

## Anterior Openbite Study

### Practitioner's Enrollment Visit Form

Visit Date: |\_\_|\_|/|\_\_|\_|/|\_2\_|\_0\_|\_1\_|\_|  
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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\_|\_0\_|\_1\_|\_|  
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2. From today's date, what is the estimated time remaining until treatment is complete?

- ≤ 6 months
- 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 Diagnoses					
Profile:	<input type="checkbox"/> Convex	<input type="checkbox"/> Straight	<input type="checkbox"/> Concave		
Molar Class (Right side):	<input type="checkbox"/> Class I	<input type="checkbox"/> Class II ½ cusp	<input type="checkbox"/> Class II full cusp	<input type="checkbox"/> Class III ½ cusp	<input type="checkbox"/> Class III full cusp
Molar Class (Left side):	<input type="checkbox"/> Class I	<input type="checkbox"/> Class II ½ cusp	<input type="checkbox"/> Class II full cusp	<input type="checkbox"/> Class III ½ cusp	<input type="checkbox"/> Class III full cusp
Maxillary Arch Length:	<input type="checkbox"/> Spacing	<input type="checkbox"/> No Spacing or Crowding	<input type="checkbox"/> Mild Crowding (1-3mm)	<input type="checkbox"/> Moderate Crowding (4-6mm)	<input type="checkbox"/> Severe Crowding (>6mm)
Mandibular Arch Length:	<input type="checkbox"/> Spacing	<input type="checkbox"/> No Spacing or Crowding	<input type="checkbox"/> Mild Crowding (1-3mm)	<input type="checkbox"/> Moderate Crowding (4-6mm)	<input type="checkbox"/> Severe Crowding (>6mm)
Posterior crossbite:	<input type="checkbox"/> None	<input type="checkbox"/> Unilateral	<input type="checkbox"/> Bilateral		
Facial Pattern:	<input type="checkbox"/> High angle	<input type="checkbox"/> Normal	<input type="checkbox"/> Low angle		
Habits: (Check all that apply)	<input type="checkbox"/> None	<input type="checkbox"/> Digit	<input type="checkbox"/> Tongue thrust	<input type="checkbox"/> Tongue posture	<input type="checkbox"/> Other, (please specify) _____ _____
Are any teeth missing in the maxillary arch?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please circle teeth that are missing. (Circle all that apply)		Right	Left
				8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
Are any teeth missing in the mandibular arch?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please circle teeth that are missing. (Circle all that apply)		Right	Left
				8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

## TREATMENT GOALS

6. Is correcting the openbite a goal of treatment?  
 Yes (Skip to Q7)     No (Go to Q6a)

6a. If no, why not?

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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)

SAMPLE

**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 2<sup>nd</sup> most-recommended plan, and your 3<sup>rd</sup> most-recommended plan. (Check all that apply for each recommendation.)

Treatment	Most recommended option	2 <sup>nd</sup> option (If not presented, check here <input type="checkbox"/> and skip to Q9)	3 <sup>rd</sup> option (If not presented, check here <input type="checkbox"/> and skip to Q9)
Fixed appliances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clear aligners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temporary anchorage devices (TAD) mini-plates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaw surgery (Maxilla)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaw surgery (Mandible)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tongue or thumb crib	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech or myofunctional therapy (by a qualified therapist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occlusal equilibration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elastics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interproximal reduction (IPR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maxillary expansion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headgear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corticotomy (e.g. Wilckodontics®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vibration therapy (e.g., Aceledent®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (write in box)			
9. Please indicate the plan that was accepted by the patient. (Check one only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: Please transfer the responses of the accepted plan to Q2 of the Practitioner's End of Active Treatment Form.

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)

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 teeth
- 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?

- Yes
- No
- Don't know

14. Approximately how old was the patient at the beginning of the previous round of orthodontic treatment?

\_\_\_\_|\_\_\_\_| years       Don't know

15. What type of prior treatment was provided? (Check all that apply)

- Fixed appliances
- Clear aligners
- Maxillary arch extraction(s)
- Mandibular arch extraction(s)
- 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., Acceleident®)
- Other, (please specify): \_\_\_\_\_
- Don't know

END OF FORM

\_\_\_\_\_  
Practitioner Signature

Date: |\_\_|\_|/|\_\_|\_|/|**2**|**0**|**1**|\_|  
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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.