





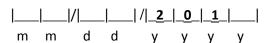
Anterior Openbite Study

Practitioner's Enrollment Visit Form

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

Consent from the patient must be obtained at enrollment prior to any study related steps, and we recommend completing the first two questions below while the patient is in your office. The rest of this form can be completed later, during non-patient times, using information from the patient's chart and diagnostic records. Please make sure that you have the initial cephalometric x-ray and initial frontal intra-oral photograph. These will need to be submitted, along with this form.

1. Date of initial orthodontic appliance placement for the current round of treatment?



- 2. From today's date, what is the estimated time remaining until treatment is complete?
 - $\Box \leq 6$ months
 - \Box 7 months to 12 months
 - □ 13 months to 18 months
 - □ 19 months to 24 months
- 3. What is the patient's chief orthodontic complaint? (Check only one)
 - □ Anterior Openbite
 - □ Crowding or crooked teeth

Overjet

- Underbite
- Crossbite
- Other, (please specify)
- 4. Were there other reasons why the patient sought orthodontic treatment? (Check all that apply)
 - □ Anterior openbite
 - □ Crowding or crooked teeth
 - □ Overjet
 - □ Underbite
 - □ Crossbite
 - Other, (please specify): _____
 - □ No other reason





5. Please complete the grid below to indicate the pre-treatment diagnoses. (Check **one** answer for each row unless indicated otherwise)

Pre-Treatment			Comer 1		
Profile:	Convex	□ Straight	Concave		
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
Maxillary Arch Length:	□Spacing	□ No Spacing or Crowding	☐ Mild Crowding (1-3mm)	Crowding (4-6mm)	Severe Crowding (>6mm)
Mandibular Arch Length:	Spacing	□ No Spacing of Crowding	☐ Mild Crowding (1-3mm)	☐Moderate Crowding (4-6mm)	Severe Crowding (>6mm)
Posterior crossbite:	□None	Unilateral	Bilateral	-	
Facial Pattern:	☐ High angle .	Normal	Low angle	-	
Habits: (Check all that apply)	None	Digit	□Tongue thrust	□Tongue posture	Other, (please specify)
Are any teeth missing in the maxillary arch?	□Yes □No	If yes, please circle teeth that are missing. (Circle all that apply)		Right 87654321 1234	Left 5 6 7 8
Are any teeth missing in the mandibular arch?	No	If yes, please circle teeth that are missing. (Circle all that apply)		Right 87654321 1234	Left 5 6 7 8





TREATMENT GOALS

- 6. Is correcting the openbite a goal of treatment?
 - \Box Yes (Skip to Q7) \Box No (Go to Q6a)
 - 6a. If no, why not?

- 7. What are the other goals of treatment? (Check all that apply)
 - □ Alignment of teeth
 - □ Anterior-posterior correction of posterior teeth
 - □ Transverse correction of posterior teeth
 - □ Overjet correction
 - □ Underbite correction
 - □ Profile improvement
 - Other, (please specify):
 - □ No other goal

Please continue on to the next page(s)





TREATMENT OPTIONS

8. Please complete the grid below based on your treatment recommendations and chart notes. Specify the component(s) of your most-recommended plan, your 2nd most-recommended plan, and your 3rd most-recommended plan. (Check all that apply for each recommendation.)

Treatment	Most recommended option	2 nd option (If not presented, check here □ and skip to Q9)	3 rd option (If not presented, check here 🗆 and skip to Q9)
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 87654321 12345678	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 87654321 12345678
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)			
9. Please indicate the plan that was accepted by the patient. (Check one only)			

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ORANGE

- 9a. If the patient did not accept your most recommended plan, please check the reason(s) why? (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): ___

10. Do you feel that the plan chosen by the patient will compromise your ability to close the openbite?

Yes (Go to Q10a)	No (Go to Q11)
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10a. If yes, explain how: _____

- 11. What additional adjunctive treatments are you recommending to the patient, either now or after completion of orthodontic treatment? (Check all that apply)
 - □ Periodontal surgery
 - □ Full coverage or veneer restorations of the anterior teet
 - □ Full mouth reconstruction/rehabilitation of the dentition
 - □ Sleep apnea management
 - □ Splint therapy
 - □ Other, (please specify):
 - □ None

THE FOLLOWING QUESTIONS PERTAIN TO TREATMENT THE PATIENT MAY HAVE UNDERGONE PRIOR TO THIS ROUND OF TREATMENT

12. Has the patient ever had prior orthodontic treatment?

Yes (Go to Q13)

No (Thank you, this survey is complete)

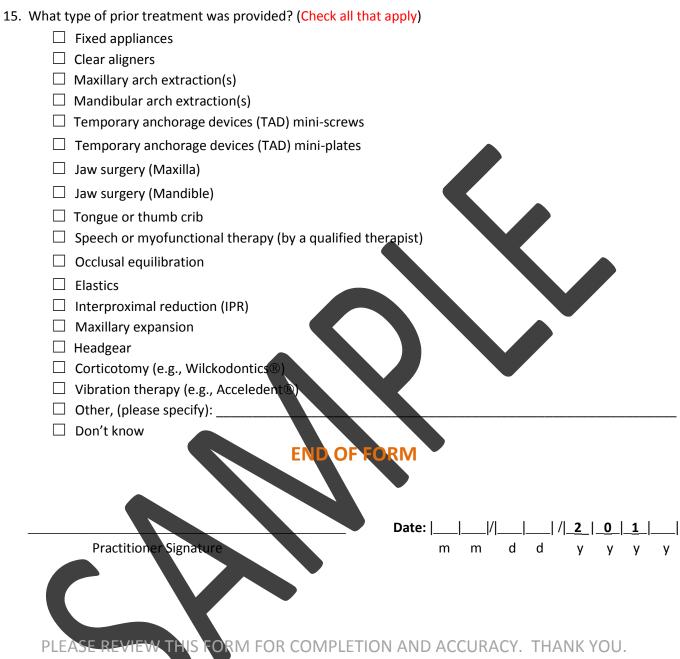
- Don't know (Thank you, this survey is complete)
- 13. Was correcting the openbite a goal of treatment?
- 14. Approximately how old was the patient at the beginning of the previous round of orthodontic treatment?

|____| years 🛛 Don't know









Questions? Contact your RC at the phone or email provided on the front of the binder.