and teeth will be made from computer generated pictures taken during the *"Records."* Impressions of upper and lower teeth (from which plaster models will be fabricated) and head X-rays (from which a skeletal analysis will be made) will also be done. If the position of your lower jaw is not in harmony with the maximum intermeshing of your teeth, further diagnostic procedures and/or X-rays may be necessary to accurately assess your dental and skeletal problems.

The fee for the compilation of records, the diagnostic study, and the treatment discussion is between $420-$615. **This fee is due on the day that the records are accumulated, but it will be deducted from your case fee once treatment begins.** This appointment will last approximately one and one-half hours.

Some malocclusions are very complex and may require orthodontics combined with other specialties (periodontics, endodontics, oral and maxillofacial surgery) to achieve your treatment goals. If necessary, Dr. Gallerano will recommend appropriate consultations for you and coordinate a "team approach" to treatment through your family dentist and the other specialists that may be involved.

TREATMENT DISCUSSION

If Dr. Gallerano still considers treatment advisable after having analyzed the full records carefully, he will explain his recommendations to you at the Treatment Discussion. If Dr. Gallerano recommends services by other dental professionals, those **fees will be in addition to your quoted orthodontic case fee.** This appointment will last approximately one hour.

Arrangements for the payment of fees vary, however there is no interest or handling charge on our accounts if kept current.

Dr. Gallerano and his staff have made a commitment to provide exceptional care for you and your family. Thank you for giving us the privilege of serving you!!

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Patient Information

Date ____________

Patient's Name ____________ Last ____________ First ____________ Middle

Address ____________ Street ____________ City ____________ State ____________ Zip

Home Phone ( ) ____________ Birthday ____________ Month Day Year Social Security # ____________

If patient is a minor, give parent's or guardian's name ____________

School ____________ Grade ____________ Dentist ____________

Brothers (Ages) ____________ Sisters (Ages) ____________

How did you hear about Dr. Gallerano? ____________

Responsible Party Information

Name ____________ Last ____________ First ____________ Middle ____________ Marital Status

Address ____________ Street ____________ City ____________ State ____________ Zip

How long at this address ____________ Home Phone ( ) ____________ Mobile Phone ( ) ____________

Previous Address (if less than 3 yrs.) ____________ Street ____________ City ____________ State ____________ Zip

Social Security # ____________ Birthdate ____________ Relationship to Patient ____________

Employer ____________ Occupation ____________ Work Phone ( ) ____________

Spouse's Name ____________ Last ____________ First ____________ Middle

Spouse's Employer ____________ Occupation ____________

Work Phone ( ) ____________ Mobile Phone ( ) ____________

Spouse's Birthdate ____________ Spouse's Social Security # ____________

Dental Insurance Information

Insured's Name ____________ Insured's Soc. Sec. # ____________

Insurance Company ____________ Group No. ____________ Phone No. ( ) ____________

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name ____________ Insured's Soc. Sec. # ____________

Insurance Company ____________ Group No. ____________ Phone No. ( ) ____________

Insurance Co. Address ____________

Insured's Employer ____________

Emergency Information

Name of nearest relative not living with you ____________

Complete Address ____________

Phone ____________

Signature of person completing this form (parent's signature if minor). ____________

I understand that where appropriate, credit bureau reports may be obtained. ____________

I have received a copy of this office's Notice of Privacy Practices. ____________

Updates (date and initial) ____________

ADULT
MEDICAL AND DENTAL HISTORY

Your answers to the following questions are extremely important for an accurate diagnosis.
Thank you for your patience in answering the following questions.

Patient's Name: ________________ Nickname: ________________ Date: ________________

		Yes	No
1.	Have you recently (within the past year) received treatment from a medical professional? (Chiropractor, Family Physician, Internist, Psychiatrist, Osteopath, etc.) For What? ________	☐	☐
2.	Are you taking any medication? (name of medicine) ________	☐	☐
	List allergies to any medication ________		
3.	Have you ever had rheumatic fever? ________	☐	☐
	heart disease? ________	☐	☐
	diabetes? ________	☐	☐
	asthma? ________	☐	☐
	hay fever? ________	☐	☐
	Other allergies (e.g. latex)? ________	☐	☐
	convulsions? ________	☐	☐
	positive HIV test (AIDS)? ________	☐	☐
	tonsilitis? ________	☐	☐
	hepatitis? ________	☐	☐
	prolonged bleeding? ________	☐	☐
	any other medical problems? ________	☐	☐
	photosensitivity or glaucoma? ________	☐	☐
	does patient wear contact lenses? ________	☐	☐
	Sleep apnea? ________	☐	☐
	Treatment for Osteoporosis? ________	☐	☐
4.	Have you been ill for more than 5 days in the last year? ________ Name illness: ________	☐	☐
5.	Have you ever had any extensive X-ray therapy **for tumors or cancer?** ________	☐	☐
6.	Have you been to a dentist in the last 12 months? ________ Cooperation with dentist has been: Excellent _____ Good _____ Fair _____ Poor _____ Approximate month and year of last check up with dentist ________	☐	☐
7.	Have you ever had operations on, or injuries to the head or neck? ________ If so, when? ________	☐	☐
8.	Have you ever received a severe blow on the teeth or jaws? ________ If so, approximately at what age? ________	☐	☐
9.	Do you constantly have sore or bleeding gums? ________	☐	☐
10.	Have any of your teeth been removed? ________	☐	☐
11.	Do you brush your teeth in the morning? ________	☐	
	after lunch? ________	☐	
	after dinner? ________	☐	
	before retiring? ________	☐	
	How often do you floss your teeth? ________		
12.	Do you or did you ever suck fingers, thumb, lips or tongue? ________ (Circle "Do you" or "did you" if answer is yes)	☐	☐
13.	Do you bite your lips, tongue, fingernails, pencil or other objects? ________	☐	☐
14.	Are you aware of gritting, grinding, or clenching your teeth at night? During the day? ________	☐	☐
	Do you have frequent (4-5 times per week) headaches or neckaches? ________	☐	☐
	Do you wake up in the morning with sore jaw muscles? ________	☐	☐

(Please continue on the other side)

	Yes	No
15. Do you consider yourself a "nervous person"? ______	☐	☐
16. Have your tonsils and/or adenoids been removed? ______	☐	☐
17. Do you breathe through your mouth most of the time? ______	☐	☐
18. Do you play a wind musical instrument? ______ What kind? ______	☐	☐
19. Are you dissatisfied with the appearance of your teeth? ______	☐	☐
20. Are you concerned about other aspects of your facial features (nose, chin, jawline, etc.)? ______ If so, what in particular? ______	☐	☐
Have you ever been teased about the appearance of your teeth or face? ______	☐	☐
21. Do you have any difficulty in chewing or swallowing food? ______ Please describe ______	☐	☐
22. a. Do you have any clicking or snapping of the joint of the lower jaw when opening or closing the mouth? ______	☐	☐
b. Have you ever received treatment for a jaw joint disorder? If so, when? ______	☐	☐
23. Is your attitude toward wearing orthodontic appliances one of eagerness? ______	☐	
willingness? ______	☐	
complacency? ______	☐	
resignation? ______	☐	
antagonism? ______	☐	
24. Does any member of the family or close relatives have similar arrangement of teeth or similar appearance of jaws? ______	☐	☐
25. Has any member of the family had orthodontic treatment? ______ Others in family? ______ Names and Ages: ______	☐	☐
26. Who first noticed the need for orthodontic treatment?		
Dentist? ______	☐	☐
Patient? ______	☐	☐
Other? ______	☐	☐
27. Are you interested in having orthodontic treatment for appearance? ______	☐	☐
better digestion? ______	☐	☐
better speech? ______	☐	☐
on advice of dentist? ______	☐	☐
on advice of friends? ______	☐	☐
28. Are you aware that orthodontic appointments will probably infringe on your work schedule? ______	☐	☐
29. Have you ever had "braces" before? Approximate time period: ______ to ______	☐	☐
30. Do you smoke? ______	☐	☐

Hobbies: ______

Other interests ______

This form completed by ______ Date ______

THANK YOU.

___/___/___ UPDATED ______ INITIALS ___/___/___ UPDATED ______ INITIALS

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Patient: ______________________

Date: ______________________

TEMPOROMANDIBULAR AND FACIAL PAIN QUESTIONNAIRE

Please circle Y or N on every item in the applicable categories below - feel free to ask for assistance if you do not understand a question.

YES NO Questionnaire #1

Y N Does your jaw make noise so that it bothers you or others?

Y N Does your jaw get stuck so that you can't open freely?

Y N Does it hurt when you chew or open wide to take a big bite?

Y N Do you have earaches or pain in front of the ears?

Y N Do you have pain in the face, cheeks, jaws, throat or temples?

Y N Do you have difficulty opening your mouth as far as you want to?

Y N Do you suffer from frequent headaches?

Y N Does your jaw "feel tired" after a big meal or dental visit?

Y N Are you aware of an uncomfortable or bad bite?

YES NO Questionnaire #2

Y N Are you aware that you grind your teeth at night?

Y N Do you have a habit of clamping or "setting" your teeth?

Y N Do you have any jaw symptoms or headache upon waking in the morning?

Y N Must you chew exclusively on one side?

Y N Have you had a blow to the jaw? (trauma)

Y N Are you a habitual gum-chewer, pipesmoker, or nailbiter?

YES NO Questionnaire #3

(If you are not experiencing any pain, please skip ***this*** *section)*

Y N Does the jaw pain or jaw discomfort disturb your sleep?

Y N Does the jaw pain or jaw discomfort interfere with your daily routine or other activities?

Y N Do you take medications or pills for the jaw pain or jaw discomfort? (Pain relievers, muscle relaxants, anti-depression pills)

Y N Does the jaw pain or jaw discomfort affect your appetite?

Y N Do you find the jaw pain or jaw discomfort extremely frustrating or depressing?

Briefly describe what the pain keeps you from doing: ______________________

____

____

YES NO Questionnaire #4

Y N Do you suffer from arthritis or pain in other joints?

Y N Do you suffer from nervous stomach or ulcers?

Y N Do you suffer from constipation? Colitis?

Y N Do you suffer from back or neck pain? (whiplash)?

Y N Do you suffer from skin problems or allergies?

Y N Have you ever been treated for a jaw muscle or jaw joint disorder?

Y N Are you "double jointed" in any of your joints?

I have reviewed the information above. It is correct and accurate.

Patient's Signature: ______________________ Date: __________
(Parents, please sign for children under 18 years old)

Updates (date and initial)______________________

AAO Member American Association of Orthodontists

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12920 Highway 6
Santa Fe, Texas, 77510

ADULT S.T.O.P. B.A.N.G.* Questionnaire

Date:___________

Patient Name____

DOB________________ Age__________

Height_________ Weight__________ BMI__________

Neck Circumference_______inches

1. Snoring
   Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
   Yes____ No____
2. Tired
   Do you often feel tired, fatigued, or sleepy during daytime?
   Yes____ No____
3. Observed
   Has anyone observed you stop breathing during your sleep?
   Yes____ No____
4. Blood pressure
   Do you have or are you being treated for high blood pressure? Yes____ No____
5. BMI
   BMI more than 35? (If you don't know your BMI, you can find an easy-to-use calculator on Google)
   Yes____ No____
6. Age
   Age over 50 yr old?
   Yes____ No____
7. Neck Circumference
   Neck Circumference ≥ 17 inches for male, ≥ 16 inches for female
   Yes____ No____
8. Gender
   Gender male?

*S.T.O.P. - B.A.N.G. is an acronym, which **stands for** Snoring, Tiredness, Observed apnea, Blood Pressure, Body mass index, Age, Neck circumference and Gender.

October, 2021