Anterior Openbite Study

PATIENT’s Enrollment Visit Form

You have been invited to participate in this study because you have an anterior openbite, a condition in which your upper front teeth do not touch your lower front teeth. We would like to ask you a few questions about yourself, your teeth, and your orthodontic treatment. Thank you for participating in this important study.

Today’s Date: __________/________/________

DEMOGRAPHICS

1. Your gender:
   - [ ] Male
   - [ ] Female

2. Your date of birth: __________/________/________

3. Your ethnicity:
   - [ ] Hispanic or Latino
   - [ ] Not Hispanic or Latino
   - [ ] I don’t know
   - [ ] Decline to answer

4. Your race (Check all that apply):
   - [ ] White
   - [ ] Black or African American
   - [ ] Asian
   - [ ] American Indian or Alaska Native
   - [ ] Native Hawaiian or Other Pacific Islander
   - [ ] I don’t know
   - [ ] Decline to answer
5. Your **dental** insurance type or third party coverage for any type of dental care (Check all that apply):
   - ☐ No dental insurance coverage (Go to Q6)
   - ☐ Private insurance (e.g., employer sponsored, commercial, HMO, etc.)
   - ☐ Public/government insurance (Medicaid, military or veterans benefit, etc.)
   - ☐ Other (please specify): ____________________________________________________________
   - ☐ I don’t know

5a. Does your private or public/government **dental insurance** cover orthodontic treatment? (Check only one)
   - ☐ Yes
   - ☐ No
   - ☐ Don’t know

5b. Does your private or public/government **dental insurance** cover jaw surgery? (Check only one)
   - ☐ Yes
   - ☐ No
   - ☐ Don’t know

6. Does your private or public/government **medical insurance** cover jaw surgery? (Check only one)
   - ☐ Yes
   - ☐ No
   - ☐ Don’t know
   - ☐ Don’t have medical insurance

7. Indicate your highest level of education:
   - ☐ Less than a high school diploma
   - ☐ High school graduate (including equivalency, GED, etc.)
   - ☐ Some college or Associate Degree
   - ☐ Bachelor’s degree
   - ☐ Graduate degree (including Master’s, Doctoral, etc.)
   - ☐ Decline to answer

8. ZIP code where you live: [___] [___] [___] [___] [___]

**CHIEF COMPLAINT**

9. What is the most important reason you are currently getting orthodontic treatment? (Check only one)
   - ☐ Anterior openbite (upper front teeth do not touch lower front teeth)
   - ☐ Crowded or crooked teeth
   - ☐ Overbite (buck teeth)
   - ☐ Underbite (lower front teeth in front of upper front teeth)
   - ☐ Crossbite (upper jaw too narrow)
   - ☐ Other, (please specify): ____________________________________________________________
10. Are there other reasons why you are currently getting orthodontic treatment? (Check all that apply)
☐ Anterior openbite (upper front teeth do not touch lower front teeth)
☐ Crowded or crooked teeth
☐ Overbite (buck teeth)
☐ Underbite (lower front teeth in front of upper front teeth)
☐ Crossbite (upper jaw too narrow)
☐ Other, (please specify): ____________________________________________________________
☐ No other reason

11. Has your anterior openbite caused any of the following problems for you? (Check all that apply)
☐ Unable to bite food with your front teeth (e.g., a piece of pizza or a piece of lettuce)
☐ Unable to speak clearly
☐ Problems with the fit or function of your bite
☐ Problems with your jaw joint (e.g., clicking, popping, or pain)
☐ Embarrassment about appearance of teeth
☐ Other, (please specify): ____________________________________________________________
☐ None of above

12. Is fixing your openbite a specific treatment goal?  ☐ Yes (Skip to Q13)  ☐ No (Go to Q12a)

12a. If no, why not?
______________________________________________________________________________

PATIENT HISTORY
13. Did you ever suck your thumb or finger?  ☐ Yes  ☐ No  ☐ Don’t remember

14. Do you still suck your thumb or finger?  ☐ Yes  ☐ No

15. What treatments were recommended as the most ideal by your practitioner? (Check all that apply)
Orthodontic treatment
☐ Braces attached to each tooth (metal or clear)
☐ Clear aligners (e.g., Invisalign)
Removing teeth (other than wisdom teeth)
☐ Upper teeth
☐ Lower teeth
Temporary anchorage devices (TAD)
☐ TAD mini-screws (these are small screws that are placed directly into your jaw)
☐ TAD mini-plates (these are metal plates placed under the gums, usually by an oral surgeon or periodontist [gum specialist])
Jaw surgery (An oral surgeon cuts your jaw and repositions it to correct your bite)
☐ Upper jaw surgery
☐ Lower jaw surgery
☐ Jaw surgery, not sure about upper or lower jaw
16. Did you accept the plan that your practitioner recommended as the most ideal?
   ☐ Yes (Skip to Q17)        ☐ No (Go to Q16a)

16a. If no, select the reasons why you did not accept the ideal plan (Check all that apply)
   ☐ Treatment too invasive or too risky
   ☐ Treatment too costly
   ☐ Did not want extraction(s) of teeth
   ☐ Did not want jaw surgery
   ☐ Treatment time too long
   ☐ Other, (please specify): ______________________________________________________

17. Were any of these additional procedures recommended as part of your ideal treatment? (Check all that apply)
   ☐ Tongue or thumb crib (a device that blocks your tongue from thrusting forward or prevents you from putting your thumb in your mouth)
   ☐ Speech therapy or myofunctional therapy (muscle exercises for the tongue and lips) provided by a qualified therapist
   ☐ Occlusal equilibration (reshaping of the chewing surfaces of your back teeth to improve your bite)
   ☐ Rubber bands (elastics)
   ☐ Interproximal Reduction (narrowing the width of your individual teeth)
   ☐ Expander for upper jaw (an appliance that widens your upper jaw)
   ☐ Headgear (a wire appliance that attaches to your upper back teeth and is connected to a strap that goes around your neck or the back part of your head)
   ☐ Gum surgery techniques (e.g., Wilkodontics® or other techniques to speed up tooth movement by making cuts or punctures into the bone around your teeth)
   ☐ Vibration therapy (e.g., Acceledent® - a device you bite on which generates a vibratory force)
   ☐ Other, (please specify):
   ☐ None of above

Please continue on to the next page
18. Did you ever undergo any previous orthodontic treatment prior to your current treatment?  
☐ Yes (Go to Q18a)  ☐ No (Thank you, this form is complete)  

18a. If yes, please check all treatments that you previously underwent (Check all that apply)  
**Orthodontic treatment**  
☐ Braces attached to each tooth (metal or clear)  
☐ Clear aligners (e.g., Invisalign)  

**Removing teeth (other than wisdom teeth)**  
☐ Upper teeth  
☐ Lower teeth  

**Temporary anchorage devices (TAD)**  
☐ TAD mini-screws (these are small screws that are placed directly into your jaw)  
☐ TAD mini-plates (these are metal plates placed under the gums, usually by an oral surgeon or periodontist [gum specialist])  

**Jaw surgery (An oral surgeon cuts your jaw and repositions it to correct your bite)**  
☐ Upper jaw surgery  
☐ Lower jaw surgery  
☐ Jaw surgery, not sure about upper or lower jaw  

**Other procedures**  
☐ Tongue or Thumb Crib (a device that blocks your tongue from thrusting forward or prevents you from putting your thumb in your mouth)  
☐ Speech therapy or myofunctional therapy (muscle exercises for the tongue and lips) provided by a qualified therapist  
☐ Occlusal equilibration (Reshaping of the chewing surfaces of your back teeth to improve your bite)  
☐ Rubber bands (elastics)  
☐ Interproximal reduction (narrowing the width of your individual teeth)  
☐ Expander for upper jaw (an appliance that widens your upper jaw)  
☐ Headgear (a wire appliance that attaches to your upper back teeth and is connected to a strap that goes around your neck or the back part of your head)  
☐ Gum surgery techniques (e.g., Wilkodontics® or other techniques to speed up tooth movement by making cuts or punctures into the bone around your teeth)  
☐ Vibration therapy (e.g., Acceledent® - a device you bite on which generates a vibratory force)  
☐ Other, (please specify): ____________________________________________________________  

19. Was correcting an openbite a specific treatment goal during your previous round of orthodontic treatment?  
☐ Yes (Thank you, this form is complete)  ☐ No (Go to 19a)  ☐ Don’t know  

19a. If no, why not?  
______________________________________________________________________________  
______________________________________________________________________________  

Please complete the Contact Information Form now, and leave both forms with your dentist’s staff. Thank you!