

ALIGNER SEATERS

Clenchy



定價NT\$3,300/50小包/100個 | 買10送1

Clenchy 2



定價NT\$6,700/50小包/100個 | 買1送1

	Clenchy	Chewies
Seats aligners with two textures	✓	✓
Offers soft and firm textures	✓	
2 in 1 aligners seating and removal	✓	
Created by a dental patient	✓	
Hygienic	✓	
Compact	✓	
Durable	✓	
Recyclable	✓	



Product Info

INSTRUMENTS



SDC-IPR G5-ProLign Starter Kit

Utilized for Orthodontic Braces and Aligner Treatments



Includes G5-ProLign 0.5 mm

Description:

- 4 G5-ProLign files 0.1, 0.2, 0.3, 0.4, 0.5 mm 2 sides
- 2 G5-ProLign files 0.1, 0.2 mm 1 side
- 1 G5-UltraSoft file 6 μm 2 sides
- 1 CombiStrip file 6 μm (ultra-fine) polishing, 2 sides
- 1 CombiStrip file 15 μm (fine) contouring, 1 side
- 1 Hand piece NSK Ti Max X55 with Water
- 1 Measuring gauge 5 thicknesses
- 20 G5-Shanks Pink (Metal HP)
- 1 Nozzle for spray lubrication
- 1 Extractor for some instruments
- 1 IFU

定價NT\$69,500/盒 | 特價NT\$39,999

AIR ABRASION

MicroEtcher IIA™ Sandblaster

Extraoral Sandblaster, Autoclavable



定價NT\$23,100/支
單件7折

Macrocab Plus Dust Collector

Self Contained Dust Collection System



定價NT\$37,000/台
單件7折

ISOLATION

Contact Matrix Trial Kit

Sectional Matrix System



定價NT\$5,100/盒
單件7折

MEGA V Clinical Trial Kit

Sectional Matrix System



定價NT\$8,500/盒
單件7折



線上購物



即時客服

Performance. Price. Technology

“Let Us Help You Do Great Root Canals.”

— Charles J. Goodis, DDS
Endodontist, Albuquerque, NM, USA
Founder & Owner, EdgeEndo®



UNMATCHED FLEXIBILITY



INCREDIBLE STRENGTH



NO BOUNCE BACK



COMPATIBLE

Nickel Titanium Rotary Files

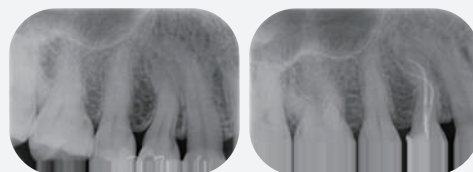
1 EdgeTaper Platinum™

Heat-Treated FireWire™ NiTi / pkg of 6



2 EdgeFile® X7

Heat-Treated FireWire™ NiTi / pkg of 6



賴博堂醫師case圖
(使用產品：EdgeFile X7)

3 EdgeTaper™

Non-Heat Treated NiTi / pkg of 6



4 EdgeGlidePath™

Heat-Treated FireWire™ NiTi / pkg of 4



5 EdgeSequel Sapphire™

Heat-Treated FireWire™ NiTi / pkg of 4



6 EdgeOne Fire™ GlidePath

Heat-Treated FireWire™ NiTi / pkg of 3



7 EdgeOne Fire™

Heat-Treated FireWire™ NiTi / pkg of 3



8 EdgeFile® XR

Non-Heat Treated NiTi / pkg of 4



定價NT\$2,400/盒 | 特價NT\$1,350/盒 | 20盒以上NT\$1,250/盒 | 50盒以上NT\$1,150/盒





Dental Products

Must-Have Secret Weapons

Autoclavable

Double Retractors 2.0

Double Retractors x2, Black Board x2

While keeping the same lip & cheek two-way design, the new Double Retractors 2.0 is upgraded to medical grade PPSU.

NEW

Stainless Steel Mirror 2.0

Strong, durable stainless steel, autoclave-proof, the specially designed size, improved shape and thickness ensure maximum intra-oral view without sacrificing patient comfort.



Bite Turbo 3.0

Handle x1, BT molds x6, BT extended molds x6, Button molds x6
Designed by Dr. Chris Chang, the new Bite Turbo 3.0 allows you to solve all kinds of deep bite and large horizontal overjet. A simple and powerful tool you should add to your kit!



NEW DESIGN Stainless Steel Mirror 2.0

全新**不鏽鋼口鏡**曲線設計**更舒適**亦方便握持，一支即可拍攝全口照片，提供照相最廣可視範圍。

專利設計

咬合面拍攝



鏡面改良

側面拍攝



成像清晰

加倍舒適

無鍍膜的**不鏽鋼拋光鏡面**，可增加影像清晰度、色澤穩定度。**多道修邊工序**，可適應不同大小的口腔環境，增加患者口腔舒適感。

圓滑邊角

新品上市特惠價，詳情請洽金牛頓



這個鏡子最厲害的是頰側鏡的長度，拍頰側面不會因為鏡面長度不夠，切到前牙的影像（坊間其他這種一邊頰側鏡一邊咬合鏡的拍照鏡大多都有這個問題）。



桃園 宗醫師



它牌口鏡



不鏽鋼口鏡2.0



Class II Excessive Overjet and Deep Bite with a Congenitally Missing Lower Incisor

Abstract

Introduction: An 11-year-old female presented with chief complaints of flared upper central incisors and protrusive lips.

Diagnosis: The cephalometric analysis revealed a skeletal Class II relationship (SNA, 84°; SNB, 76°; ANB, 8°) and proclined upper incisors. An intraoral assessment revealed a congenitally missing lower right lateral incisor, large overjet, deep overbite, and lower midline deviation 3 mm to the right. There was 4-5 mm of crowding in the lower anterior dentition. The Discrepancy Index (DI) was 23.

Treatment: A Damon® system appliance with passive self-ligating brackets was applied to correct the dental malocclusion after extracting both upper first premolars. Asymmetrical extraction of the lower left central incisor was carried out due to the congenitally missing lower right lateral incisor. Space closure and midline correction were accomplished with elastomer chains and Class II elastics. The active treatment time was 28 months.

Results: Improved dentofacial esthetics and occlusal function were achieved after treatment. The Cast-Radiograph Evaluation (CRE) was 27, and the Pink and White esthetic score was 3. Neither significant root resorption nor periodontal problems were noted.

Conclusions: This case report demonstrates the use of passive self-ligating appliances to resolve a severe anterior overjet with deep bite without using an orthodontic bone screw. (*J Digital Orthod* 2023;72:56-70)

Key words:

Skeletal Class II, excessive overjet, deep bite, congenitally missing lower incisor, proclined anterior teeth, midline deviation

The dental nomenclature for this case report is a modified Palmer notation with four oral quadrants: upper right (UR), upper left (UL), lower right (LR), and lower left (LL). Teeth are numbered 1-8 from the midline in each quadrant, e.g., a lower right lateral incisor is LR2.

Introduction

Congenitally missing teeth are defined as the developmental absence of one or more teeth in the primary or permanent dentition, excluding the third molars.¹ The diagnosis depends on a thorough clinical examination and panoramic radiographs.² The etiology is multifactorial. Both environmental

and genetical factors can contribute to its occurrence. Factors such as infection, trauma, drugs, and gene associated syndromes such as cleft lip, cleft palate, ectodermal dysplasia, and Down syndrome can disturb tooth germ formation.³ Sometimes these factors can delay formation of the tooth germ, allowing surrounding tissues to close the space needed for tooth development and resulting in a missing tooth.⁴

The prevalence of congenitally missing teeth differs between continents and races. It is not frequent in the primary dentition, ranging between 0.1% to 2.4%. In the permanent dentition (excluding the third molars) it ranges between 0.15% to 16.2%. Women

Yi-Hsuan Lin,

Training Resident, Beethoven Orthodontic Center (Left)

Joshua S. Lin,

Associate Director, Beethoven Orthodontic Center (Center left)

Chris H. Chang,

Founder, Beethoven Orthodontic Center

Publisher, Journal of Digital Orthodontics (Center right)

W. Eugene Roberts,

Editor-in-Chief, Journal of Digital Orthodontics (Right)



are usually more affected,⁵ and the male-to-female ratio is about 2:3.⁶ Among Asians, the mandibular incisors are the most commonly missing (60%), followed by maxillary second premolars (10%) and maxillary lateral incisors (8%).⁷ Congenitally missing teeth are more commonly bilateral, rather than

unilateral, and there is a higher prevalence in the anterior segment, but there is no difference between right and left sides.

A Class II occlusion with a large overjet is difficult to treat using only traditional orthodontic treatment



■ Fig. 1: Pre-treatment facial and intraoral photographs

methods. The condition is characterized by protrusive and proclined upper anterior teeth, which results in lip protrusion and increased facial convexity. A beak-like facial profile with lip protrusion is the main characteristic of these patients, and facial esthetics is the main reason to seek orthodontic treatment. Gum impingement caused by an anterior deep bite is problematic for patients. The etiology of a large overjet is multifactorial. Skeletal patterns are predominantly genetically determined, and oral behaviors such as thumb-sucking, lip trap, and anterior tongue posture can alter the development process and may be the etiology of malocclusion. Conventional treatments for patients with a severe overjet may involve headgear and orthognathic surgery.^{8,9}

This case report demonstrates the treatment of a patient with a congenitally missing lower right lateral incisor and a large overjet with a Class II molar relationship. No temporary skeletal anchorage devices (TSADs) such as bone screws were used. Reducing the dental and soft tissue convexity resulted in a satisfying outcome.

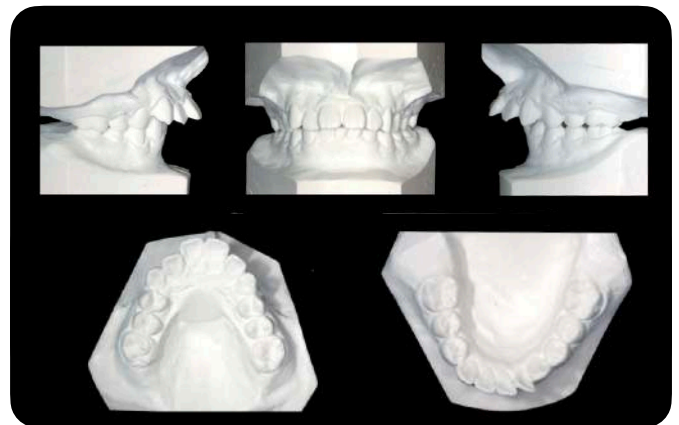
Diagnosis and Etiology

An 11-year-old female presented for orthodontic evaluation with misaligned teeth, a large overjet, and protrusive lips (Figs. 1-3). Medical and dental histories were non-contributory. From the cephalometric analysis, a convex profile with protrusive upper and lower lips to the E-line were noted (Fig. 4; Table 1). A clinical examination revealed a large overjet, a deep curve of Spee in the lower arch, and palatal impingement. The upper and lower dental midlines were not coincident due to the congenitally missing LR2, which was clearly shown in the panoramic radiograph (Fig. 5). The temporomandibular joint (TMJ)



■ Fig. 2:

A close-up shot of the proclined upper anterior teeth and large overjet



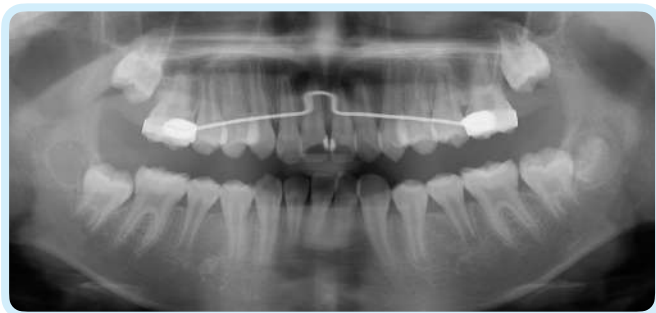
■ Fig. 3: Pre-treatment dental models (casts)

morphology was normal in the open and closed positions (Fig. 6), and there were no signs or symptoms of temporomandibular dysfunction (TMD).

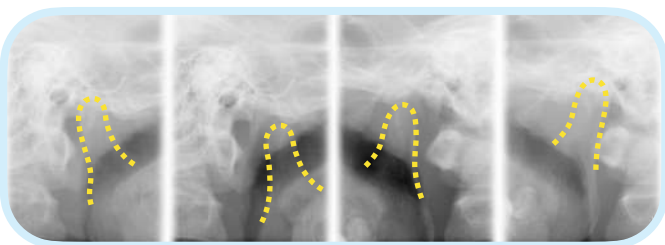
The American Board of Orthodontics (ABO) Discrepancy Index (DI) was 37 points, as shown in Worksheet 1 at the end of this report.¹⁰ The patient had no known contributing habits, so the etiology of the malocclusion appeared to be an interaction of environmental (lip trap) and hereditary (missing incisor) factors.



■ Fig. 4: Pre-treatment cephalometric radiograph



■ Fig. 5: Pre-treatment panoramic radiograph



■ Fig. 6: Transcranial radiographs of the temporomandibular joints (TMJs) prior to treatment are shown. From left to right are: right TMJ closed, right TMJ open, left TMJ open, and left TMJ closed. The mandibular condyles are outlined in yellow.

CEPHALOMETRIC SUMMARY			
	PRE-TX	POST-TX	DIFF.
SKELETAL ANALYSIS			
SNA° (82°)	84°	79°	5°
SNB° (80°)	76°	77°	1°
ANB° (2°)	8°	2°	6°
SN-MP° (32°)	34°	34°	0°
FMA° (25°)	27°	27°	0°
DENTAL ANALYSIS			
U1 TO NA mm (4 mm)	9.5	4.5	5
U1 TO SN° (104°)	120°	101°	19°
L1 TO NB mm (4 mm)	6.5	4.5	2
L1 TO MP° (90°)	97°	96°	1°
FACIAL ANALYSIS			
E-LINE UL (-1 mm)	8	1	7
E-LINE LL (0 mm)	8	2	6
%FH: Na-ANS-Gn (53%)	53%	55%	2%
Convexity:G-Sn-Pg' (13°)	15°	7°	8°

■ Table 1: Cephalometric summary

Treatment Objectives

1. Improve esthetics by correcting facial convexity and retracting the lips to the E-line.
2. Correct the anterior large overjet and deep bite to an ideal occlusion.
3. Correct the Class II canine and molar relationships to a Class I occlusion.
4. Correct the midline discrepancy.

Treatment Plan

Traditional treatment for a large overjet (OJ = 13 mm) was orthognathic surgery. Since the patient was very young and her mother was worried about the risks of surgery, they were strongly opposed to surgical treatment and mentioned that only conservative approaches combined with extraction would be considered.

According to Chang's extraction decision chart, extraction is the first choice for a case with flared central incisors and protruded lips (Table 2). Since the patient was open to extraction, extractions of UR4 and UL4 were planned in order to correct the anterior crowding and flaring. LL2 extraction was also scheduled after the anterior overjet decreased to within a normal range for midline correction. Space closure by retracting the upper and lower arches also retracts the lips. A series of bite turbos

(BTs) expedite the leveling of the curve of Spee. They are placed first on the lower molars and then on the upper incisors. Class II elastics are indicated to protract the mandible and rotate the occlusal plane clockwise, in order to correct the sagittal discrepancy. Bilateral infrazygomatic crest (IZC) bone screws were also considered as an option if further overjet correction was necessary. Both fixed and clear retainers were to be prescribed for retention of the arches after active treatment. The previously inserted upper trans-palatal arch appliance (TPA) was removed before the treatment commenced (Fig. 1).

Treatment Progress

A 0.022-in slot Damon Q® fixed appliance (Ormco, Glendora, CA) with passive self-ligating (PSL) brackets was selected along with all specified archwires and orthodontic auxiliaries. To meet the patient's esthetic demands, Damon™ Clear brackets were used on the upper anterior teeth. Before active orthodontic treatment started, the patient was referred to have the UR4 and UL4 extracted. Two weeks later, Damon™ Clear 0.022-in PSL brackets (Ormco, Glendora, CA) were bonded on the upper arch, utilizing standard-torque brackets in the anterior segment and high-torque brackets on the canines, and a 0.014-in CuNiTi archwire was engaged. One month later, the lower arch was bonded with brackets, using low torque for the lower anterior teeth. Two bite turbos (BTs) constructed with FUJI II glass ionomer cement (GIC) were installed on LR6 and LL6 to prevent bracket interference. Early light short Class II elastics (Parrot, 5/16-in, 2.0 oz; Ormco) were applied on both sides to protract the mandible and extrude the lower molars. They were bilaterally attached from U3 drop-in hooks and extended to L6 hooks.

	Ext	Non
1. Profile	Protrusive	Straight
2. Md.angle	High	Low
3. Bite	Open	Deep
4. Ant. Inclination	Flaring	Flat
5. Crowding	> 7 mm	Non
6. Decay/ missing	Present	?
7. P't perception	OK	No
8. Etc		

■ **Table 2:** Chang's Extraction Decision Table

Early alignment of the upper and lower arches was achieved with progressive 0.014x0.025-in CuNiTi and 0.017x0.025-in TMA archwires. In the 6th month, two resin BTs were bonded on the palatal surfaces of UR1 and UL1. Class II elastics (Fox, 1/4-in, 3.5 oz; Ormco) were applied on both sides to accelerate the reduction of the excessive overjet.

In the 8th month of treatment, figure-eight ties were applied from canine to canine in the upper arch in order to fix the anterior teeth as a segment. A four-ring power chain was placed bilaterally from the maxillary canines to the maxillary 1st molars to close the extraction spaces.

In the 12th month of treatment, the brackets on LR3, LR1, LL1, and LL3 were repositioned to correct the axial angulation. LL7 was bonded with a bracket since it was then fully erupted. In the 15th month, the overjet decreased to 0 mm, and the patient was referred for LL1 extraction. In the 16th month, a more rigid 0.016x0.025-in SS archwire was used for final space closure. An additional 12 months were required to detail the occlusion.

The treatment progress is documented in a progressive series of intraoral photographs in the frontal, right buccal, left buccal, maxillary occlusal, and mandibular occlusal views (Figs. 7-11). After 28 months of active treatment, all fixed appliances were removed, and fixed retainers were delivered on the maxillary anterior 2-2 and the mandibular lingual 3-3, respectively. Removable clear overlay retainers were provided to maintain both arches. Posttreatment records were collected: intra- and extra-oral photographs, panoramic and lateral

cephalometric radiographs, as well as casts (Figs. 12-16).

Results Achieved

The facial esthetics and intermaxillary occlusion were both significantly improved after 28 months of active treatment (Fig. 12). The canine and molar relationships were improved to Class I. The posttreatment panoramic radiograph documented acceptable root parallelism (Fig. 15). The superimposed cephalometric tracings illustrated that the UR6 and UL6 were protracted 5 mm due to the closing of the extraction spaces using elastic forces (Fig. 13). The axial inclination of the upper incisor (U1-SN) decreased 19° after treatment (120° to 101°), and the axial inclination of the lower incisors (L1-MP) was tipped only slightly lingually (97° to 96°). The upper and lower lips were both retruded following the retraction of the anterior segments. The mandibular plane angle (SN-MP) was well-maintained. The facial convexity decreased from 15° to 7° (Table 1). The Cast-Radiograph Evaluation (CRE)¹¹ score was 27 points, as shown in the supplementary Worksheet 2. The Pink and White dental esthetic score¹² was 3 points (Worksheet 3). The patient was pleased with the final result.

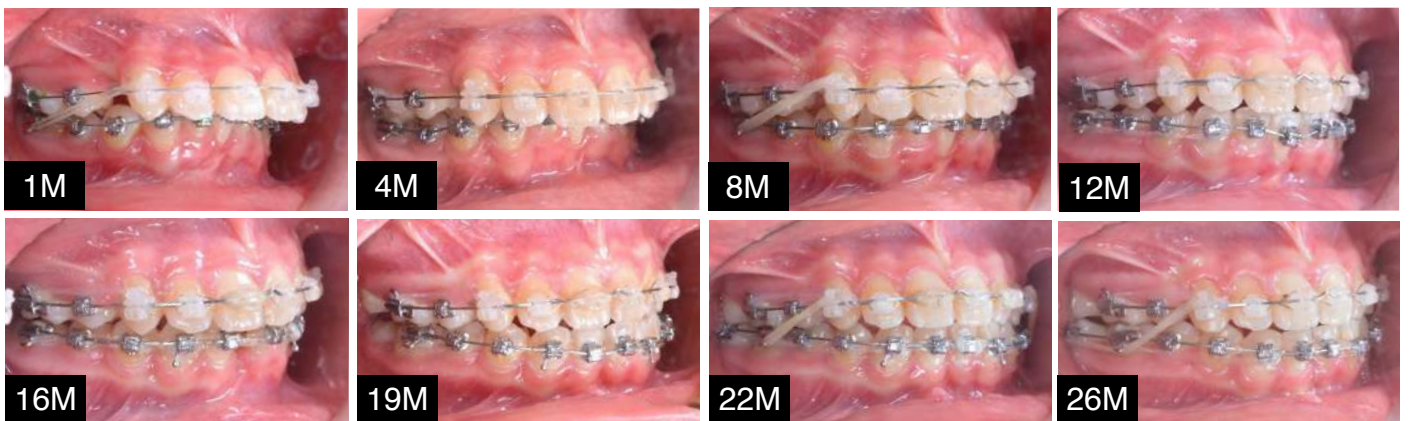
Discussion

Extraction considerations for treating cases with congenitally missing teeth

Treatment plans mainly depend on the number and position of missing teeth, the type of malocclusion, severity of crowding, and facial profile.¹³ For young and adolescent patients, bone growing potential



■ Fig. 7: Treatment sequence from the frontal view is shown in months (M): 0M, 4M, 8M, 12M, 16M, 19M, 22M, and 26M.



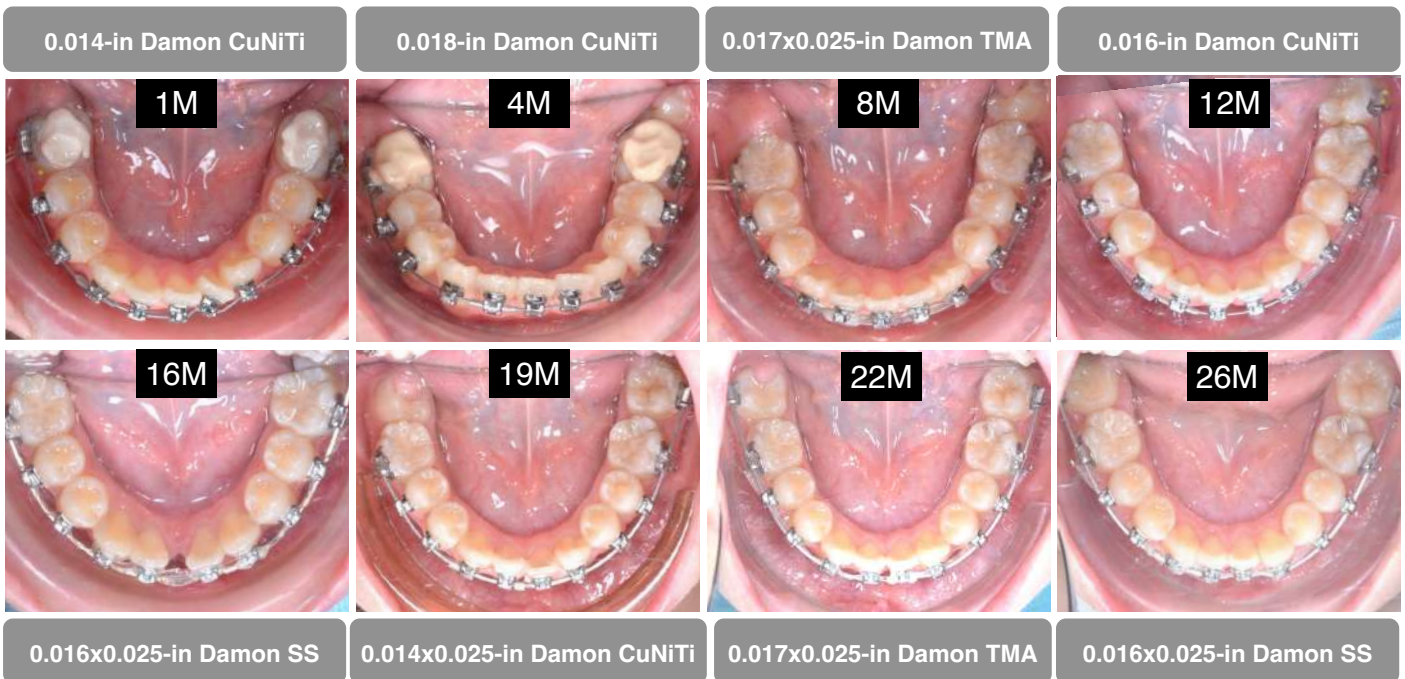
■ Fig. 8: Treatment sequence from the right buccal view is shown in months (M): 1M, 4M, 8M, 12M, 16M, 19M, 22M, and 26M.



■ Fig. 9: Treatment sequence from the left buccal view is shown in months (M): 1M, 4M, 8M, 12M, 16M, 19M, 22M, and 26M.



■ Fig. 10: Treatment progress from the maxillary occlusal view is shown in months (M): 0M, 4M, 8M, 12M, 16M, 19M, 22M, and 26M.



■ Fig. 11: Treatment progress from the mandibular occlusal view is shown in months (M): 1M, 4M, 8M, 12M, 16M, 19M, 22M, and 26M.

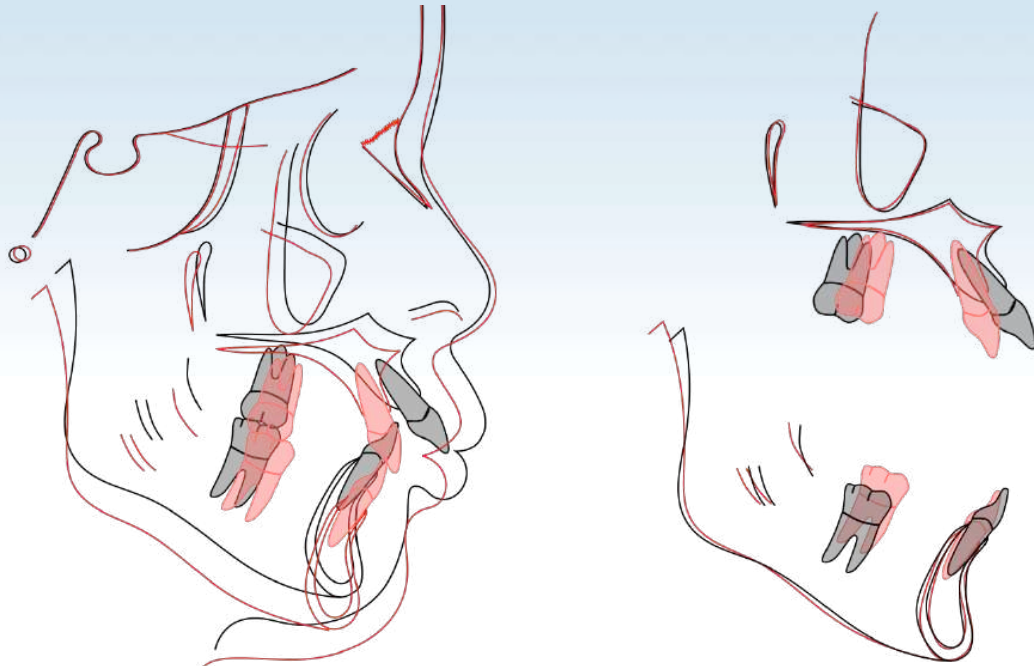
must also be taken into consideration. The edentulous space can be either left open for further restoration or closed by orthodontic means.¹⁴ Dental midline, molar relationships, and teeth conditions such as caries, root canal treatments, and periodontal disease must also be considered. Keeping the arches symmetrical by balancing bilateral tooth numbers is often preferred by many patients.

In this case, the unilateral congenitally missing tooth combined with crowded anterior teeth would often require extracting the opposite tooth, in order to

relieve the crowding and balance bilateral tooth numbers for the purpose of symmetry. The initial treatment plan was to extract LL2 which was symmetrical to the congenitally missing LR2. However, after 15 months of alignment, the lower anterior teeth flared out, which decreased the overjet to 0 mm, and became much more prominent in the central area, especially with obvious gingival recession. The lower dental midline was deviated 3 mm to the right. Since the patient's three lower anterior incisors looked similar in size



■ Fig. 12: Posttreatment facial and intraoral photographs



■ Fig. 13:

Pre-treatment (black) and posttreatment (red) cephalometric tracings are superimposed on the anterior cranial base (left), the maxilla (upper right), and the mandible (lower right). The incisors were retracted, and protrusion was reduced.



■ Fig. 14: Posttreatment cephalometric radiograph



■ Fig. 15: Posttreatment panoramic radiograph



■ Fig. 16: Posttreatment dental models (casts)

and shape, the actual treatment plan changed to extract LL1 instead of LL2, followed by space closure with both sides symmetrical. This made the treatment process much easier for midline correction, and the lower anterior teeth were corrected to a straighter angulation.

Bite turbos combined with Class II elastics

Anterior bite turbos are very useful when opening a deep overbite; they serve as vertical stops at the desired vertical dimension of the occlusion. They provide space for the posterior teeth to spontaneously extrude to desired positions on the occlusal plane, and the biting force exerted on them results in a vertical load, which intrudes both upper and lower incisors. They can also be employed to level the curve of Spee and correct a deep overbite. In this case, the upper anterior BTs kept the vertical occlusion vertical during extraction space closing, to avoid deepening the bite.

For patients with a large overjet, anterior BTs also serve as an anterior positional guide, and when combined with Class II elastics, which further guide the mandible forward efficiently, they enable repositioning of the mandible in a more forward position, thereby decreasing the overjet. Anterior BTs should be bonded more gingivally and should be long enough in the initial stages to allow the patients to occlude on them more easily.

For some patients, posterior BTs may also be necessary to help them get used to their new forward occlusal position and raise their bite to prevent hitting the brackets.

Anterior BTs are usually made with composite resin, and posterior BTs are constructed with glass ionomer cement. The advantages of BTs are that they are easy to use, work full-time, and require zero patient cooperation. However, placing them on endodontically treated teeth should be avoided, to prevent potential tooth fracture.

In this case, extracting the upper bilateral first premolars opened the space to retract the upper anterior teeth, which further decreased the overjet and returned the flared upper anterior teeth to a normal upright position. Combining the BTs and Class II elastics effectively solved the deep overbite and brought the large overjet back to a normal occlusion.

Conclusions

This large overjet with anterior deep bite and congenitally missing tooth was treated to an acceptable result. With Chang's Extraction Decision Table (Table 2), a feasible treatment plan was completed with a pleasant outcome without headgear or surgery. In retrospect, the treatment time could have been decreased by using buccal shelf miniscrews. The occlusion was stable at the 3-year follow-up (Fig. 17).



■ **Fig. 17** Posttreatment 3 year follow-up photos show that the occlusion was stabled.

References

- Huang YT, Management of congenital missing in bilateral mandibular incisors. *Taiwanese Journal of Orthodontics* 2019;31(1):34-42.
- Kim YH. Investigation of hypodontia as clinically related dental anomaly: prevalence and characteristics. *ISRN Dent* 2011;2011:246135.
- Wu CC, Wong RW, Urban Hägg U. A review of hypodontia: the possible etiologies and orthodontic, surgical and restorative treatment options-conventional and futuristic. *Hong Kong Dent J* 2007;4:113-121.
- Goya HA, Tanaka S, Maeda T, Akimoto Y. An orthopantomographic study of hypodontia in permanent teeth of Japanese pediatric patients. *J Oral Sci* 2008;50:143-150.
- Nik-Hussein NN. Hypodontia in the permanent dentition: a study of its prevalence in Malaysian children. *Aust Orthod J* 1989;11:93-95.
- Rakhshan V. Congenitally missing teeth (hypodontia): A review of the literature concerning the etiology, prevalence, risk factors, patterns and treatment. *Dent Res J (Isfahan)* 2015;12(1):1-13.
- Polder BJ, Van't How MA, Van Der Linden FB, Kuijpers-Jagtman AM. A meta-analysis of the prevalence of dental agenesis of permanent teeth. *Community Dent Oral Epidemiol* 2004;32:217-226.
- Miguel JAM. Dentoskeletal effects of the maxillary splint headgear in the early correction of Class II malocclusion. *Prog Orthod* 2020;21:11.
- Tulloch JFC. Surgical versus orthodontic correction for Class II patients: age and severity in treatment planning and treatment outcome. *Semin Orthod* 1999;5(4):231-240.
- Lamberton CM, Reichart PA, Triratnanimit P, B Cangialosi TJ, Riolo ML, Owens SE Jr et al. The ABO discrepancy index: A measure of case complexity. *Am J Orthod Dentofacial Orthop* 2004;125:270-278.
- Casko JS, Vaden JL, Kokich VG, Damone J, James RD. American board of orthodontics: Objecting grading system for dental casts and panoramic radiographs. *Am J Orthod Dentofacial Orthop* 1998;114(5):589-599.
- Su B. IBOI Pink and White esthetic score. *Int J Orthod Implantol* 2013;28:80-85.
- Fekonja A. Hypodontia in orthodontically treated children. *Eur J Orthod* 2005;27:457-460.
- Kokich VG, Kokich VO. Congenitally missing mandibular second premolars: clinical options. *Am J Orthod Dentofacial Orthop* 2006;130:437-444.

Discrepancy Index Worksheet

TOTAL D.I. SCORE 23

OVERJET

- 0 mm. (edge-to-edge) =
- 1 - 3 mm. = 0 pts.
- 3.1 - 5 mm. = 2 pts.
- 5.1 - 7 mm. = 3 pts.
- 7.1 - 9 mm. = 4 pts.
- > 9 mm. = 5 pts.

Negative OJ (x-bite) 1 pt. per mm. Per tooth =

Total = 5

OVERBITE

- 0 - 3 mm. = 0 pts.
- 3.1 - 5 mm. = 2 pts.
- 5.1 - 7 mm. = 3 pts.
- Impinging (100%) = 5 pts.

Total = 5

ANTERIOR OPEN BITE

0 mm. (Edge-to-edge), 1 pt. per tooth
Then 1 pt. per additional full mm. Per tooth

Total = 0

LATERAL OPEN BITE

2 pts. per mm. Per tooth

Total = 0

CROWDING (only one arch)

- 1 - 3 mm. = 1 pt.
- 3.1 - 5 mm. = 2 pts.
- 5.1 - 7 mm. = 4 pts.
- > 7 mm. = 7 pts.

Total = 2

OCCLUSION

- Class I to end on = 0 pts.
- End on Class II or III = 2 pts. per side _____ pts.
- Full Class II or III = 4 pts. per side _____ pts.
- Beyond Class II or III = 1 pt. per mm. additional _____ pts.

Total = 0

LINGUAL POSTERIOR X-BITE

1 pt. per tooth Total = 0

BUCCAL POSTERIOR X-BITE

2 pts. Per tooth Total = 0

CEPHALOMETRICS (See Instructions)

ANB $\geq 6^\circ$ or $\leq -2^\circ$ = 4 pts.

Each degree $< -2^\circ$ _____ x 1 pt. = _____

Each degree $> 6^\circ$ 2 x 1 pt. = 2

SN-MP

$\geq 38^\circ$ = 2 pts.

Each degree $> 38^\circ$ _____ x 2 pts. = _____

$\leq 26^\circ$ = 1 pt.

Each degree $< 26^\circ$ _____ x 1 pt. = _____

I to MP $\geq 99^\circ$ = 1 pt.

Each degree $> 99^\circ$ _____ x 1 pt. = _____

Total = 6

OTHER (See Instructions)

Supernumerary teeth _____ x 1 pt. = _____

Ankylosis of perm. Teeth _____ x 2 pts. = _____

Anomalous morphology _____ x 2 pts. = _____

Impaction (except 3rd molars) _____ x 2 pts. = 2

Midline discrepancy (≥ 3 mm) @ 2 pts. = 2

Missing teeth (except 3rd molars) _____ x 1 pt. = _____

Missing teeth, congenital _____ x 2 pts. = 1

Spacing (4 or more, per arch) _____ x 2 pts. = _____

Spacing (Mx cent. diastema ≥ 2 mm) @ 2 pts. = _____

Tooth transposition _____ x 2 pts. = _____

Skeletal asymmetry (nonsurgical tx) @ 3 pts. = _____

Addl. treatment complexities _____ x 2 pts. = _____

Identify:

Total = 5

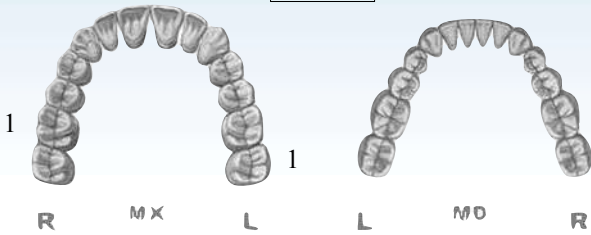
Cast-Radiograph Evaluation

Total Score:

27

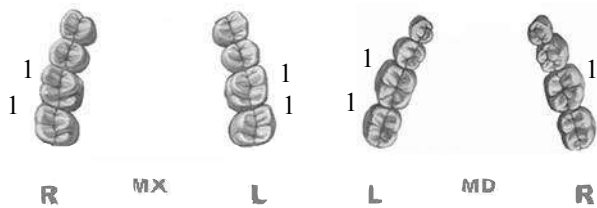
Alignment/Rotations

2



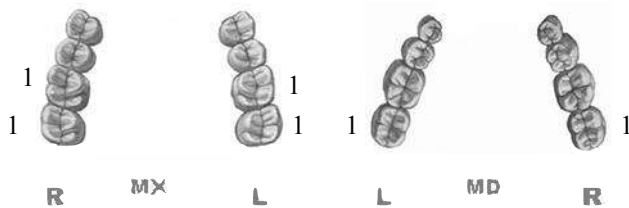
Marginal Ridges

7



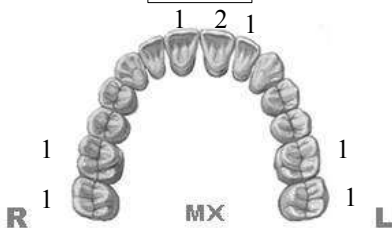
Buccolingual Inclination

6



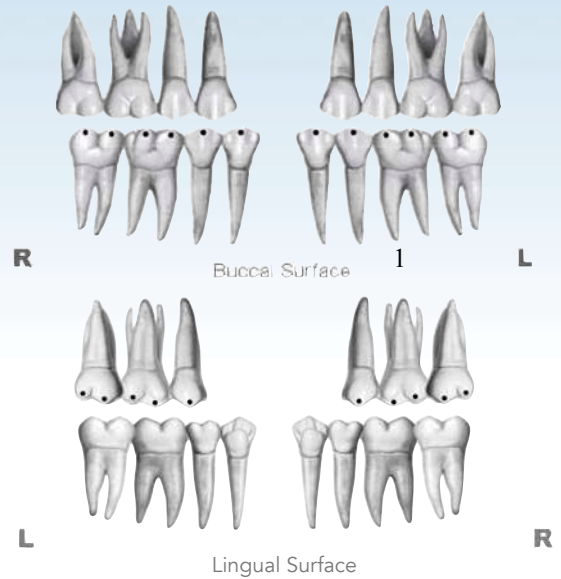
Overjet

8



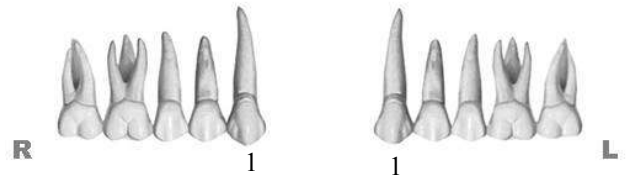
Occlusal Contacts

1



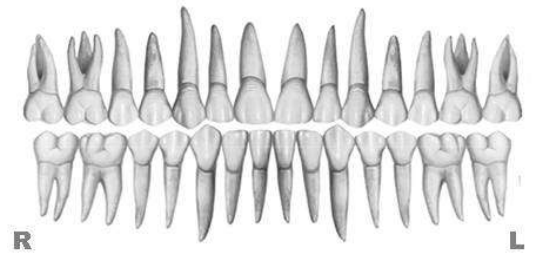
Occlusal Relationships

2



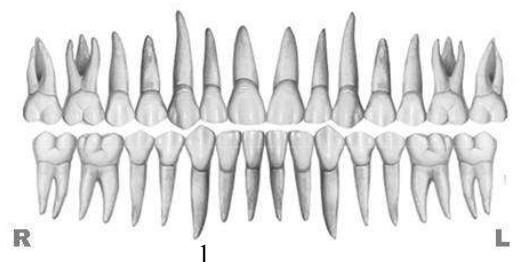
Interproximal Contacts

0



Root Angulation

1



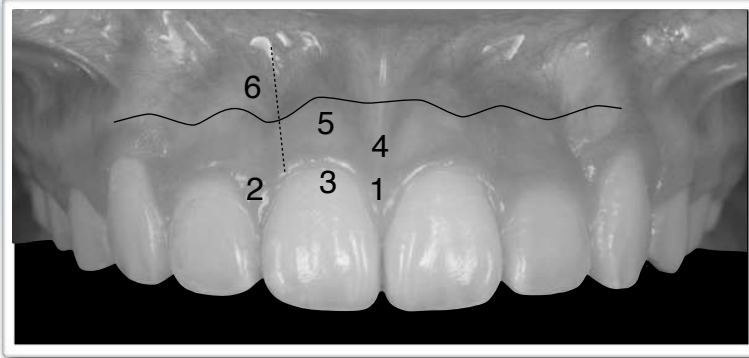
INSTRUCTIONS: Place score beside each deficient tooth and enter total score for each parameter in the white box. Mark extracted teeth with "X". Second molars should be in occlusion.

IBOI Pink & White Esthetic Score

Total Score = 3

1. Pink Esthetic Score

Total = 0



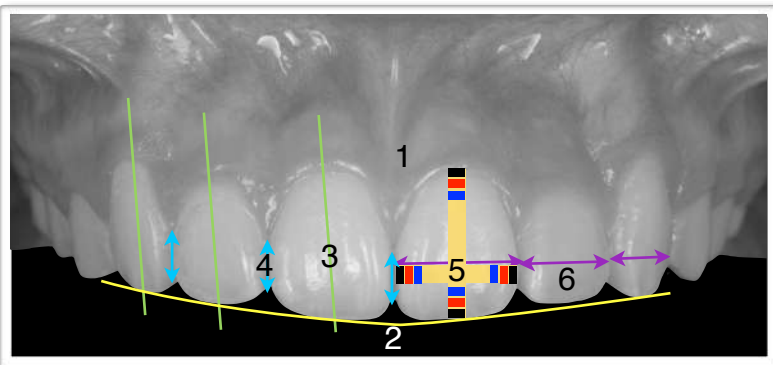
1. M & D Papillae	0	1	2
2. Keratinized Gingiva	0	1	2
3. Curvature of Gingival Margin	0	1	2
4. Level of Gingival Margin	0	1	2
5. Root Convexity (Torque)	0	1	2
6. Scar Formation	0	1	2



1. M & D Papillae	0	1	2
2. Keratinized Gingiva	0	1	2
3. Curvature of Gingival Margin	0	1	2
4. Level of Gingival Margin	0	1	2
5. Root Convexity (Torque)	0	1	2
6. Scar Formation	0	1	2

2. White Esthetic Score (for Micro-esthetic)

Total = 3



1. Midline	0	1	2
2. Incisor Curve	0	1	2
3. Axial Inclination (5°, 8°, 10°)	0	1	2
4. Contact Area (50%, 40%, 30%)	0	1	2
5. Tooth Proportion	0	1	2
6. Tooth to Tooth Proportion	0	1	2



1. Midline	0	1	2
2. Incisor Curve	0	1	2
3. Axial Inclination (5°, 8°, 10°)	0	1	2
4. Contact Area (50%, 40%, 30%)	0	1	2
5. Tooth Proportion	0	1	2
6. Tooth to Tooth Proportion	0	1	2

2023-2024 第十五年度 貝多芬 矯正精修班



時間：週二上午 09:00-12:00

地點：金牛頓教育中心（新竹市建中一路 25 號 2 樓）

上課日期：

2023 4/18、5/16、6/13、7/11、8/15、9/12、10/3、11/7、12/19

2024 1/9、3/12

- ▶ 09:00 ~ 10:00 精選文獻分析
- ▶ 10:00 ~ 10:30 精緻完工案例
- ▶ 10:50 ~ 12:00 臨床技巧及常犯錯誤分享

全新的第十五年度 2023-24 貝多芬精修班，是由國際知名講師張慧男醫師主持，並偕同貝多芬牙醫團隊住院醫師群共同主講。

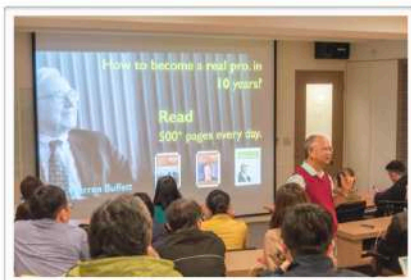
每月一次的課程之中，包含了：

1. 精選矯正權威期刊 AJODO 的文章做文獻分析與評讀。
2. 精緻完工 ABO 案例報告，其中因應數位矯正的世界趨勢，Insignia 與 Invisalign 病例為課程探討的主要內容之一。
3. 分享臨床上常犯的錯誤以及解決方法。

2023-24 貝多芬精修班內容豐富精彩，讓您經由每個月一次的課程，在面對各式的臨床案例時，更能游刃有餘、得心應手。

學習目的：

研讀最新趨勢文章可以窺知世界文獻公認的治療方式，而藉由評論文章的優缺點不僅能夠訓練判斷與思考能力，更可以清楚比較作法上的不同，達到完理解治療方向、內容與穩定性的目標。



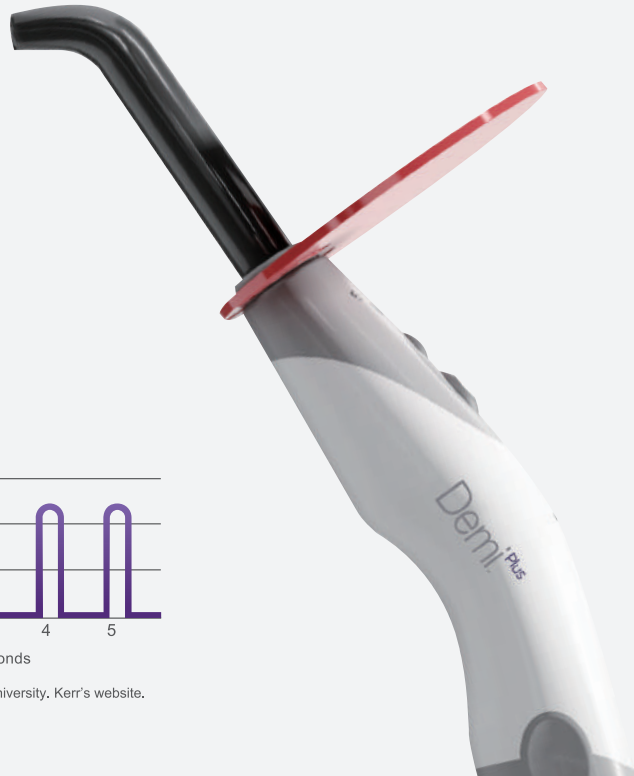
報名專線：03-5735676 #218 陳小姐

CURING LIGHT

Demi Plus 120V Curing Light

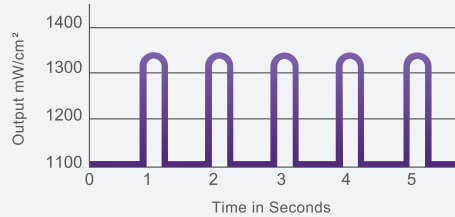
LED Light Curing System

- ⌚ True 5-second cure for A3 or lighter shades.
- ✳️ Extended Light Guide +28% additional reach.
- ✍️ Lightweight, ergonomic design.
- 🔋 Advanced Battery Design.
- ✳️ Fan-Free for improved Cooling System.



PLS Technology with 5-Second Exposure

Demi Plus employs the power of Periodic Level Shifting, or PLS technology, Shifting output intensity from 1100 mW/cm² to a peak of 1330 mW/cm², curing cycle with a wavelength of 450 nm to 470 nm.



Source: Nova Southeastern University, Kerr's website.



定價NT\$65,000/支
買1送1

CEMENT

NX3 Dual-Cure Syringe

Universal Adhesive Resin Cement



定價NT\$3,800/5g/支
買3送1 | 買10送6

NX3 Light-Cure Syringe

Universal Adhesive Resin Cement



定價NT\$3,200/1.8g/支
買3送1 | 買10送6

Maxcem Elite™ Refill

Self-Etch, Self-Adhesive,
Universal Resin Cement



定價NT\$6,100/10g/2支/盒
買3送1 | 買10送6

Maxcem Elite™ Chroma Refill

Self-Etch, Self-Adhesive,
Universal Resin Cement with
Cleanup Indicator



定價NT\$6,100/10g/2支/盒
買3送1 | 買10送6

Silane Primer Refill

Indirect Composite Bonding Agent,
application to metal free surface
before bonding



定價NT\$3,300/5ml/瓶
買3送1 | 買10送6

TEMPORARY CEMENT

Temp-Bond™ Tube / NE

Temporary Dental Cement



定價NT\$2,000/盒
買2送2

BONDING AGENTS

Optibond™ FL Bottle Kit

4th Total-Etch
Two-Component, 48% Filled Adhesive



定價NT\$9,400/16ml/2瓶/盒
特價NT\$6,000/盒

Optibond™ S Bottle Refill

5th Total-Etch
Single-Component Adhesive



定價NT\$3,200/6ml/瓶
特價NT\$1,550/瓶 | 5瓶以上NT\$1,450/瓶

Optibond™ Universal Bottle Refill

8th Self-Etch
Single-Component
Universal Adhesive



定價NT\$3,600/5ml/瓶
特價NT\$1,750/瓶 | 5瓶以上NT\$1,650/瓶

Optibond™ Extra Universal Bottle Kit

9th Two-Component Universal Adhesive
One Brand. One Protocol. Any Procedure.



定價NT\$7,500/10ml/2瓶/盒
特價NT\$5,500/盒

Gel Etchant Refill

37.5% Phosphoric Acid Gel



定價NT\$3,100/9g/3支/盒
買3送1 | 買10送6

OPTIBOND™ FAMILY

	Optibond™ FL	Optibond™ S	Optibond™ Universal	Optibond™ eXTRa
Generation	4th Generation	5th Generation	8th Generation	9th Generation
System	2 Bottle	1 Bottle	1 Bottle	2 Bottle
Volume	8ml/bottle	6ml/bottle	5ml/bottle	5ml/bottle
Filler	48%	15%	7%	15%
Film Thickness	Not Indicated for Indirect	5-10 microns	5-10 microns	5-10 microns
Etch	Total-Etch	Total-Etch	Self-Etch, Total-Etch	Self-Etch, Total-Etch
Delivery	Bottle, Unidose™	Bottle, Unidose™	Bottle, Unidose™	Bottle, Unidose™
Recommend	The Gold Standard Best for IDS	Optimal Simplification Steps for Total-Etch	Aesthetic with Harmonize Composite	Best with NX3 Cement for BPR



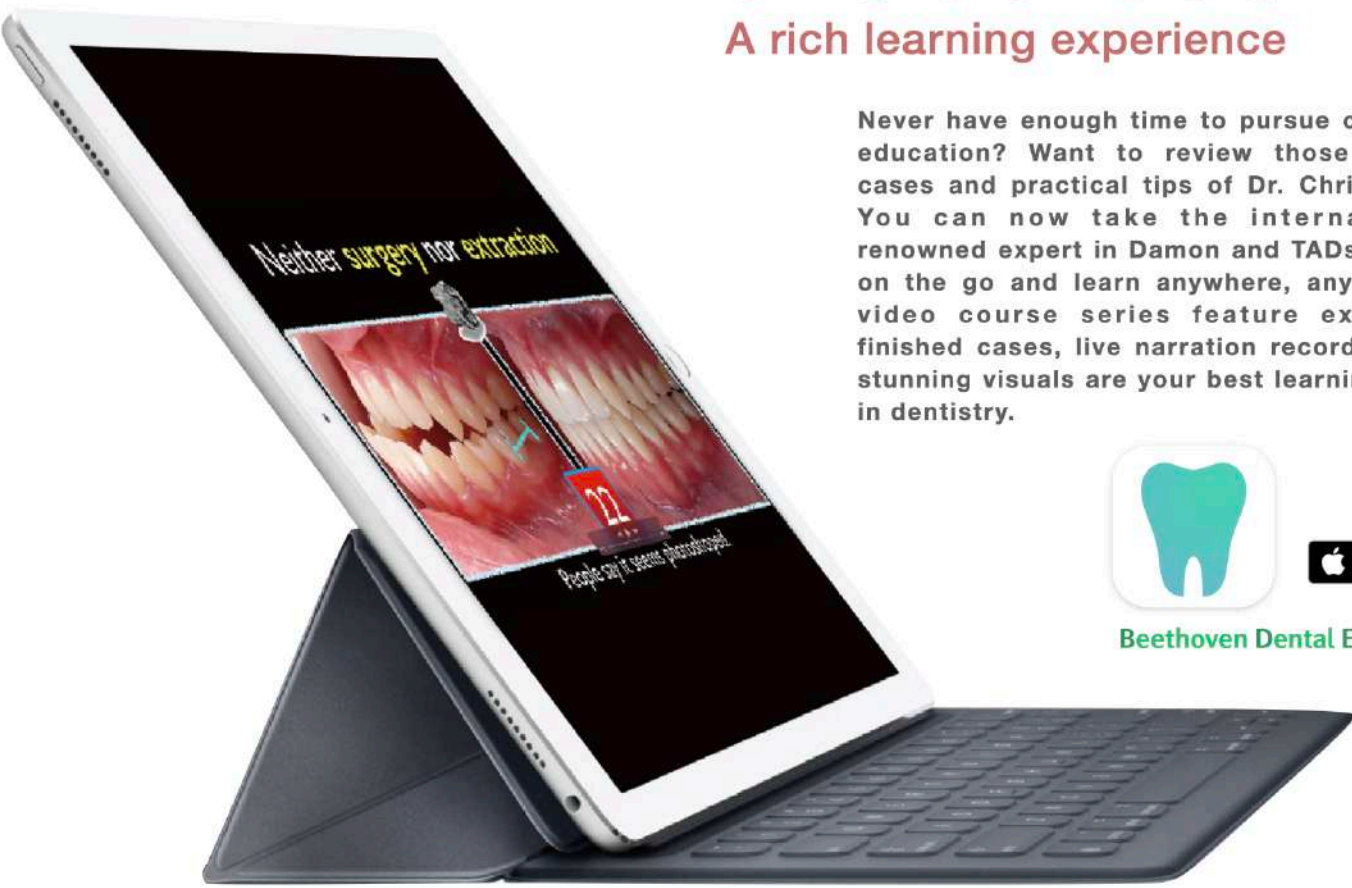
e-Courses

A rich learning experience

Never have enough time to pursue continuing education? Want to review those amazing cases and practical tips of Dr. Chris Chang? You can now take the internationally renowned expert in Damon and TADs with you on the go and learn anywhere, anytime. The video course series feature excellently finished cases, live narration recordings, and stunning visuals are your best learning source in dentistry.



Beethoven Dental E-Learning



Series Each video course is valid for 3 years



Damon Master



E-Lecture



OBS (TAD)



Finishing
(14 seasons)



Implant Forum
(9 seasons)



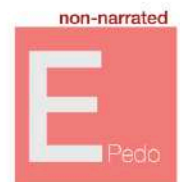
Assistant



E-Ortho



E-Implant



E-Pedo

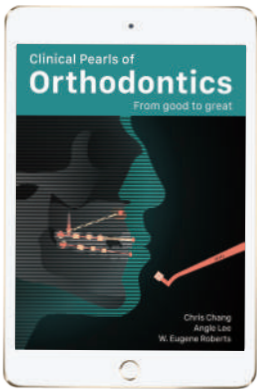
Note:

1. Most video courses are available in both English and Chinese and are sold separately.
2. Damon Master and OBS (TAD) are renewed annually and each renewal is to be purchased separately with a 50% discount.

e-Books

Learn it your favorite way!

Best of all



+ BUY BOOK

This book requires iBooks 3.0 or later and iOS 5.0 or later.

The World's Best e-Textbook

Beethoven Dental Encyclopedia e-Books collection

Beethoven Orthodontic and Implant Group has been publishing the International Journal of Orthodontics and Implantology since 2007. This Journal features excellently finished case reports evaluated by objective grading systems.

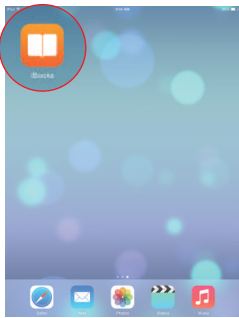
The Orthodontics and Implant Dentistry eBook series is a special selection of exciting cases with interactive functions and multimedia resource. Once opening this book, your understanding of dentistry will never be the same!

Now available in **iBooks Store** in **51** countries:

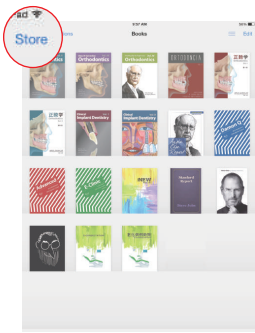
Argentina, Australia, Austria, Belgium, Bolivia, Brazil, Bulgaria, Canada, Chile, Colombia, Costa Rica, Cyprus, Czech Republic, Denmark, Dominican Republic, Ecuador, El Salvador, Estonia, Finland, France, Germany, Greece, Guatemala, Honduras, Hungary, Ireland, Italy, Japan, Latvia, Lithuania, Luxembourg, Malta, Mexico, Netherlands, New Zealand, Nicaragua, Norway, Panama, Paraguay, Peru, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom, United States, and Venezuela.



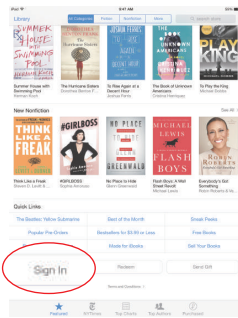
Step-by-step Instructions



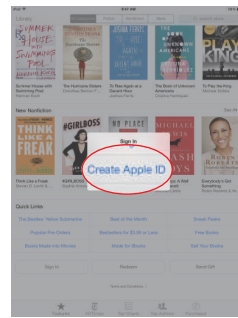
1. Launch "iBooks" app on your iPad.



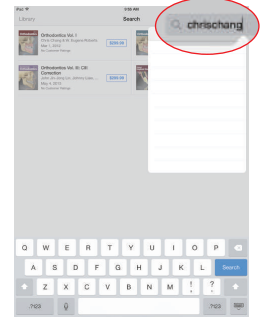
2. Click "Store."



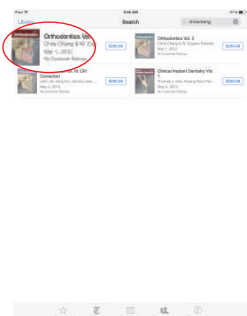
3. "Sign in" with your Apple ID.



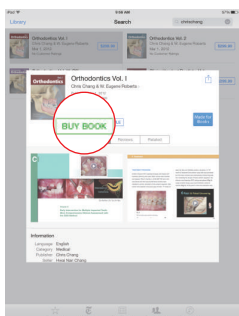
4. "Create Apple ID" if you don't have one.



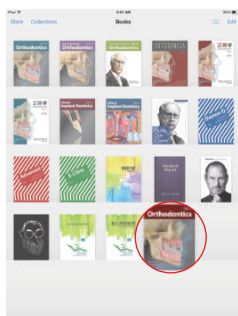
5. Search for "chrischang."



6. Click the book's icon.



7. Check the price and click "BUY BOOK."



8. Once downloaded, click the book's icon to launch the e-book and enjoy.

If you are interested in our paid video or medical products, contact newton.dental@gmail.com for more information.

+886-3-573-5676

orthobonescrew.com

iNewton