My Crooked Smile

Craniofacial Habilitation
Updated March 24, 2020

Left lateral incisor replacement with a five-unit fixed bridge

- Long term outcome: Failure of the fixed bridge short of 20 year projected life
- Long term outcome: Facial asymmetry

Self-report by author:
Neil J. Gillespie
8092 SW 115th Loop
Ocala, Florida 34481
Tel. 352-854-7807
Email: neilgillespie@mfi.net

My Crooked Smile

Self-report by Neil J. Gillespie, author

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Waiver of confidentiality

In furtherance of craniofacial science, I hereby waive confidentiality under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/

Left lateral incisor replacement with a five-unit fixed bridge

- Five-unit fixed bridge expense $11,775, including partial removal[1]
- In service 17 years, 6 months, 12 days (20-year projected life)

My left lateral incisor (tooth #10) was missing, along with the supporting bone and gingiva, due to a cleft palate. This empty space remained until age 18, when I got a retainer with a prosthetic left lateral incisor attached. The retainer was secured by a wire. Eating meals was difficult while wearing this plastic retainer. Denture adhesive cream may have better secured the retainer, had I been advised. By age 31 I wanted a better restoration for the missing left lateral incisor. (#10).

My craniofacial team in Philadelphia recommended a five-unit fixed bridge. I questioned sacrificing four good teeth (#8 thru #12) in order to replace one missing tooth. An alveolar bone graft filled the empty space at tooth #10. I asked about having a single dental implant instead. The team prothodontist said an implant would cost more than a five-unit bridge. I explained cost was not an issue; I was prosperous and owned a business. Earlier in my life, cost would have been a consideration, but not in 1987. The issue was foreclosed without adequate discussion.

My records show the five-unit fixed bridge was completed August 17, 1987. The multi-visit procedure included grinding down four good teeth, which I vividly remember because of the intense pain I experienced. On April 4, 2002 tooth #12 had an apicoectomy under the bridge. The five-unit fixed bridge failed February 17, 2005. A dentist removed a three tooth section (#10-#11-#12) of the bridge while removing #11 and #12 that failed. A flipper with prosthetic teeth for #10, #11 and #12 was provided. Tooth #9 failed June 1, 2006, and was removed with another part of the bridge. A diagram follows this page. A consult May 30, 2006 suggested the use of cadaver bone now instead of the alveolar bone graft procedure done in 1986.

Opinion: A quality metal partial, with a prosthetic left lateral incisor, with or without a speech bulb, would be preferable to a five-unit fixed bridge. (in lieu of implants). My experience with the five-unit fixed bridge shows it was not a good long-term decision. It failed after 17+ years. I might have three more teeth today if I had done nothing. (teeth #9, #11 and #12 are gone; #8 is loose). Restoration now is not likely due to unaffordable expenses, my lower tolerance of pain, and the futility of these procedures now that I am age (62) and resolved to my mortality.

amount	date	provider
$3,800	March 10, 1986	Rosario F. Mayro, D.M.D., orthodontic services
$ 125	December 23, 1987	Rosario F. Mayro, D.M.D.
$3,765	For the year 1986	Mark B. Snyder, D.M.D., periodontal surgery
$2,858	August 5, 1987	Dennis Sanfacon, D.M.D., prosthodontist, five-unit bridge
$10,548		
$ 135	April 4, 2002	David M Pedley, DMD, St. Pete, apicoectomy on #12
$ 570	February 17, 2005	Robert S. Pastorius D.D.S. St. Pete, extracted #11 and #12, cut five-unit bridge, provided a flipper for #10-#11-#12
$ 75	May 30, 2006	Michael Gluhareff, DDS, Ocala, consultation
$ 447	June 1, 2006	Thomas Harter, D.M.D. Ocala, extracted #9, added prosthetic #9 to existing flipper.
$11,775		

[1] Dental-related procedures only; alveolar bone graft and related surgeries are shown separately elsewhere.

Five-unit bridge:
Installed August 5, 1987,
Failed February 17, 2005.
In service 17 years,
6 months, 12 days.
(20-year projected life)

Prepared January 12, 2015

Diagram of the Tooth Numbering System

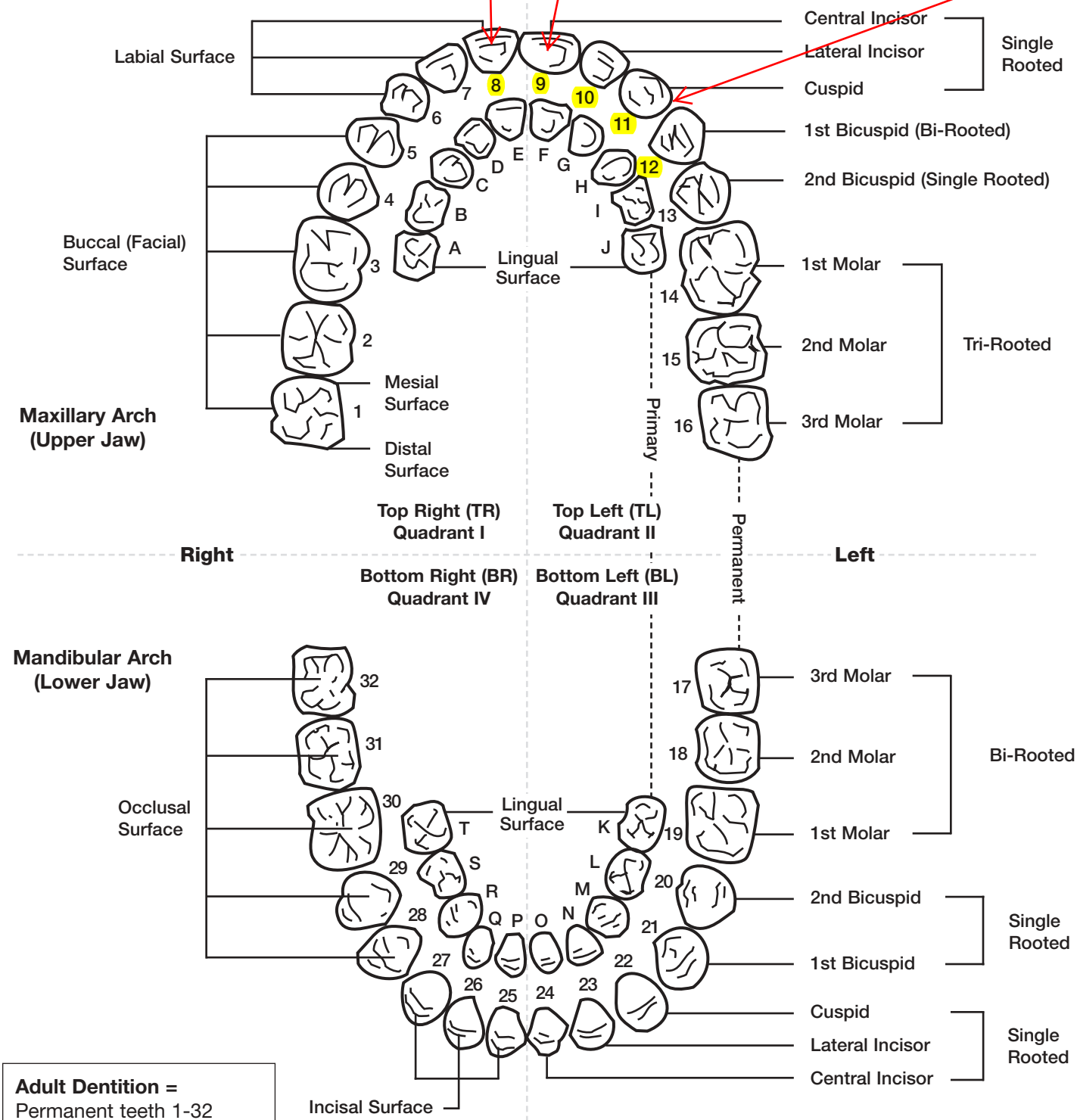
(viewed as if looking into the mouth)

only #8 remains

#9 extracted June 1, 2006

#11 & #12 were extracted February 17, 2005.

Prosthetic #10 was removed with the bridge section



Adult Dentition = Permanent teeth 1-32

Child Dentition = Primary teeth A-T

Wisdom Teeth = 1, 16, 17, and 32

Images of the five-unit bridge, after partial removal
(#8 remains in place)

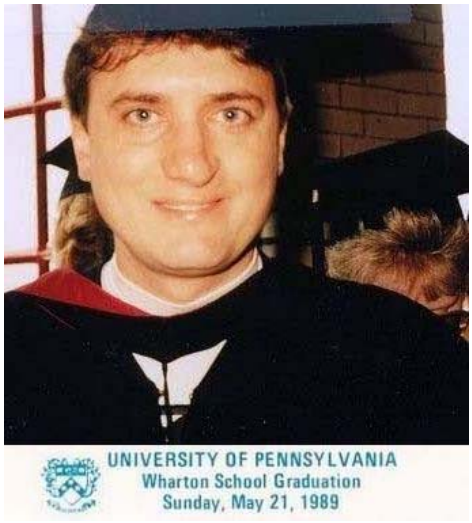
above - #12, #11, #10, #9

above - #12, #11, #10, #9

Long term outcome: Facial asymmetry

One long-term outcome of cleft reconstructive surgery, *inter alia*, is the failure of underlying structures over time. Compare/contrast the post-operative images from 1989 and 1992 with the facial asymmetry shown in the 2013 image. The left side of my mouth/face is moving downward. This is not the result of smoking, or facial paralysis. I am a lifetime nonsmoker.

Images below of Neil J. Gillespie



Graduation, Sunday May 21, 1989
After the Aug-1986 alveolar bone graft, cleft lip repair, septoplasty. After the Dec-1986 reconstructive rhinoplasty, and cleft lip revision.

Passport photo March 25, 1992
After the Dec-1990 cleft rhinoplasty with submucous resection, pharyngeal flap, and cleft lip correction.

Passport photo 2013
Mouth/face not symmetric; failure of underlying structures, bone loss, tooth loss.

- Complete unilateral cleft lip (L), cleft palate
- Initial surgeries, 1956 and 1958 (Philadelphia, PA)
- Secondary surgeries, 1986 (Philadelphia, PA) and 1990 (Miami, FL)

August 12, 1986 alveolar bone graft, cleft lip repair, septoplasty.
December 15, 1986 reconstructive rhinoplasty, cleft lip revision.
December 14, 1990 cleft rhinoplasty with submucous resection, pharyngeal flap[1], cleft lip correction.
Also as shown in this self-report: Orthodontics, endodontics, prothodontics, periodontics, and dentistry.

Conclusion: A high quality metal partial, with a prosthetic left lateral incisor, with or without a speech bulb, would be preferable to a five-unit bridge, in my opinion, given my experience with the latter.

[1] The flap was to correct velopharyngeal insufficiency (VIP), a speech disorder, but failed a month later. Subsequently I got a speech bulb obturator to correct VPI; it worked for a number of years, but ultimately failed, *inter alia*, due to lack of maintenance, and the unavailability of a specially trained prothodontist.

National Foundation for Facial Reconstruction

317 EAST 34TH STREET
NEW YORK, NY 10016

212-263-6656 1-800-422-FACE
FAX-212-263-7534

April 15, 1994

Mr. Neil J. Gillespie
266 7th Ave NE, Apt 5
St. Petersburg, FL 33701

Dear Mr. Gillespie,

I am pleased to send you a copy of the proceedings of the National Foundation for Facial Reconstruction's Conference, "SPECIAL FACES: Understanding Facial Disfigurement" which you attended.

Thanks to an outstanding panel of conference participants, this book will serve as an invaluable aid to patients, families and professionals and help to further the NFFR's goal to provide greater awareness and understanding about the problem of facial disfigurement.

The conference book will be distributed to medical libraries, parent and patient support groups, plastic surgery units and rehabilitation agencies throughout the country. It is our hope that the nearly 500,000 Americans who are disfigured each year by congenital birth defects, fires, accidents and tumors will be the ultimate beneficiaries and will be given the opportunity they deserve to become happy and productive individuals.

Sincerely,

Peter Hoguet

J. Peter Hoguet

JPH/jg
Enclosure

MARGY MAROUTSIS: I work for the orthodontist at the Institute at NYU and my question for Dr. Blumenfeld is why aren't pre-and post-surgical orthodontic procedures covered when they are such an integral part of the facial reconstruction procedure?

DR. BLUMENFELD: Any pre- or post-operative services requiring an orthodontist are covered only when a rider to the policy so states. The fee for the surgery performed by a plastic surgeon or an oral surgeon covers all of the procedures that are necessary to properly perform the surgery. If the oral or plastic surgeon wants to have an orthodontist involved in the care, that is their choice. However, if an orthodontist is requested or required, the orthodontist's services may only be reimbursed if there is a rider on the policy specifically for this type of care.

MS. MAROUTSIS: I'm not referring to the work done during the procedure; I'm referring to the work done before and after this procedure, which is essential for the successful outcome of this operation.

DR. BLUMENFELD: Again, reimbursement for the orthodontics, pre- or post-operatively, is based on whether or not a patient's contract has a rider for this service.

NEIL GILLESPIE: My question is also to Dr. Blumenfeld. It touches on the previous question. I was covered by Blue Cross/Blue Shield and they paid for a bone transplant in 1986. However, I also required orthodontics, periodontics and prosthodontics. None of that was paid by Blue Cross. These three procedures, which were over $10,000 were absolutely part of the bone transplant. When I was an adolescent I had separate orthodontics and that was something different. This is orthodontics specifically to arrange the upper jaw to accept the bone graft. Is that covered?

DR. BLUMENFELD: Your policy must be examined before your question can be answered. I would be happy to speak to you afterwards about who can best answer it for you.

AMERICAN ONCOLOGIC HOSPITAL

PROGRESS REPORT

Note progress of case, complications, changes in diagnosis condition on discharge, instructions to patient

CHART COPY

GILLESPIE, Neil #74123

7/22/85

The patient is a 29 year old white male referred by Dr. Carver who is status post left unilateral Class IV lip and palate repair at approximately age two years old. He is unclear about the details of the degree of his defects, the surgical procedures, who performed this, or exactly where it was done. Apparently, after the initial bout of surgeries to repair the lip and hard and soft palate, he had no further surgical intervention. He had no ongoing follow-up for this problem. At approximately age 13 to 14 years old, he underwent orthodontic treatment at Temple University Hospital's Dental School and this ultimately resulted in the placement of a retainer with a prosthetic left lateral incisor. He has worn this since that time. He notices drainage of food into the left nasal floor. His left and right nostrils are opened, although the left is somewhat stuffy and occluded.

His main concerns upon presentation are related to the persistent cleft in the left alveolus, the draining fistula, and the possibility of foregoing the need for a prosthetic device. In addition, however, it is obvious on confronting the patient that he has a moderate amount of nasal deformity, flattening of the left side in the premaxillary region, and lip distortion, particularly at the vermilion. In addition, the patient has a significantly hypernasal speech pattern with obvious velopharyngeal incompetence.

On physical examination beginning externally, the patient has a slightly large nose with a small dorsal hump. The size of the nose is slightly larger than proportional to his face, although not exaggeratedly so. The right alar dome is full. The left alar cartilage is posteriorly and laterally displaced and somewhat hypoplastic compared to the left side. The left alar base is also laterally displaced. The nostril sill is flattened, and there is an obvious fistula between the distal nasal floor and the oral cavity. The left columella, likewise, is somewhat hypoplastic and twisted. The upper lip scar is well healed and appears to be a LeMesurier or Tennison-Randall type repair. The upper lip tubercle is preserved, but the vermilion border is somewhat irregular. Length appears, however, to be satisfactory. There is a lateral orbicularis bulge of the left upper lip. Internally, there is a wide cleft of the left alveolar ridge at the level of the lateral incisor with a fistula into the nasal floor. This runs posteriorly and nearly to the end of the secondary palate. The soft palate has a linear scar. it is very short, and there is lateral movement but no central movement of note.

continued....

My impression and recommendation to the patient generated three specific areas of interest. One relates to the scar revision of his upper nose and the relationships of his nasal tip, nose, and secondary deformities in this area. The second area of interest in importance is the alveolar cleft with the naso-oral fistula. The third area is the palate with obvious velopharyngeal incompetence and a foreshort and scarred palate.

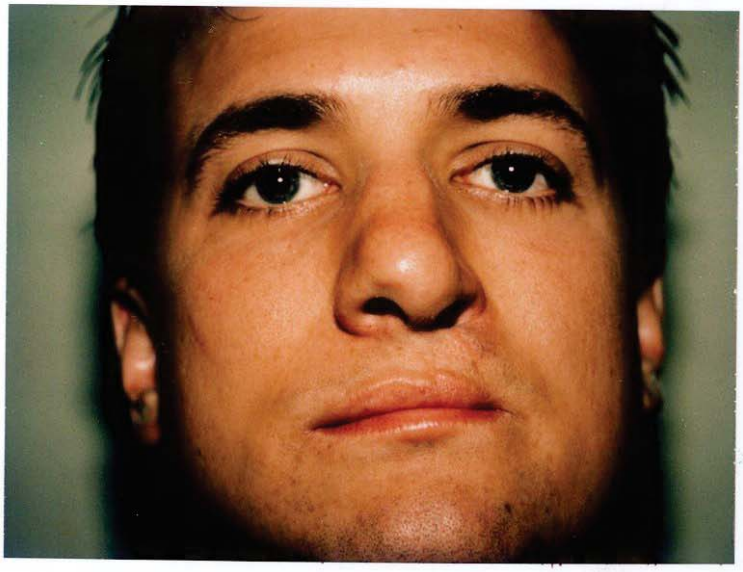
My initial recommendations will be that the patient undergo orthodontic evaluation. I will arrange for him to see Dr. Rosario Mayro for evaluation as well as x-rays to assess his occlusal relationships. It also should be noted that he, in general, had a fairly satisfactory occlusal relationship with some lateral collapse and crossbite on the minor segment on the left and evaluate his adequacy as a candidate for bone grafting, which I think he would qualify. Subsequent to this, I will have him see Dr. Harvey Rosen concerning the actual surgical procedure and also he will be seen by Miss Marilyn Cohen, a speech pathologist with special interest in patients having cleft lip and palate for an evaluation concerning feasibility of posteropharyngeal flap in a patient of this age group. Concerning the external revisions, this can be accomplished concerning the upper lip, possibly at the same time as the fistula closure with orbicularis redirection, a revision of the nostril sill and the lateral alar base, and also possibly tip rhinoplasty or this can be accomplished at a later date with a formal rhinoplasty in concert with other procedures. In addition, the vermilion border should be repaired. This can be done by Z-plasty technique.

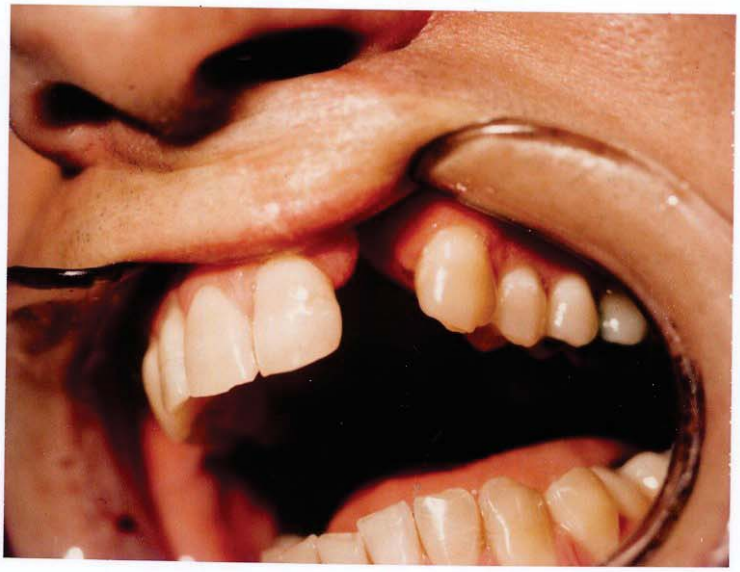
The patient, therefore, will be seen by the consultants and a general plan with timing for surgery, etc., will be made. We will arrange to make these arrangements and follow-up with the patient. No letter.

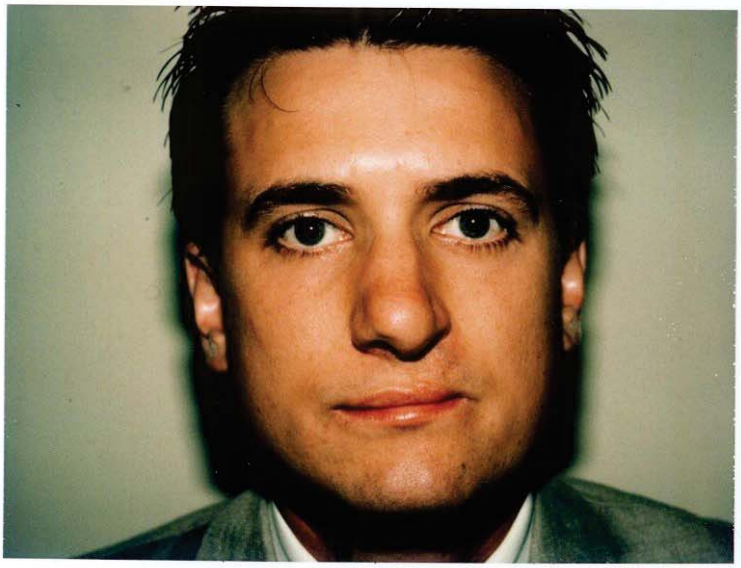
RECD AUG 1985

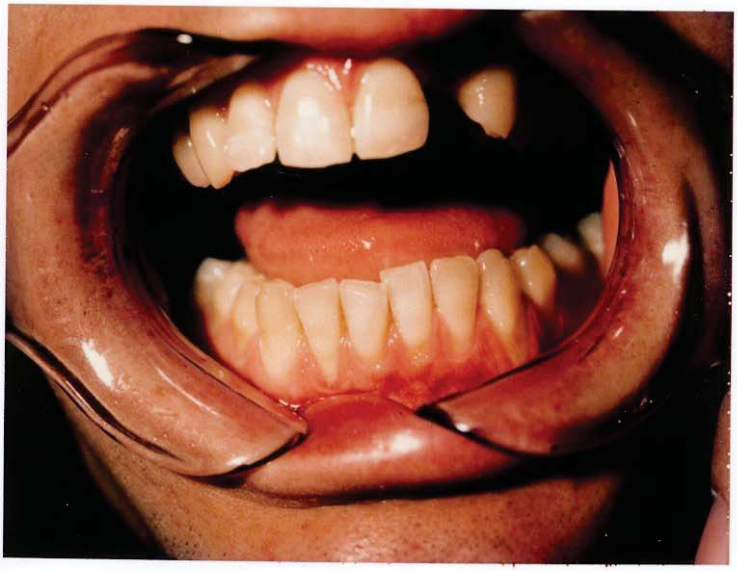
Joseph Kusiak, M.D.
Plastic & Reconstructive Surgery

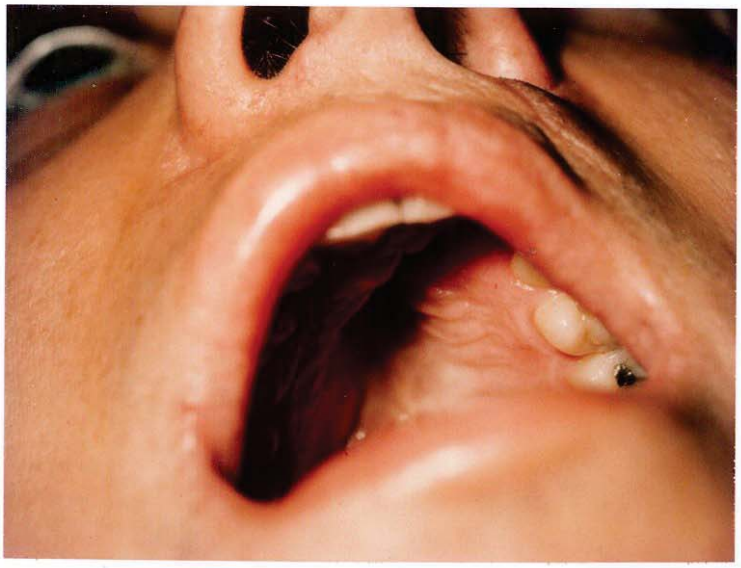
JK:bsm
T--8/1/85
D--7/23/85











GILLESPIE, Neil #74123

POLACOLOR® H8S 4738

ROSARIO FELIZARDO MAYRO, D.M.D.
1830 Rittenhouse Square
Philadelphia, Pennsylvania 19103

FEDERAL TRUTH-IN-LENDING DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES TO BE RENDERED

We wish to confirm the verbal arrangements made with you for orthodontic treatment.

PATIENT: Neil Gillespie

RESPONSIBLE PARTY: Same

ESTIMATED TIME OF TREATMENT: 15-18 mos.

ESTIMATED TIME OF RETENTION: To be determined

The undersigned hereby agrees to the financial arrangements and office policies outlined in this memorandum.

TREATMENT FEE:
(Includes initial payment, regular payments~~xxxxxxxxxxxxxxxxxx~~ $3800.00

INITIAL PAYMENT:
(Due on day of separation): $800.00

BALANCE:
Payable in 15 equal payments of $ 200.00 and a retention payment of $ to be determined making the account paid in full. The first payment is due 10 and all subsequent payments are due on the same day of each month. The retention payment and any past due payments are payable in full prior to appliance removal.

FINANCE CHARGE: None for accounts that are maintained on a current status: 18% annually for accounts that are delinquent by 30 days or more.

TIME ESTIMATE AND EXTENDED TREATMENT:
Treatment time and retention time are estimates based on previous experience. We will do everything possible to alert you to poor progress and reverse poor progress to keep treatment time within the estimate. When continued poor cooperation and failed appointments prolong treatment time beyond 15 mos~~xxx~~, an additional treatment fee of $ 200.00 per month will be continued until appliances are removed. Once the remaining retention fee is paid, the account will be paid in full.

PAYMENT SCHEDULE:
The above payment schedule is arranged for your convenience in making payments and has no relation to the number of office visits per month. In the event of vacations or ordinary illness of the patient, payments are not discontinued. Monthly payments begin 30 days following appliance placement and quarterly payments begin 90 days following appliance placement.

PAYMENT BOOKLET:
Since our office does not send monthly statements, the enclosed booklet is provided for your convenience in making and recording payments. It has been noted that the 10 day of each month is best suited for making these payments. A booklet slip should accompany each payment. To verify your payment records, a copy of your office ledger will be supplied at any time on request.

EXCLUSIONS:
Charges for dental services not routinely performed in our office such as filings, extractions, x-rays taken by your family dentist, etc., are not included in this fee.

EXTRA CHARGES:

Treatment Redesign:
When orthodontic treatment is initially begun on a non-extraction basis, there can arise physiologic factors as well as cooperation factors which do not permit adequate resolution of the orthodontic problem. Should extraction be required, the changes in appliance design and treatment procedures will necessitate an additional charge of $ not applicable for the ensuing extra care.

Broken or Lost Appliances:
Normal wear and tear on appliances is expected. Unwarranted breakage or loss of appliances will require an additional charge. There is a charge of $50 for replacement of a retainer, positioner, or lingual arch lost or damaged beyond repair.

MISSED APPOINTMENTS:
We realize that many problems may cause a missed appointment, but, with the exception of cases of extreme emergency, we ask that you call the office 24 hours in advance to cancel routine appointments. Appointments such as banding and debandings are of great importance to you and to others. If it becomes absolutely necessary to cancel such an appointment, call at least one week prior in order that we may reschedule someone who may be anxiously waiting for care. Since the banding and debanding time is so valuable to our patients, a staffing and administrative charge will be added to your account if your scheduled time cannot be reappointed because of inadequate notice.

PROGRESS REPORTS:
Approximately every six months it is advisable to have a check-up with your family dentist. We will at that time tell you whether or not treatment is on schedule. Should there be any treatment delays, we will tell you the reasons. A detailed monitoring of treatment progress is done within one year of the start of care. When the monitoring findings show that the orthodontic treatment objectives are being met, we do not schedule a progress consultation. Should you at any time, though, wish a treatment update from the doctors, do not hesitate to ask.

INSURANCE BENEFITS:
Once you have verified through the Confirmation of Eligibility Form that you are entitled to orthodontic benefits under your health care plan, our office will submit claim forms to your insurance carrier *following* appliance placement or *following* the consultation if no treatment is currently needed. Since professional services are rendered to you and not to your insurance carrier, you are responsible for the above fee arrangement and its payment schedule. Any benefits which you qualify for under your orthodontic health care plan must be paid directly to you by your carrier. However, we will help in any way we can to assure you that you receive the insurance benefits you are entitled to.

(over)

FEDERAL TRUTH-IN-LENDING DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES TO BE RENDERED

TAX DEDUCTIONS:

All orthodontic fees paid within a calendar year can be combined with other medical dental expenses incurred within that year to be used as a tax deductible medical expense. Depending on an individual's tax bracket, the savings in taxes can be substantial by paying the orthodontic treatment fee balance within one year. Our bookkeeper will assist you in this matter should more information be needed.

CREDIT REFERENCES:

Accounts paid according to the above terms may feel free to use our office for future credit references.

TRANSFER OF TREATMENT:

In the event you must transfer your orthodontic treatment to another city, our office will find you a new orthodontist and will forward all diagnostic records and instructions. An account balance for services not yet performed will be transferred. A refund will be arranged for any overpayment. Records will not be transferred if an account is past due.

DISCONTINUE TREATMENT:

Treatment will be temporarily halted for patients whose accounts are 90 days or more past due. No additional charge will be made to the account during this time. Treatment will resume when the past due balance has been paid in full. During this temporary halt in treatment, periodic office visits will be requested to insure appliance stability.

In the event a patient wishes to permanently discontinue treatment, a "Waiver of Treatment" form must be signed. Once this form has been signed and any current account balance has been paid in full, the appliances will be removed.

ACCOUNT COLLECTION:

If it becomes necessary to institute collection proceedings on this account, the undersigned agrees to pay all costs and expenses therefore, including a reasonable attorney fee and all court costs incurred.

It is agreed that a signed copy of this statement and agreement will be returned before active treatment begins.

I/We hereby certify that I/We have read and received a copy of the foregoing Disclosure Statement and Memorandum Agreement this 10 day of March, 19 86.

Person responsible for account

Person responsible for account

Rosario Felizardo Mayro, D.M.D.

	DATE	DESCRIPTION	FEE	PAYMENT RECEIVED	BALANCE	AMOUNT NOW DUE
	12-23-87	Spring retainer	125 -		125 -	125 -

ROSARIO FELIZARDO MAYRO, D.M.D.
PRACTICE LIMITED TO ORTHODONTICS
1830 RITTENHOUSE SQUARE, IA
PHILADELPHIA, PA. 19103

TELEPHONE (215) 735-5211

↑ THIS IS YOUR RECEIPT FOR THIS AMOUNT

↑ STATEMENT PLEASE PAY THIS AMOUNT

Paid
1-1-88
Ck # 859

IV—Initial Visit
C—Consultation
SM—Study Models
TF—Total Fee
PI—Phase I Fee
PII—Phase II Fee
PIII—Phase III Fee
AF—Appliance Fee
MC—Monthly Charge
SP—Surgical Preparation
RET—Retainer
POS—Positioner
RA—Replacement Appliance
NK—Unkept Appointment
ROA—Received on Account
PIF—Paid in Full

TO

Mr. Neil Gillespie
2020 Walnut Street Apt. 30-A
Philadelphia, PA., 19103

3895

1830 Rittenhouse Square, 1-A
Philadelphia, Pennsylvania 19103
(215) 735-5211

ELANC

ROSARIO FELIZARDO MAYRO, D.M.D., D.D.S.
Practice Limited To Orthodontics

Member American Association of Orthodontists

Children's Hospital of Philadelphia
34th and Civic Center Boulevard
Philadelphia, Pennsylvania 19104
(215) 596-9338

STATEMENT

MARK B. SNYDER, D.M.D. , P.C.

220 SOUTH SIXTEENTH STREET, SUITE 900
PHILADELPHIA, PENNSYLVANIA 19102
(215)546-0729

CHARGES OR PAYMENTS MADE AFTER LAST DATE SHOWN WILL APPEAR ON YOUR NEXT STATEMENT

MR. NEIL GILLESPIE
2020 WALNUT STREET APT. #30 A
PHILADELPHIA, PA 19103

DETACH AND RETURN WITH YOUR REMITTANCE

AMOUNT ENCLOSED $_____

DATE	DESCRIPTION	TOTAL FEE	BALANCE FORWARD PAYMENTS	BALANCE FORWARD ADJ.	BALANCE
4/22/86	CONSULTATION	25 00	25 00		-0-
5/8/86	SURGERY (PERIODONTAL)	3500 00	3500 00		-0-
8/4/86	MAINTENANCE (PREVENTIVE)	60 00	60 00		-0-
9/29/86	MAINTENANCE (PREVENTIVE)	60 00	60 00		-0-
11/4/86	MAINTENANCE (PREVENTIVE)	60 00	60 00		-0-
12/12/86	MAINTENANCE (PREVENTIVE)	60 00	60 00		-0-

PLEASE PAY LAST AMOUNT IN BALANCE COLUMN

A-Allergy
BI-Biopsy
C-Consultation
CPX-Complete Physical
DR-Dressings
EKG-Electrocardiogram
EX-Examination
HC-Hospital Care
HV-House Visit
INJ-Injection
LAB-Laboratory
NC-No Charge
OB-Obstetrical
OS-Office Surgery
OV-Office Visit
PR-Proctoscopic
PT-Physiotherapy
ROA-Received on Account
S-Surgery
TR-Treatment
UR-Urinalysis
X-X-Ray

STATEMENT

08/05/87

Anthony W. Rinaldi, D.M.D.
The Carlton House
1829 John F. Kennedy Blvd.
Philadelphia, PA 19103
215-561-0555

For Your Information

Neil Gillespie
Apt. 27K
2020 Walnut Street
Philadelphia PA 19103

ACCOUNT NO. 2117

DA	PATIENT	DESCRIPTION	CHARGES	CREDITS	BALANCE
07/08 87		Previous Balance			0.00
07/17 87	Neil	PROSTH. CONSULT	35.00		35.00
07/1 87	Neil	CROWN	550.00		585.00
07/1 87	Neil	CROWN	550.00		1135.00
07/1 87	Neil	CROWN	550.00		1685.00
07/17 87	Neil	CROWN	550.00		2235.00
07/1 87	Neil	CROWN	550.00		2785.00
07/27 87	Neil	X-RAYS (RADIOGRAPHS)	73.00		2858.00
07/27 87	Neil	Check Payment		-73.00	2785.00
07/27 87	Neil	Check Payment		-33.62	2751.38
07/27 87	Neil	ABOVE PAYMENT FROM AMERICAN EXPRESS			
07/27 87	Neil	Credit Adjustment		-1.38	2750.00
07/27 87	Neil	ABOVE CR ADJ IS AMERICAN EXPRESS CHARGE			
07/27 87	Neil	FOR PROCESSING			

Account Total 2750.00

ected Ins Balance = 0.00

Pa nts made after the billing date shown above
wi appear on your next statement.

rrent	30 Days	60 Days	90 Days	120+ Days
[2 .00]	[0.00]	[0.00]	[0.00]	[0.00]

STATEMENT

08/10/87

Anthony W. Rinaldi, D.M.D.
The Carlton House
1829 John F. Kennedy Blvd.
Philadelphia, PA 19103

215-561-0555

Neil Gillespie
Apt. 27K
2020 Walnut Street
Philadelphia PA 19103

ACCOUNT NO. 2117

DAT	PATIENT	DESCRIPTION	CHARGES	CREDITS	BALANCE
08/05/87		Previous Balance			2750.00
08/10/87	Neil	ONGOING PROSTHODONIC TR.	0.00		2750.00
08/10/87	Neil	Check Payment		-916.00	1834.00

Account Total 1834.00

ected Ins Balance = 0.00

Current	30 Days	60 Days	90 Days	120+ Days
[1 .00]	[0.00]	[0.00]	[0.00]	[0.00]

Dennis G. Sanfacon, D.M.D.
Prosthodontist

CROWN AND BRIDGE • RESTORATIVE • COSMETIC
REMOVABLE AND MAXILLOFACIAL DENTISTRY

THE CARLTON HOUSE, 1829 JOHN F. KENNEDY BOULEVARD
PHILADELPHIA, PENNSYLVANIA 19103
PHONE: 215/561-0199

Alex M. Gluhareff D.D.S., M.A.G.D, P.A.
3040 SW. 27th Ave. Suite 101
Ocala, FL 34474

STATEMENT DATE	AMOUNT DUE
05-30-06	

DUE DATE	REMITTANCE

Neil Gillespie
8092 SW 115th Loop
Ocala, FL 34481

MAKE CHECKS PAYABLE TO:
Alex M. Gluhareff D.D.S., M.A.G.D, P.A.
Phone Number: 352-237-7241

CURRENT	30 DAYS	60 DAYS	90+ DAYS	TOTAL BAL	INS ESTIMATE	DEFERRED	DUE NOW
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

DATE	PATIENT	DESCRIPTION	CHARGES	PAYMENTS	BALANCE	YOUR PORTION
05-30-06		PREVIOUS BALANCE			0.00	0.00
05-30-06	Neil	AMG** Periapical single, first (#9)	20.00		20.00	20.00
05-30-06	Neil	AMG** Limited oral evaluation	55.00		75.00	75.00
05-30-06	Account	FAC** VISA card payment		75.00	0.00	0.00

NOTES

We always welcome your referrals!

PROVIDERS **

AMG Michael Gluhareff
FAC DDS,PA Alex M Gluhareff

STATEMENT OF SERVICES RENDERED

DR. HARTER &
ASSOC
8602 SW. ST. RD. 200
SUITE P
OCALA, FL 34481
(352)873-1335

CHART NO.	PAGE NO.
GI0070	1

BILLING DATE
06/01/2006

GUARANTOR NAME AND MAILING ADDRESS

NEIL GILLESPIE
8092 SW 115TH LOOP
OCALA, FL 34481

PATIENT	TOOTH	SURF	DESCRIPTION	CHARGE	CREDIT
NEIL			Occlusal adjustment-limited	88.00	
NEIL	9	D	Unspecif restorative proced B/R	50.00	
NEIL	9		Add tooth to exist part denture	139.00	
NEIL	9		Extract,erupted th/exposed rt	170.00	
NEIL			VISA Card Payment -Thank You		-447.00

PRIOR BALANCE		CURRENT CREDITS		CURRENT CHARGES		NEW BALANCE		DENTAL INS. EST.		PLEASE PAY
0.00	-	447.00	+	447.00	=	0.00	-	0.00	=	0.00

PATIENT	DATE	TIME	REASON

EFFECTIVE APRIL 1, 2005 WE WILL NO LONGER OFFER THE 10% SENIOR DISCOUNT. SORRY FOR ANY INCONVENIENCE THIS MAY CAUSE. THANK YOU FOR YOUR UNDERSTANDING.

Replacing a Missing Tooth

Patients born with cleft lip and/or palate often find that they are missing one or more teeth, most often the lateral incisor (immediately next to the front central incisor). This tooth may be missing on one or both sides; in either case, special planning is needed to solve the functional and cosmetic problems the absence creates.

Who will be involved in dealing with the missing tooth?

Several types of dental specialists will be important in planning treatment. Orthodontists align improperly placed teeth, while prosthodontists can replace missing teeth in a variety of ways. Oral and maxillofacial surgeons perform surgery on the teeth, mouth, and surrounding areas of the head and face. Coordinated planning by all specialists involved is necessary to select the best method of treatment and achieving the best result.

What role does the orthodontist play in replacing a missing tooth?

The large majority of patients with clefts will require full orthodontic treatment, especially if the cleft has passed through the tooth-bearing ridge. The goals of treatment will be to line up the teeth in the arch of the upper jaw, create an arch form that is harmonious with the lower dental arch, and center the upper jaw over the lower jaw. When a tooth is missing, the other teeth may be shifted off center, and their positioning must be corrected too. A space is often opened up and maintained for later replacement of the missing lateral incisor.

During orthodontic treatment, an artificial tooth may be attached to the orthodontic wire as a temporary replacement for the lateral incisor. When the braces are take off, a removable retainer with an artificial tooth will serve to maintain the space and improve speech and appearance until a definitive restoration is made.

Can the space of the missing tooth be filled by another tooth?

In many instances, the space for the lateral incisor will be orthodontically and/or surgically closed by moving the canine tooth forward into the space normally occupied by the lateral incisor. The canine must then be modified to make it look like a lateral incisor, which is often accomplished by adding plastic or porcelain filling material or a porcelain crown.

What options are available for permanent replacement of the lateral incisor?

Treatment options for the permanent replacement of the lateral incisor depend upon whether or not the cleft has been repaired with a bone graft. (See below for information about patients who have had bone grafts) In a non-grafted dental arch, there are two options for replacement.

In the first option, a removable partial denture may be used to replace the missing tooth. While this option may be made to look acceptable, it has several disadvantages. The removable prosthesis must cover most of the palate for support, which may cause irritation on the roof of the mouth or at the gumline where it rests. Many patients also object to the

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extra bulk and the removable nature of the partial denture, reporting that it feels unnatural. This type of prosthesis is best used as a temporary replacement.

The second option for a patient without a bone graft is a fixed bridge. The missing tooth is replaced by an artificial one connected to crowns (caps) on the teeth on each side of the cleft. Because there is too little supporting bone beneath the teeth directly next to the cleft, *two* teeth on each side must usually be crowned to give adequate support to the bridge. This type of prosthesis is not removable. Its contours and appearance look and feel more natural than a removable partial denture. However, it does require grinding down the support teeth in order to crown them and connect them to the artificial tooth. Cleaning between the crowned teeth is also more difficult since they are connected.

At what age can a fixed bridge be made?

In a teenager or young adult, the nerves and blood vessels in the tooth pulps are rather large. Drilling these teeth down for crowns may expose the pulps and require root canal therapy. Therefore, this type of treatment must usually wait until middle adulthood when the pulps are smaller.

What options are available for a patient who has had a bone graft?

Bone grafting the cleft site in the upper jaw creates a more normal arch and may make tooth restoration easier. (See CPF's Factsheet *Bone Grafting the Cleft Maxilla* for more information on this procedure) A conventional fixed bridge as described above may then be used to replace the tooth. In many cases, however, only one tooth on either side of the cleft needs to be crowned, since the graft has stabilized the arch and added bone. If the teeth that hold the bridge are not otherwise in need of restoration, a resin-bonded fixed bridge requires much less tooth reduction of adjacent teeth, and there is no danger of nerve involvement. A porcelain replacement tooth is held in place by metal extensions cemented to the backs of the adjacent teeth. This process requires less interference with other teeth, but still requires connecting teeth together.

The most natural, lifelike restoration for a patient with a bone graft is a single porcelain crown attached to an osseointegrated dental implant. This method involves a surgical procedure in which a titanium screw the size and shape of a tooth's root is inserted into the bone at the site of the missing tooth. It is covered by the gum for six months while the bone bonds to the implant surface. Then the implant is uncovered, and an artificial tooth (crown) is attached. While this procedure does require minor surgery, it does not require cutting down or crowning any other teeth. Cleaning is also easier because the replacement tooth is not connected to any other teeth. This restoration gives the most natural result, but does require that sufficient bone is present in order to hold the screw.

For further information on cleft lip and palate, or for a referral to a cleft palate/craniofacial team, please contact:

Cleft Palate Foundation
1504 East Franklin Street, Suite 102
Chapel Hill, NC 27514

800.24.CLEFT
919.933.9044
919.933.9604 fax
info@cleftline.org
www.cleftline.org

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Missing Tooth Fact Sheet

Patients with cleft lip or cleft lip and palate are often born with a missing tooth, most often the lateral incisor (immediately next to the front central incisor). This may occur unilaterally or bilaterally, but special planning is needed to solve the functional and cosmetic problems the absence creates.

Who will be involved in dealing with the missing tooth?
Several dental specialists will be most important in planning treatment. Orthodontists align improperly placed teeth, while prosthodontists can replace missing teeth in a variety of ways. Oral and maxillofacial surgeons perform surgery to the teeth, mouth, and surrounding areas of the head and face. Coordinated planning by all specialists involved is necessary for the best result.

What role does the orthodontist play in replacing a missing tooth?
The large majority of patients with clefts will require full orthodontic treatment, especially if the cleft has passed through the tooth-bearing ridge. Goals of treatment will be to line up the teeth in the upper arch, create an arch form that is harmonious with the lower dental arch, and line up the midline of the upper arch with that of the lower arch. When a tooth is missing, the upper midline is usually shifted, so this must be corrected. A space is often opened up and maintained for later replacement of the missing lateral incisor.

During orthodontic treatment, an artificial tooth may be attached to the orthodontic wire as a temporary replacement for the lateral incisor. When the braces are removed, a removable retainer with an artificial tooth serves to maintain the space and improve speech and appearance until a definitive restoration is made.

Is the missing tooth always replaced?
In many instances, the space for the lateral incisor will be orthodontically and/or surgically closed by moving the canine forward into the space normally occupied by the lateral incisor. This will then require modification of the canine to make it appear as a lateral incisor. This may be accomplished by adding plastic or porcelain filling material or a porcelain crown to reshape its appearance.

What options are available for permanent replacement of the lateral incisor?
Treatment options for the permanent replacement of the lateral incisor depend upon whether or not the cleft has been repaired with a bone graft. In a non-grafted dental arch, there are two options for replacement:

- First, a removable partial denture may be used to replace the missing tooth. While this option may be made to look acceptable, it has several disadvantages. The removable prosthesis must cover most of the palate for support. This may cause irritation on the roof of the mouth or at the gumline where it rests. Many patients also object to the extra bulk and removable nature of the partial denture and report that it feels unnatural. This type of prosthesis is best as a temporary replacement as described above.

- The second option in a patient without a bone graft is a fixed bridge. The missing tooth is restored with an artificial one connected to crowns (caps) on teeth on each side of the cleft. Because there is loss of supporting bone at each tooth on either side of the cleft, two teeth on each side must usually be crowned to give adequate support to the bridge. This type of prosthesis is not removable. Its contours and appearance look and feel more natural than a removable partial denture. However, it does require grinding down the support teeth in order to crown them and connect them to the artificial tooth. Cleaning between the crowned teeth also becomes more difficult since they are connected.

Can a fixed bridge be made immediately after braces?
In a teenager or young adult, the nerves and blood vessels in the tooth pulps are rather large. Drilling down these teeth for crowns may expose the pulps and require root canal therapy. Therefore, this type of treatment must usually wait until adulthood when the pulps are smaller.

What options are available for a patient who has had a bone graft?
Bone grafting the cleft site in the upper jaw creates a more normal arch and eliminates special restorative considerations relative to the cleft. A conventional fixed bridge as described above may be used. In many cases, only one tooth on either side of the cleft needs to be crowned, since the graft has stabilized the arch and added bone. If the teeth that hold the bridge are not otherwise in need of restoration, a resin-bonded fixed bridge may be chosen. This type of bridge requires much less tooth reduction of adjacent teeth, and there is no danger of nerve involvement. A porcelain replacement tooth is held in place by metal extensions cemented to the backs of the adjacent teeth. This is a more conservative restoration with regards to tooth preparation but still requires connecting teeth together.

The most natural, lifelike restoration for a patient with a bone graft is a single porcelain crown attached to an osseointegrated dental implant. This involves a surgical procedure where a titanium screw the size and shape of a tooth's root is inserted into the bone at the site of the missing tooth. It is covered by the gum for six months while the bone bonds to the implant surface. Then the implant is uncovered and an artificial tooth (crown) is attached. While this procedure does require minor surgery, it does not require cutting down or crowning any other teeth. Cleaning is also easier because the replacement tooth is not connected to any other teeth. This restoration does give the most natural result but does require that sufficient bone is present in order to hold the screw.

In summary:

- Finding the best treatment for a missing tooth requires cooperation and planning among several specialists
- A variety of options for successful tooth replacement are available
- Patients with missing teeth and/or their parents should thoroughly discuss treatment options with the multidisciplinary team before making a decision.

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American Cleft Palate-Craniofacial Association

ACPA/CPF
1504 East Franklin Street, Suite 102
Chapel Hill, NC 27514-2820 USA
(919) 933-9044 , Fax: (919) 933-9604
info@cleftline.org

Cleft Palate Foundation

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