Ronald L. Gallerano, D.D.S., M.S.D., P.A.
DIPLOMATE OF
THE AMERICAN BOARD OF ORTHODONTICS

P.O. Box 1145
12920 Hwy. 6
Santa Fe, Texas 77510
(409) 925-6505

INTRODUCTORY INFORMATION

Welcome to our office! We are honored that you have chosen us to care for your child. It is our desire to address your concerns about your child's bite problem (or "malocclusion") during your first visit, which we call the ***examination.***

The determination of *"when to treat"* is dependent on the nature and extent of the malocclusion. Sometimes a malocclusion is better treated in two phases, because of the stage of dental eruption and age of the patient. Certain malocclusions lend themselves best to begin treatment during the mixed dentition *stage [when some primary or baby teeth are still present]*. Others should start later, after the remaining permanent teeth are either close to erupting or completely erupted.

The detailed information that you have provided in the Health 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. When the examination is concluded, Dr. Gallerano will 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?

DEPENDING ON THE ANSWERS TO THE ABOVE QUESTIONS, DR. GALLERANO WILL ADVISE ONE OF TWO ALTERNATIVES:

(1) WAIT! Treatment now will not have sufficient benefit to warrant the expense and time involved for correction unless there is a "social issue" i.e. the child being teased. You will be recalled in 6-12 months for another visit.

Or

(1) MAKE AN APPOINTMENT TO COMPILE DIAGNOSTIC RECORDS - Each child's malocclusion presents a unique orthodontic problem, and therefore, demands an individualized diagnosis and a treatment plan specific to his/her problems. A complete diagnosis and treatment plan necessitates records, i.e., head X-rays, panoramic X-rays, computer-generated photographs of the face and teeth, and plaster models of the teeth. Approximately 1 hour in our office is required to obtain all records, except special X-rays such as Cat Scan, if needed. **The fee for the records, diagnosis, and treatment discussion ($295.00-$450.00) is due the day that the diagnostic records are accumulated.** This amount will be applied to the total treatment fee for full treatment.

(2) MAKE AN APPOINTMENT FOR A TREATMENT DISCUSSION - If treatment is advised, the diagnostic records are carefully analyzed by Dr. Gallerano. He will present his recommendations to both parents, if possible, at the treatment discussion - approximately 2-3 weeks after accumulating records.

Arrangements for the payment of fees vary, however there is no interest or handling charges on our accounts.

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!!

Member American Association of Orthodontists

More Information At:
SForthoTX.com

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

CONTINUED ON REVERSE

If you have any specific questions about your child's malocclusion, you may use this space below to list them while Dr. Gallerano examines your child. You may also use this area for your notes at the chairside explanation.

RONALD L. GALLERANO, D.D.S., M.S.D., P.A.
DIPLOMATE OF THE AMERICAN BOARD OF ORTHODONTICS

Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

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

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) _____

RG-100
REV. 10/05

PEDIATRIC
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. Is patient presently under a physician's care? _____ For what? _____	☐	☐
2. Is the patient currently taking any medication? (name of medicine) _____	☐	☐
3. Has the patient ever had rheumatic fever? _____	☐	☐
heart disease? _____	☐	☐
diabetes? _____	☐	☐
asthma? _____	☐	☐
hay fever? _____	☐	☐
allergies? _____	☐	☐
convulsions? _____	☐	☐
positive HIV test (AIDS)? _____	☐	☐
any other problems? _____	☐	☐
sore throats? _____	☐	☐
tonsilitis? _____	☐	☐
hepatitis? _____	☐	☐
prolonged bleeding? _____	☐	☐
photosensitivity or glaucoma? _____	☐	☐
does patient wear contact lenses? _____	☐	☐
allergies to medicines (list) _____	☐	☐
4. Has the patient been ill for more than 5 days in the last year? _____ Name illness: _____	☐	☐
5. Has the patient ever had any extensive X-ray therapy **for tumors or cancer?** _____	☐	☐
6. Has the patient 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? _____ Cleaning? _____	☐	☐
7. Has the patient ever had operations or injuries of the head or neck? _____ If so, when? _____	☐	☐
8. Has the patient ever received a severe blow on the teeth or jaws? _____ If so, approximately at what age? _____	☐	☐
9. Does the patient constantly have sore or bleeding gums? _____	☐	☐
10. Have any of the patient's teeth been removed? _____	☐	☐
11. Does the patient brush his/her teeth in the morning? _____	☐	
after lunch? _____	☐	
after dinner? _____	☐	
before retiring? _____	☐	
12. Does/did (Circle one) the patient ever suck fingers, thumb, lips or tongue? _____	☐	☐
13. Does/did (Circle one) the patient bite his/her lips, tongue, fingernails, pencil or other objects?	☐	☐
14. Does the patient grit, grind, or clench his/her teeth at night? _____	☐	☐
15. Have the tonsils and/or adenoids been removed? If so, when? _____	☐	☐
16. Does the child routinely snore? _____	☐	☐
17. Is the child a restless sleeper? _____	☐	☐
18. Does the patient breathe through his/her mouth most of the time _____	☐	☐

	Yes	No
19. Does the patient play a wind musical instrument (trumpet or other "horn" type, clarinet, etc.)? ___ What kind? _____	☐	☐
20. Is the patient dissatisfied with the appearance of the teeth? _____	☐	☐
21. Has the patient ever been teased about the appearance of his/her teeth? _____	☐	☐
22. Is there any difficulty in chewing or swallowing food? _____ Please describe _____	☐	☐
23. Is there any clicking/snapping of the lower jaw when opening/closing the mouth? _____	☐	☐
24. Is the patient aware of or concerned about his/her orthodontic problem? _____	☐	☐
25. Is the patient's attitude toward wearing orthodontic appliances one of eagerness? _____	☐	
willingness? _____	☐	
complacency? _____	☐	
resignation? _____	☐	
antagonism? _____	☐	
26. Does any member of the family or close relatives have a similar arrangement of teeth or similar appearance of jaws? _____	☐	☐
27. Has any member of the family had orthodontic treatment? _____ Others in family? _____ Names and Ages: _____	☐	☐
28. Who first noticed the need for orthodontic treatment?		
Parents? _____	☐	
Dentist? _____	☐	
Patient? _____	☐	
Other? _____	☐	
29. Are the parents interested in having orthodontic treatment for appearance? _____	☐	☐
better digestion? _____	☐	☐
better speech? _____	☐	☐
on advice of dentist? _____	☐	☐
on advice of friends? _____	☐	☐
30. Are the parents aware that some orthodontic appointments will infringe on school time? _____	☐	☐
31. Has the patient experienced a sudden increase in height? _____	☐	☐
32. If the patient is male, has his voice changed? _____	☐	☐
has he started to shave? _____	☐	☐
33. If the patient is female, has she started period? If so, date of the first cycle. ____/____ (mo / yr)	☐	☐

	Height	Brothers' Names/Ages	Height	Sisters' Names/Ages	Height
Patient's					
Father's					
Mother's					

Sports _____

Hobbies _____

This form was completed by _____ Date _____

THANK YOU.

____/____/____ UPDATED _____ INITIALS ____/____/____ UPDATED _____ INITIALS

RONALD L. GALLERANO, D.D.S., M.S.D., P.C.
DIPLOMATE,
AMERICAN BOARD OF ORTHODONTICS

Member American Association of Orthodontists

RONALD L. GALLERANO, D.D.S., M.S.D., P.A.
DIPLOMATE OF
THE AMERICAN BOARD OF ORTHODONTICS

P.O. Box 1145
12920 Hwy. 6
Santa Fe, Texas 77510
(409) 925-6505

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 <u>any</u> 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)_____

Ronald L. Gallerano, DDS, MSD
12920 Highway 6
Santa Fe, Texas, 77510

Pediatric Sleep Questionnaire

Patient Name: _____ Date of Birth: _____

Person filling out this form_____ Initials_____

	Yes	No	Don't Know
While sleeping does your child/			
Snore more than half the time?			
Always snore?			
Snore loudly?			
Have "heavy" or loud breathing?			
Have trouble breathing or struggle to breathe?			
Have you ever/			
Seen your child stop breathing during the night?			
Does your child/.			
Tend to breathe through the mouth during the day?			
Have a dry mouth on waking up in the morning?			
Occasionally wet the bed?			
Wake up feeling un-refreshed in the morning?			
Have a problem with sleepiness during the day?			
Has a teacher or other supervisor commented that your child appears sleepy during the day?			
Is it hard to wake your child up in the morning?			
Does your child wake up with headaches in the morning?			
Did your child stop growing at a normal rate at any time since birth?			
Is your child overweight?			
This child often/			
Does not seem to listen when spoken to directly			
Has difficulty organizing tasks			
Is easily distracted by extraneous stimuli			
Fidgets with hands or feet or squirms in seat			
Is "on the go" or often acts as if "driven by a motor"			
Interrupts or intrudes on others (e.g. butts into conversations or games)			

Total # of "Yes" Responses ____ Total # "No" Responses____

DIVIDE # YES BY # NO **(DO NOT COUNT "DON'T KNOW")** **> 0.33 REFER FOR ENT EVALUATION**

8 or more answered "Yes", REFER for sleep evaluation.

CHERVINE ET AL, PEDIATRIC SLEEP QUESTIONNAIRE: VALIDITY AND RELIABILITY OF SCALES FOR SLEEP DISORDERED BREATHING, SNORING, SLEEPINESS, AND BEHAVIORAL PROBLEMS, SLEEP MEDICINE 2000;1:21-32

R. L. GALLERANO, DDS, MSD, PA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies, We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You *may* obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, a charge will be made. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information, (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances,

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Dr. Ronald Gallerano

P.O. BOx 1145/12920 Hwy 6

Santa Fe, TX 77510

409-925-6505