Anterior Openbite Study

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

Visit Date: | | | | | | | |
  m m d d y y y y

1. 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:
       ☐ 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

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
   ☐ 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?
   ☐ 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
       ☐ Different appliance, (please specify): ____________________________________________________________
       ☐ Other, (please specify): ____________________________________________________________
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 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.