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Anterior Openbite Study

Practitioner's End of Active Treatment Form

Visit Date: |___|___|/|___|___| /|_2_|_0_|_1_|___|
m m d d y y y y

Date of appliance removal: |___|___|/|___|___| /|_2_|_0_|_1_|___|
m m d d y y y y

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 have been taken at the time of appliance removal, and submit them with this form.

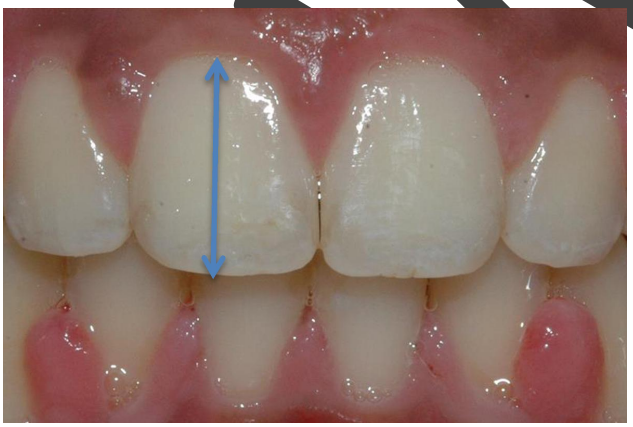
a. The post-treatment cephalometric x-ray,

b. An intra-oral frontal photograph taken in maximum intercuspation, and

c. An intra-oral frontal photograph taken with the incisors slightly apart.

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, as shown in the sample photo below.)

|___|___|▪ |___| mm



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2. Please complete the "Accepted plan" column based on your response to Q9 of the Practitioner's Enrollment Visit Form. Use your chart notes to complete the "Added procedures" or "Removed procedures" columns. (Check all that apply for each column).

Treatment	Accepted plan	Added procedures	Removed procedures
Fixed appliances	☐	☐	☐
Clear aligners	☐	☐	☐
Maxillary arch extractions (circle teeth in upper arch)	Right Left 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8	Right Left 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8	Right Left 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
Mandibular arch extractions (circle teeth in lower arch)	Right Left 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8	Right Left 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8	Right Left 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
Temporary anchorage devices (TAD) mini-screws	☐	☐	☐
Temporary anchorage devices (TAD) mini-plates	☐	☐	☐
Jaw surgery (Maxilla)	☐	☐	☐
Jaw surgery (Mandible)	☐	☐	☐
Tongue or thumb crib	☐	☐	☐
Speech or myofunctional therapy (by a qualified therapist)	☐	☐	☐
Occlusal equilibration	☐	☐	☐
Elastics	☐	☐	☐
Interproximal reduction (IPR)	☐	☐	☐
Maxillary expansion	☐	☐	☐
Headgear	☐	☐	☐
Corticotomy (e.g, Wilckodontics®)	☐	☐	☐
Vibration therapy (e.g., Acceledent®)	☐	☐	☐
Other (write in box)			

3. Is the anterior openbite closed?
   ☐Yes (Skip to Q4) ☐No (Go to Q3a)

   3a. If no, why not: _____

4. Do you expect the current openbite relationship to be stable?
   ☐Yes (Skip to Q5) ☐No (Go to Q4a)

   4a. If no, why not: _____

5. After orthodontic treatment, does the patient still have any residual oral habits?
   ☐Finger or thumb sucking
   ☐Tongue thrust
   ☐Tongue posture
   ☐Other, (please specify): _____
   ☐None

6. Was the patient's compliance with prescribed treatment acceptable during treatment? (e.g., use of elastics, headgear)
   ☐Yes (Skip to Q7) ☐No (Go to Q6a)

   6a. If no, why not: _____

7. Were there any unusual or unexpected events during the treatment (other than routine orthodontic problems like broken appliances)?
   ☐Yes (Go to Q7a) ☐No (Skip to Q8)

   7a. If yes, specify: _____

8. Please 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 ½ 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

9. 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 teeth
   ☐ Full mouth reconstruction/rehabilitation of the dentition
   ☐ Sleep apnea management
   ☐ Splint therapy
   ☐ Other, (please specify):_____
   ☐ None

10. Please indicate the recommended retention technique and the recommended regimen for retainer use at the time when the first set of retainers is delivered.

Maxillary Arch

Retention Technique: (Check only one)

- ☐ Hawley-style or circumferential
- ☐ Essix-style (clear overlay shell)
- ☐ Bonded retainer
- ☐ Other, (please specify): _____

Prescribed regimen for removable retainer at time retention begins: (Check one only)

- ☐ Full-time
- ☐ Nights (Half-time)
- ☐ Other, (please specify): _____

Mandibular Arch

Retention Technique: (Check only one)

- ☐ Hawley-style
- ☐ Essix-style (clear overlay shell)
- ☐ Bonded retainer
- ☐ Other, (please specify): _____

Prescribed regimen for removable retainer at time retention begins: (Check one only)

- ☐ Full-time
- ☐ Nights (Half-time)
- ☐ Other, (please specify): _____

11. Any additional comments regarding treatment, treatment outcome, or retention?

_____

_____

END OF FORM

_____ **Date:** |___|___|/|___|___| /|**2**|**0**|**1**|___|

Practitioner Signature m m d d y y y 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.