

Anterior Openbite Study

Practitioner's Final Visit Form

Please make sure to measure the height of your patient's right maxillary central incisor and record it below. Also, please make sure that the following records are obtained at this one-year follow-up time, and submit them with this form.

- An intra-oral frontal photograph taken in maximum intercuspation, and
- An intra-oral frontal photograph taken with the incisors slightly appri-

Visit Date: |___|/|__|/|_2 |_0 |_1 |__| m m d d v v v v

1. Please measure and record the greatest height of your patient's right maxillary central incisor, perpendicular to the incisal edges of the incisors. (You should measure from the gingival margin to

the incisal edge, to the nearest tenth of a millimeter.)

- 2. Has the anterior openbite relationship been stable since the end of treatment?
 - □ Yes (Go to Q3) □ No (Go to Q2a)

2a. If no, indicate the current overbite status:

- □ The overbite has lessened, but there is still incisal overlap
- □ The overbite has lessened, and there is no longer incisal overlap
- □ The overbite has deepened, and there is more incisal overlap
- □ The overbite has deepened, but there is no incisal overlap
- 3. Indicate the molar relationship on the patient's right side and left side. (Check only one for each side)

Molar Class (Right side):	Class I	Class II 1/2 cusp	□Class II full cusp	□Class III ½ cusp	□Class III full cusp
Molar Class (Left side):	Class I	Class II ½ cusp	Class II full cusp	Class III ½ cusp	Class III full cusp

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- 4. Have there been any changes in alignment of the <u>upper incisors</u>?
 - Significant changes
 - □ Minor changes
 - □ No changes
- 5. Have there been any changes in alignment of the lower incisors?
 - □ Significant changes
 - □ Minor changes
 - □ No changes





- 6. Rate the patient's compliance with retainers.
 - □ Patient is using retainer(s) exactly as requested
 - □ On average, patient is using retainer(s) less than the requested amount of time
 - □ On average, patient is using retainer(s) more than the requested amount of time
- 7. Are the retainers and retention regimen the same as that prescribed at debanding?
 - □ Yes (Skip to Q8)
 - □ No (Go to Q7a)

7a. If no, please describe the changes: (Check all that apply)

- \Box Reduced from full time to half time use
- □ Different appliance, (please specify): _____
- Other, (please specify): _____

8. What additional adjunctive treatments have been completed since orthodontic treatment began?

(Check all that apply)

- □ Periodontal surgery
- □ Full coverage or veneer restorations of the anterior te
- □ Full mouth reconstruction/rehabilitation of the dentitio
- □ Sleep apnea management
- □ Splint therapy
- □ Other, (please specify):____
- □ None
- 9. Please indicate any additional comments regarding the retention phase of treatment.

(Check all that apply)

- Lost upper/maxillary retainer
- Lost lower/mandibular retainer
- Poor compliance
- Patient has residual finger or tongue habit
- □ Other, (please specify):
- □ None

END OF FORM

	Date:	_	_ /	_	_ / _ 2 _	0	<u>1</u>	
Practitioner Signature	m	m	d	d	y	у	у	y

PLEASE REVIEW THIS FORM FOR COMPLETION AND ACCURACY. THANK YOU.

Questions? Contact your RC at the phone or email provided on the front of the binder.