

Anterior Openbite Study

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

PLEASE PRINT YOUR INFORMATION

Your responses will be kept confidential, and will be sent directly to the central data management center to be recorded anonymously.

Visit Date: |__|_|_|/|__|_|_|/|_2_|_0_|_1_|_|_|
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1. Do your upper front teeth touch or overlap your lower front teeth at this time?

- Yes
 No

2. How much do you wear your upper retainer each day at this point in your treatment?

- Full-time
 Nights (half-time)
 Other, (please specify): _____
 I have a fixed (non-removable) upper retainer

3. How much do you wear your lower retainer each day at this point in your treatment?

- Full-time
 Nights (half-time)
 Other, (please specify): _____
 I have a fixed (non-removable) lower retainer

4. On average, are you using your retainer(s) as requested by your doctor each day?

- Yes, exactly as requested
 No, I use my retainer(s) less than the requested amount of time
 No, I use my retainer(s) more than the requested amount of time

**Please place this form in the pre-addressed envelope, seal it, and leave it with your dentist's staff.
Your responses will be sent directly to the central data management center to be recorded
anonymously. Thank you!**