





Anterior Openbite Study

Practitioner's Retainer Use Form (to be completed at all regularly scheduled retainer check visits)

Visit Date: |___|/|__| /| 2 | 0 | 1 |___| m m d d y y y y

Has the anterior openbite relationship been stable since the end of treatment?
□ Yes (Skip to Q2)
□ No (Go to Q1a)

1a. If no, indicate the current overbite status:

- \Box The overbite has lessened, but there is still incisal overlap
- $\hfill\square$ The overbite has lessened, and there is no longer incisal overlap
- □ The overbite has deepened, and there is more incisal overla
- □ The overbite has deepened, but there is no ineisal overlap
- 2. Have there been any changes in alignment of the upper incisors
 - □ Significant changes
 - □ Minor changes
 - □ No changes
- 3. Have there been any changes in alignment of the lower incisors?
 - □ Significant changes
 - □ Minor changes
 - □ No changes
- 4. 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
 - \Box On average, patient is using retainer(s) more than the requested amount of time
- 5. Are the retainers and retention regimen the same as that prescribed at debanding? \Box Yes (Skin to CE) \Box No (Co to CE)
 - Yes (Skip to Q6) No (Go to Q5a)
 - 5a. If no, please describe the changes: (Check all that apply)
 - □ Reduced from full time to half time use

 - Other, (please specify): _____

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The nation's network PURPLE 6. What additional adjunctive treatments have been completed since retention began? (Check all that apply) □ Periodontal surgery □ Full coverage or veneer restorations of the anterior teeth □ Full mouth reconstruction/rehabilitation of the dentition □ Sleep apnea management □ Splint therapy Other (please describe): _____ □ None 7. 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 Other, (please specify): □ None END OF FOR Date: _|/|_ /__2 |__0__1__| **Practitioner Signature** m d d v y y У 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.