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A to Z ORTHODONTICS

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ORTHODONTIC MCQ

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Malocclusion

1. Malocclusion means –

Normal alignment of teeth

Irregularities of teeth

Carious teeth

Misaligned teeth with traumatic bite

open bite

2. Main cause of malocclusion –

Misalignment of teeth within jaw

Disproportion between jaw size & tooth size

Tumors of mouth

Fracture of the bone

Crowding & spacing

3. Classification of malocclusion helps in –

Diagnosis & treatment planning for the patient

Communicating

Identifying the chronic disease of mouth

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Identifying the various malocclusion

Identifying the problem of irregular tooth

4. When crown of lower central incisor is placed lingually but root is in its normal position, then it's called –

Lingual inclination

Lingual tipping tooth

Lingual tilting of tooth

Retroclination

Proclination

5. When both crown & root of a tooth is incorrectly positioned, it's called –

Displacement

Bodily movement of tooth

Tipping movement of tooth

Rotation

Translation

6. When a tooth is partially erupted & yet not reached occlusal plane, then it's called –

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Infra version

Supra occlusion

Infra occlusion

Inter occlusion

Intra occlusion

7. When 2 teeth have reversed their position, it's –

Interchange

Transposed

Imbrications

Rotation

Reverse cross bite

8. Malocclusion of dental arches take place in 3 planes which are –

antero-posterior, horizontal, vertical

vertical, sagital, transverse

antero-posterior, vertical, transverse

mandibular, vertical, sagital

horizontal,vertical,transverse

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9. Maxillary posterior teeth occlude in central fossa of mandibular teeth –

Reverse cross bite

Cross bite

Edge to edge bite

Incomplete overbite

Open bite

10. When incisal edge of lower incisors touch in palate, it's called –

Traumatic bite

Increased deep bite

Excessive overbite

Incomplete deep bite

Complete over bite

11. When upper & lower incisors occlude edge to edge, then it's called –

Edge to edge bite

Incomplete overbite

Class III malocclusion

Normal occlusion

Reversed over bite

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12. Keys of angle's classification are –

1st permanent molar

Antero-posterior relationship

Classification of malocclusion

Normal occlusion

Class I canine relationship

13. What occurs in case of class II division 2 malocclusion –

Upper central incisors are retroclined & lateral incisors are proclined

Upper incisors are retroclined but canines are proclined

Upper jaw proclined & lower jaw retroclined

Upper incisors are retroclined & lateral incisors are proclined & rotated with increased overbite

Mandibular proclinations.

14. Which is not the drawback of angle's classification –

When 1st permanent molar is extracted

Can't applied on deciduous dentition

Only based on antero-posterior relationship

Skeletal & dental malocclusions are differentiated from each other

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Incisor relationship is discussed

15. In case of class III malocclusion –

Overjet & overbite is zero

Overjet & overbite is reduced

Overjet & overbite is increased

Overjet & overbite may reversed

Deep bite present

16. In case of class II division 1 malocclusion lips are –

Incompetent

Competent

Potentially competent

Lower lip line is usually low & upper lip is short

Lower lip line is high & firmly attached

17. Which occlusal features are true in case of class II division 1 malocclusion –

Overjet & overbite increased with open bite

Overjet increased, overbite incomplete, unilateral crossbite

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Overjet increased but overbite reduced

Over bite & over jet is zero

Incomplete over bite & over jet

18. Main objective of class II division 1 treatment is –

The alignment & retraction of lower labial segment

Both arch alignment

Alignment & retraction of upper labial segment

Extraction of 4 4

to improve the aesthetics & the function of the teeth & jaws

19. Reduction of overbite is done by –

Posterior bite plane

Anterior bite plane

Both anterior & posterior bite plane

Anterior bite plane with adam's clasp

Labial bow with springs.

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20. In case of class II division 2 malocclusion, overbite, overjet & crossbite are –

overjet↑, overbite↓ & crossbite present

overjet↑, overbite complete & crossbite present

overbite & overjet↓ unilateral crossbite

overbite & overjet reversed & crossbite absent

overjet↑, overbite normal & crossbite present

21. In case of class II division 2 malocclusion FMA angle may be–

High

Low

Medium

Normal

Increased

22. Mandibular posture path of closure in case of class II division 2 –

May be endogenous path of closure

Forward path of closure

Backward path of closure

Downward path of closure

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Upward path of closue

23. If dental base is short & 8 8 present, for distal movementof 6 6, what will you do?

4 4 & 5 5 extraction

7 7 extraction

8 8 extraction

Both 7 7 & 8 8 extraction for more space

Only 4 4 extraction

24. In severe case of class II division 2 malocclusion, treatment is done in upper & lower arch by

Removable appliance

Myofunctional appliance

Fixed appliance

Andersen's appliance

Initially removable,then fixed appliance

25. In case of class III malocclusion, overjet & overbite are –

Increased

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Zero

Reduced

2 – 3 mm

reversed

26. In case of class III malocclusion, the upper incisors are –

Proclined

Retroclined

Spaced

Rotated

Normal

27. In case of reverse overjet but increased overbite –

Posterior bite plane may be incorporated

Anterior bite plane may be used

Labial is used for leveling the lower labial segment

Fixed appliance is used

Posterior bite plane with Adam's

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28. Severe class III malocclusion due to maxillary deiciency is treated by –

Mandibular set back procedure

Maxillary advancement procedure

Le fort – I osteotomy

Le fort – III osteotomy

Le fort – II osteotomy

Tooth movement

29. The term refers to tooth movement around its long axis called-

displacement

rotation

imbrications

spacing

transposition

30. Transposition means-

condition where two teeth have reversed their position

overlapping of adjacent teeth

where both crown & root of the tooth is incorrectly position

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where upper &lower teeth are retarded

upper & lower teeth reversed their position

31. Over jet increased in-

normal occlusion

class II case

class III case

pre-normal occlusion

ideal occlusion

32. What is over bite?

vertical overlapping of upper & lower anterior

horizontal overlapping

lack of vertical overlapping

all above

neither one

33. When the maxillary post teeth placed completely inside or outside of mandibular teeth called-

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cross bite

sicissors bite

deep bite

reverse cross bite

open bite

34. Close bite seen in-

class I malocclusion

class II division 1 occlusion

class II division 2 occlusion

class III malocclusion

normal occlusion

35. In class III malocclusion over jet?

normal

increased

decreased

zero

reversed

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36. Causes of pseudo class III malocclusion

occlusal prematurity

premature contact of deciduous posterior

a child with enlarge adenoid

gingivitis

tongue thrusting

37. Effect of tongue thrust-

retroclination of anterior teeth

decreased over jet

proclination of anterior teeth

spacing of teeth

crowding

38. Preventive treatment of crowding

extraction of 4/4

correction of thumb sucking

space maintainer

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ext of supernumerary teeth

disking

39. Mid line diastema can be correct by using-

palatal finger spring

self supporting buccal spring

pin & tube appliance

coffin spring

modified labial bow

40. Developed anterior cross bite can be treated by-

Z spring

posterior bite plane

expansive screw

quad helix

coffin spring

41. Cross elastic use to correct-

over bite

single tooth cross bite

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open bite

deep bite

edge to edge bite

42. The adaptive movement of the mandible in order to achieve normal occlusion called-

replacement

median diastema

deviation

central line shifting

spacing

43. Box elastic use for the correction of-

cross bite

deep bite

open bite

reduced over bite

reduced over jet

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Tissue change in orthodontics

44. Biology of tooth movement can be divided into three types. They are –

a. Physiologic

b. Pathologic

c. Migration

d. Orthodontic

e. Inclination

45. Which statement is correct for Physiologic tooth movement-

a. This is normal or reduction in nature

b. Minor changes of tooth position in growing persons and adults

c. Slight tipping of tooth occur in the socket during functioning

d. Changes of tooth position in young person's during and after tooth eruption

e. Changes occur when ever pressure is applied

46. Types tooth movement are –

Tipping movement

Bodily movement

Mesial movement

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Distal movement

Depression movement

47. Tilting movement means –

a. Root moves in opposite direction of crown.

b. Only removable appliance is required.

c. Root and crown moves in same direction.

d. 25-30 gm force is required.

e. Functional appliance is required.

48. Which statement is correct for elongation of tooth movement –

Tooth moves towards the occlusal plane.

Tooth moves towards the socket.

Tooth moves around the long axis.

Multiband technique is required.

50-75 gm force is required.

49. Which statement is correct for Rotation movement –

Tooth moves towards the occlusal plane.

Tooth moves towards the socket.

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Tooth moves around the long axis.

Force is required 50-75 gm.

Force is required 100-125 gm.

50. Which statement is correct for bodily movement –

Root moves in opposite direction of crown.

Root and crown moves in same direction.

A strong anchorage is required.

Multiband technique is required.

Functional appliance is required.

51. Which statement is correct for torque movement –

The movement of root without causing significant of movement of the crown.

The movement of root with causing significant of movement of the crown.

Resorption more in extensive apical areas.

Force is required 50-60 gm.

Force is required 100-120 gm.

52. Which statement is correct for 1st degree of biologic reaction –

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Gentle force.

Short duration of time.

Produce ideal tissue change.

No tooth movement.

Tooth movement without tissue damage.

53. Which statement is correct for 2nd degree of biologic reaction –

Gentle force.

Force does not exceed capillary blood pressure.

Produce ideal tissue change.

No tooth movement.

Tooth movement without tissue damage.

54. Which statement is correct for 3rd degree of biologic reaction –

Firmly strong force.

Force exceeds capillary blood pressure.

Reversible tissue damage

Irreversible tissue damage

Strangulation of apical vessels may lead to pulp dead.

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55. Which statement is correct for 4th degree of biologic reaction -

Strong force

Crushes and tear the pdl

Reversible tissue damage

Irreversible tissue damage

Strangulation of apical vessels may lead to pulp dead.

56. What are the change occur when a force is applied to a tooth –

In pressure area bony resorption occur

In pressure area bony deposition occur

Deposition of bone occur in tension side

New bone formation occur in tension side

Neutralization of force not occur tooth movement

57. Regarding of tissue change in mild force-

Force is 25-30 gm

Tension & pressure area produce in periodontium

Low degree of herperaemia seen

Decrease cellular activity

Increase production of osteoclast.

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58. What are the change occur in pressure side due to mild force -

PDL are stretched

Blood vessel are patent

Decreased capillary blood supply

Proliferation of cellular activity

Bone resorption occur

59. What are the change occur in tension side -

PDL are compressed

Increased vascular supply

Decreased cellular activity

Deposition of bone occur

Formation of new bone

60. What are the change occur in pressure side due to heavy force –

Crushing of PDM

Blood vessel are ruptured

PDL become cellular

Resorption of bone

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Resorption of bone fail to occur

61. What are the change occur in tension side due to heavy force -

PDF are over stretched

Blood vessel are occlude

Resorption of bone occur

Deposition of bone occur

Loosening of tooth occur

62. Which statement is correct for rapid movement of tooth -

Old age of the patient

Depend on the spongy bone

Distal movement of tooth

When ideal force is applied

Bodily movement of tooth

63. Which statement is correct for slow movement of tooth -

Young age of the patient

Depend on the compact bone

Distal movement of tooth

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When ideal force is applied

Intrusion movement of tooth

Fixed appliance

64. Which statement is correct for fixed appliance -

Attachment are not fixed to the teeth

Attachment are fixed to the teeth

This device can be removes by the patient

Force applied by muscle and bones

It allows three dimensional control of teeth

65. Passive component of fixed appliance –

Separator

Box elastic

Eyelets

Lock pins

Lingual buttons

66. Active component of fixed appliance –

Arch wire

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Cross elastics

Lingual cleats

Ligature wire

Eyelets

67. Which statements are correct for advantage of fixed appliance –

Multiple tooth movement are done at a time

Treatment cost is expensive

All type of tooth movement are done

Maintain good oral hygiene

Residual space close is excellent

68. Which statements are correct for limitation of fixed appliance –

Fixed appliance is complex

Required special training

Maintain good oral hygiene

Residual space close is not possible

Only bodily movement is possible

69. Which statements are correct for molar band –

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These are passive appliance

It helps in retention

Arch wire is attached to the band

Arch wire tube is attached to the band

These are active component

70. Which statements are correct for arch wire –

These are passive appliance

It helps in retention

Arch wire tie to the bracket by elastomer

It exert force to the teeth through bracket

These are active component

71. Which statement is correct for separators –

These are active component

These are passive component

It create space for bracket

It breaks the interdental contact

It is effective after 7 days

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72. Which statement is correct for brackets –

These are active component.

Force is transmitted from the arch wire through the bracket.

Bondable bracket indirectly attached to the teeth

Weldable bracket attached to the band

Ceramic bracket attached to the tooth by adhesion

73. Which statement is correct for elastic –

To correct median diestema by class I elastics

Distalization of canine by class III elastic

To correct open bite by cross elastic

To correct class III relation by class III elastic

To correct cross bite by box elastic

74. Which statement is correct for spring –

It is an active component

To correct tipping by uprighting spring

To correct rotation by whip spring

To close the space by open coil spring

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To open the space by close coil spring

75. Which statement is correct for tip back bend –

This bend given in arch wire

Attached to the molar band

To prevent anchorage loss

This bend resist mesial tipping

It helps to increased overbite

76. Which statement is correct for toe in bend –

Inward bend given in molar band

To prevent anchorage loss

Resist mesio lingual rotation

Resist mesial tipping

Inward bend given in arch wire

77. Which statement is correct for 1st order bend –

small bend given in arch wire

this bend gives in horizontal plane

this bend gives in vertical plane

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to compensate outside of lateral incisors

to compensate outset of canine

78. Which statement is correct for 2nd order bend –

this bend gives in vertical plane

to compensate mesio distal inclination

this bend control in anchorage

this bend gives in horizontal plane

Series of small step bend given in ligature wire.

79. Which statement is correct for 3rd order bend –

small step bend given in round arch wire

torquing bend give in arch wire

to compensate mesio distal inclination

to compensate faciolingual inclination

only root movement is possible without significant movement of crown.

80. Which statement is correct for since back –

this bend given on distal to the molar

to prevent forward movement of arch wire

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to prevent laceration of mucosa

this bend given on anterior to the molar

produce space in anterior tooth

81. Which statement is correct for tie back –

this bend given on archwire mesially to the molar tube

to prevent proclination of anterior teeth

tooth moves distally or buccaly

to resist mesio lingual rotation

to resist mesio distal inclination

82. Which statement is correct for treatment stage of fixed appliance –

alignment stage

incisors retraction stage

working stage

finising stage

retention stage

Cleft lip and palate

83. Which is correct incidence of CLP –

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Cleft lip are more frequent in boys

Cleft palate are more frequent in girls

Cleft lip are common in left side

Cleft lip are common in right side

Cleft palate are more frequent in boys

84. Which is correct etiology of CLP –

Maternal environment

Intermarriage

Radiation

Lip position

Racial

85. Which type of classification is in Kernahan & Stark's classification –

cleft of primary palate

cleft of secondary palate

cleft of both primary & secondary palate

cleft of only soft palate

cleft of secondary palate extend to hard palate

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86. Which type of classification is in Veau's classification –

Class II- cleft of secondary palate extend to hard palate

Class III- complete unilateral cleft of primary & secondary palate

Class IV- complete bilateral cleft of primary & secondary palate

Class I- cleft of secondary palate

Class V- cleft of both primary & secondary palate

87. Which type of classification is in Davis & Ritchie classification –

group I – pre alveolar clefts

group II – post alveolar clefts

group III – pre alveolar clefts

group I – cleft of lip

group II – cleft of lip and palate

88. Which type of classification is in Fogh Anderson classification –

group I – cleft of lip

group II – cleft of lip and palate

group III – cleft of lip & palate extend to incisive foramen

group II – post alveolar clefts

group III – pre alveolar clefts

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89. Which role of orthodontics treatment of CLP at neonatal stage is correct–

presurgical reposition of segment

repair of lip & palate with or without bone grafting

expansion of arch

routine orthodontic treatment

bone grafting

90. Which role of orthodontics treatment of CLP at mixed dentition stage is correct –

expansion of arch

routine orthodontic treatment

presurgical reposition of segment

repair of lip & palate with or without bone grafting

bone grafting

91. Which role of orthodontics treatment of CLP at permanent dentition stage is correct –

routine orthodontic treatment

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bone grafting

permanent retainer

presurgical reposition of segment

repair of lip & palate with or without bone grafting

92. which advantage is correct for predental treatment –

to facilitate feeding

to establish normal tongue position

to guide the tooth eruption

to establish normal lip position

to improve skeletal problem

93. Which management is done at birth of children with CLP –

initial assessment

case discussion with surgical & orthodontic teams

construction of presurgical orthopedic appliance

introduce dental care

study model at a time of lip repair

94. Which management is done at 3-6 month of children with CLP –

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introduce dental care

study model at a time of lip repair

primary surgical repair of lip

primary surgical repair of palate

primary surgical repair of lip & palate

95. Which management is done at 12 month – 2 years of children with CLP –

primary surgical repair of palate

bone grafting

study model at a time of lip repair

primary surgical repair of lip

primary surgical repair of lip & palate

96. Which management is done at 2– 6 years of children with CLP –

assessment of growth & development

tropical fluoride application

revision of lip required

maxillary expansion

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bone grafting

97. Which management is done at 6-7 years of children with CLP –

fissure sealing of 1st permanent molars

composite resin for hypoplastic teeth

preventive advise

skeletal age assessment

extraction of supernumerary teeth

98. Which management is done at 8-10 years of children with CLP –

skeletal age assessment

extraction of supernumerary teeth

assessment for maxillary expansion

surgical revision of palate

retention of palatal expansion

99. Which management is done at 11-15 years of children with CLP –

retention of palatal expansion

surgical revision if required

restoration of teeth by crown, bridge, dentures

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retention following orthodontic treatment

assessment for orthognathic surgery

100. Which management is done at 11-15 years of children with CLP –

retention of palatal expansion

surgical revision if required

restoration of teeth by crown, bridge, dentures

retention following orthodontic treatment

assessment for orthognathic surgery

Anchorage

101. Which type of anchorage is correct for according to manner of force application –

simple anchorage

compound anchorage

stationary anchorage

reciprocal anchorage

reinforced anchorage

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102. Which type of anchorage is correct for according to the number of anchorage unit –

simple anchorage

compound anchorage

stationary anchorage

reciprocal anchorage

reinforced anchorage

103. Which type of anchorage is correct for according to the jaw involved –

extraoral anchorage

intraoral anchorage

muscular anchorage

intramaxillary anchorage

intermaxillary anchorage

104. Which type of anchorage is correct for according to the site of anchorage –

extraoral anchorage

intraoral anchorage

muscular anchorage

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intraoral anchorage

interoral anchorage

105. Which type of anchorage is correct for extraoral site of anchorage –

cervical

occipital

cranial

frontal

parital

106. Which source is correct for intraoral source of anchorage –

size & number of root

root length

inclination of tooth

distalization of tooth

tongue

107. Which source is correct for extraoral source of anchorage –

cranium

back of the neck

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facial bones

frontal

occipital

108. Which example is correct for reciprocal anchorage –

arch expansion

pin & tube appliance

mid line diestema

midline shifting

flat bite plan

109. Which example is correct for reinforced anchorage –

anterior inclined bite plan

transpalatal arch

arch expansion

pin & tube appliance

mid line diestema

110. Which statement is correct for detect of anchorage loss –

position of anchor teeth

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increased overjet

inclination of anchor teeth

increased overbite

not fit the appliance in the mouth

111. Which statement is correct for increase anchorage value –

intermaxillary traction

inclined bite plane

extraoral traction

intraoral traction

flat bite plane

112. Which statement is correct for anchorage loss & sign –

mesial movement of molars

proclination of anterior teeth

spacing of teeth

distal movement of molars

retraction of canine

113. Which statement is correct for prevention of anchorage loss –

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by moving minimum number of teeth at a time

by using gentle force per single rooted tooth

by perfect fitting of the appliance in the mouth

by moving maximum number of teeth at a time

by using strong force per single rooted tooth

Myofunctional appliance

114. Which statement is correct for myofunctional appliance –

it is an active appliance

it is loose fitting appliance

forces are natural

force transmit to the bone by muscle

it allows control of force

115. Which component is correct for functional appliance –

the lips

the ligaments

the perioosteum

facial bones

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frenum

116. Which is correct for principal of treatment of myofunctional appliance –

force application

force elimination

duration of force

direction of force

amount of force

117. Which are examples of myofunctional appliance –

flat bite plane

oral screen

bionator

headgear

chin cap

118. Which example is correct for tooth borne passive appliance –

bionator

herbst

twinblock

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expansion screw

oral screen

119. Which example is correct for tooth borne active appliance –

modification of activator

expansion screw

functional regulator

oral screen

bionator

120. Which example is correct for tissue borne passive appliance –

functional regulator

oral screen

modification of activator

expansion screw

herbst

121. Which statement is correct for activator -

t is a myofunctional appliance

it is a tooth borne passive appliance

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it activates the musculatures

it is a tissue borne passive appliance

it is fixed functional appliance

122. Which example is correct for indication of activator –

class II division 1 malocclusion

class I deep bite case

in mild class III cases

severe class III cases

anterior open bite cases

123. Which example is correct for contra indication of activator –

severe class III cases

anterior open bite cases

severe crowing cases

class I deep bite cases

adult patient where growth is not complete

124. Which example is correct for indication of bite plane –

deep bite

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cuspal interference

decreased lower facial height cases

high FMA cases

severe protrusion cases

125. Which example is correct for contraindication of bite plane –

high FMA cases

severe protrusion cases

increased lower facial height cases

deep bite cases

cuspal interference

126. Which statement is correct for Sved bite plane –

it is a tooth borne active appliance

it is used to prevent proclination of anteriors

it also helps to reinforced anchorage

it is used to open bite cases

it is a tooth borne passive appliance

127. Which example is correct for indication of posterior bite plane –

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to give occlusal clearance

for diagnosis of occlusal prematurities

it is used to prevent proclination of anteriors

it also helps to reinforced anchorage

it is used to open bite cases

128. Which example is correct for indication of anterior inclined bite plane –

guide the mandible forward

proclination of retrocline lower anteriors

reduction of overbite

it is used to prevent proclination of anteriors

it also helps to reinforced anchorage

129. Which example is correct for indication of oral screen –

thumb sucking

lip biting

tongue thrusting

correction of reduce overbite

correction of retrocline anteriors

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130. Which statement is correct for frankel appliance –

it is a functional appliance

it is a tissue borne passive appliance

it regulates & correct abnormal perioral muscle.

it is a tissue borne active appliance

it is fixed functional appliance

Dentofacial orthopedics

131. Regarding of orthopedic force

it is a extra oral heavy force

force is about more than 400 gm

change the direction of bony growth

it is an intra oral heavy force

change the direction of teeth

132. Which statement is correct for effect of orthopedic force-

force is continuous

rapid tooth movement is possible

force applied about 10-12hours/day

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force is intermittent or interrupted

total effect on bones

133. Treatment result depends on of orthopedic force are –

amount of force

duration of force

age of the patient

depend on anchorage

amount of bones

34. Which example are orthopedic appliances –

headgear

chin cap

face musk

bionator

oral screen

135. Which statement is correct for head gear –

it is an orthopedic appliance

force is about more than 300gm

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used to distalize the maxillary dentition

most effective in pubertal period

anchor unit is maxilla

136. Which component is of orthopedic appliance

force delivering unit- face bow

force generating unit- elastic

anchor unit- neck strap, head cap

anchor unit- maxilla, mandible

force delivering unit- head gear

137. Which statement is correct for chin cap –

it is an orthopedic appliance

force is about more than 400gm

used to retard the growth of mandible

used to distalize the maxillary dentition

anchor unit is maxilla

138. Which statement is correct for face musk –

force is about more than 300gm

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force applied about 10-14hours/day

used to having a prognathic mandible & retrusive maxilla

anchor unit is occipital bone

used to distalize the maxillary dentition

139. What is the meant by the term Anchorage?

Resistant to unwanted tooth movement.

Resistant to reaction forces.

Efficient orthodontics-maximizing tooth movement & minimize “reactionary efforts”.

Resistant to desired tooth movement.

Efficient for maximum tooth movement

140. What are the methods of reinforced anchorage?

Screw

Retromolar implant

More orthodontic pressure

Cervical head gear

Size and number of the root

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141 # . What are the potential advantages of functional appliance?

Reduce or eliminated by functional habit

Influence growth pattern

Possibly avoid surgery

It can be used in adult patients whom growth has ceased

It can be used in severe crowded teeth

141. The characteristics of the “Mandibular hypoplasia”are-

Lack of height of the vertical ramous

Prominent progonial notch of lower border of mandible

Ankylosis or limitation of movement

Elevation of occlusal plane

Wasting of one half of the face,orbit,maxilla etc.

142. The following specialists are not the team members of cleft lip and palate-

Orthodontics

ENT surgeon

Orthopedic surgeon

Pediatrician

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Nutritionist

143. Which statements are true in cleft lip and palate cases-

most cleft lip are repaired between 3-6 months

German measles or acute viral injection during early pregnancy

Exposure of radiation during early stage of pregnancy

Both cleft lip and palate repair at 3-6 month

Primary cleft in vole/extend lip,alveolous up to the soft palate

144. Vestibular screen is-

used to perform muscle exerciser

mild distal-occlusion can be treated

work on principle both force application and force elimination

not used as a habit breaking appliance

anterior proclination cannot corrected by oral screen

145. Indication of functional appliance-

posterior position mandible

well align dental arch

lingual tipping mandibular incisor

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proclination of lower incisore

excessive vertical mandibular growth

Orthodontic diagnosis

146. Orthodontic diagnosis deals with –

Characteristics of malocclusion

Recognition of various characteristics of malocclusion

Essential clinical examinations

Collection of pertinent data & identifying the cause of malocclusion

Clinical problem of teeth

147. Brachycephalic means –

Broad & short shape head

Broad dental arch

Broad & short face form

Long & narrow face form

Narrow dental arch

148. Dolichoprosopic means –

Broad & short shape of the head

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Long & narrow face form

Broad & narrow shape of the head

Long & narrow dental arch

Broad dental arch

149. Facial asymmetry is seen –

Behind the patient

Infront of the patient

Face to face of the patient

Beside the patient

At the level of the patient

150. Facial asymmetry may cause due to –

Hemi facial hyperplasia

Condylar abnormalities

Spacing of the teeth

Class III malocclusion

Class II malocclusion

151. Facial profile is examined by –

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Standing in front of the patient

Standing at 9 o'clock to the patient

Standing beside the patient

Sitting on the side of the patient

Standing behind the patient

152. If the point A is behind & pogonion is forward then it is called

Concave profile

Class III type of malocclusion

Maxillary prognathism

Class II type of malocclusion

Class I type malocclusion

153. Skeletal pattern is assessed by –

Both SN & FH plane

Both anterioposterior plane & vertical plane

FH plane

SNA & SNB angles

FM angle & anteriorposterior plane

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154. Vertical plane is assessed by –

The Frankfurt Horizontal plane & Mandibular plane

SNA

The Frankfurt Mandibular plane angle

The Frankfurt Ramal plane angle

FM angle

155. High FMA form when –

Two planes meet infront of the ear

Two planes meet just behind the ear

Two planes meet in the mastoid region

Two planes meet at the occipital region

Two planes meet behind the occipital region

156. Two finger tests is –

Clinical test by which class I & II case can be detected

Anatomical test by which class I, II, III case can be detected

Clinical test by which class I, II, III case can be detected

Orthodontic test by which crowding can be detected

Clinical test by which all types of malocclusion can be detected

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157. In 2 fingers test if fore finger is 2-3 mm ahead of the middle finger then –

Class II malocclussion

Class I malocclussion

Normal occlussion

Ideal occlusion

class III malocclusion

158. Potentially competent lips are normal lips but fail to form lip seal due to –

Proclination of insicors

Openbite

Proclination of upper incisors & retroclination of lower incisors

Retroclination of upper incisors & proclination of lower incisors.

Nasal obstruction

159. In normal lips have –

Minimal tonicity present

Maximal tonicity present

Tonicity absent

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Weak muscular tonicity

Normal muscle tonicity present

160. When naso – labial angle is reduced –

In class III malocclusion division 2

Prognathic maxilla & retrognathic mandible

Maxillary anterior teeth proclination

In class III malocclusion

Normal occlusion

161. Mento – labial sulcus is shallow –

Normal occlusion

Normal occlusion but both jaws are protruded

Class II division 1 case

Bimaxillary protrusion

Class II division 2 case

162. Upper labial frenum may cause –

Midline diastema

Midline shifting

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Spacing inbetween upper anterior segment

Spacing in between 2 central incisors

Spacing in lower jaw

163. Abnormal lingual frenum is called –

partial ankyloglossia

ankylosia

tongue tie

Macroglossia

Tongue thrusting

164. Macroglossia is indicated by –

Imprints of the teeth at the lateral margin of the tongue

Generalized proclination with spacing

Generalized crowding

Generalized spacing

Retroclination

165. Presence of swelling in the palate indicates –

Impacted tooth

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Cyst

Oral pathosis

Muscular ulceration

Gingivitis

166. Mucosal ulceration causes –

Traumatic deep bite

Gingivitis

Open bite

Cross bite

Incomplete over bite

167. In which case overjet & overbite both increased –

Class III malocclusion with spacing

Class II division 1 malocclusion with deep bite

Class I malocclusion with deep bite

Class II division 2 malocclusion with deep bite

Crowding

168. Conditions which do not lead to altered path of closure –

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Occlusal prematurity

Class III malocclusion with unilateral cross bite

Class II division 2 malocclusion with open bite

Class I malocclusion with spacing

Open bite

169. Study model is not used in case of –

Assessment of treatment prognosis

Mature of severity of malocclusion

Assessment of soft tissue morphology

Motivation of patient

Assessed the condition of roots

170. Secondary caries is better detected in –

Periapical view

Bitewing radiograph

OPG

Occlusal view

Study model

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171. High attached lower labial frenum causes –

Spacing in between 2 central incisors

Gingivitis

Gingival recession

Cervical abrasion

crowding

Removable appliances

172. Which of these are correct about removable appliances?

It allows less chair side time

It is fixed to the patient's mouth

Bite plane can be incorporated

Oral hygiene maintenance is difficult

Tipping movement can be done

173. Limitations of removable appliance are-

Many tooth movement can be undertaken

Multiple rotation cannot be treated

Oral hygiene maintenance is easy

Uncooperative patients are difficult to manage

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It is less expensive than fixed appliance

174. Which of these are removable appliances?

Labial bow

Adam's clasp

Banded canine to canine retainer

Palatal finger spring

Bonded lingual retainer

175. Modifications of Adam's clasp are-

Adam's clasp with soldered hook

Adam's clasp with helix

Adam's clasp with soldered palatal finger spring

Adam's clasp with soldered buccal tube

Adam's clasp with soldered arch wire

176. Which of these are clasps?

Adam's clasps

'Z' spring

Palatal canine retractor

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Eyelet clasp

'T' spring

177. Which are correct about Adam's clasp?

Arrow heads should be placed at buccoproximal undercuts

Bridge should be located at middle third of tooth

Bridge should be 8mm away from the tooth surface

Bridge should be right angle to the buccal surface

Retentive arm should not interfere with the occlusion

178. Which are not correct about 'C' clasp?

It is used for retention

It is used for proclination of tooth

It can be used only on posterior teeth

If it breaks, it cannot be repaired

It can be used on partially erupted teeth

179. Uses of labial bow are-

Derotation of the rotated tooth

Retraction of anterior teeth

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Correction of cross bite

Used for reinforcement

Retention of teeth

180. Parts of Palatal finger spring are-

Active arm

Vertical loops

Two arrow heads

Helix

Retentive arm

181. Functions of the base plate are-

it helps in retraction of teeth

it helps in correction of cross bite

it transmits the force

it acts as a vehicle and carries all the components of the appliance

it partly helps in retention

182. Which points should be considered during checking the appliance when delivery to the patient?

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active components should not press upon the gingival

look for any distortion of wire components

absence of sharp margins on the fitting appliance

check any sore spots in any region

check the tooth movement

183. Which points should be consider during insertion on first visit?

Teach the patient to wear and remove the appliance

Appliance should be worn all the time day and night

Do not remove the appliance before meals

Always use Adam's clasp for removing the appliance

Wrap the appliance with tissue paper in the pocket

184. Which points should be consider during checking the appliance on second visit?

Enquire to find out the regularity of wearing the appliance

Check the tooth movement

Teach the patient to wear and remove the appliance

Whether the springs are still active or not

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Explain the patient that initially difficulty in swallowing, speech, eating may occur

185. Which of these are correct?

Short labial bow is activated by closing the loops

Split labial bow is activated by closing the loops

Robert's retractor does not require any activation

Long labial bow is activated by readapting the self straightening wire

Fitted labial bow does not require any activation

186. Which of these are correct?

Double cantilever spring is activated by closing the coil

Single cantilever spring is activated by opening the coil

Apron spring is activated by bending the vertical limb towards the teeth

Coffin spring is activated by elongating the spring

Buccal canine retractor is activated by opening the coil

187. Which of the uses are correct?

Double cantilever spring helps to move the tooth labially

Apron spring helps to retract the teeth with severe protrusion

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‘T’ spring helps the posterior tooth to move occlusally

Coffin spring helps to expand the dental arches

Buccal canine retractor are used to procline the lingually erupted canine

188. Requirements of an ideal clasp should-

Offer adequate retention

Permit usage in both fully erupted and partially erupted teeth

It should be expensive

It should be difficult to fabricate

It should impinge on the soft tissue

189. Active components of the removable orthodontic appliances are-

Adams clasps

Bow

Springs

Elastics

‘C’ clasps

190. Elastics are used for-

Retraction of incisors

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Proclination of upper anterior segment

Correction of cross bite

Inter-maxillary anchorage

Correction of generalized spacing

191. According to labial bow, which of these are not correct?

In case of bow, right angle bends starts from mesial one third of canine

Length of the bow should be from mesial one third of the canine to the opposite mesial one third of the canine

Ending of the U loop should be below 2-3 mm from the cervical margin

Retentive arm should run through the mesially to the canine

Retentive arm should hamper the occlusion

192. Modification of the Labial bow are-

Short labial bow

Robert's retractor

Canine retractor

Single cantilever spring

Mills retractor

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193. Uses of Long labial bow are-

Closure of space distal to canine

Proclination of the posterior teeth

Distalize the molar

Minor over jet reduction

Used for retention

194. Which of these are correct about ‘Z’ spring?

It is made of 0.7 mm S.S. wire

It is also called ‘Single cantilever spring’

It is made of 0.5 mm S.S. wire

It is used to move the incisors labially

It is activated by closing the coil

195. Which of these are not correct about ‘U’ loop canine retractor?

It is made of 0.16 mm S.S. wire

It consists of a U loop, an active arm and a retentive arm

Base of the U loop should be 2-3 mm below the cervical margin

It is used to correct the median diastema

It is activated by closing the loop

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196. Which of these are correct?

Chair side time is prolonged in removable appliance

Components are inexpensive incase of removable appliance

Require less frequent visit for adjustment in case of fixed appliance

In case of fixed appliance- plan, preparation and adjustment is very easy

Only a single tooth can be moved by fixed appliance

Soft tissue morphology

197. Competent lips seal maintain with –

Facial muscle relaxed & mandible in active position

Facial muscles contract & mandible in rest posture

Facial muscle relaxed & mandible in resting posture

Upper & lower lips together

Facial muscle relaxed with endogenous path of closure of mandible

198. Competent lips are habitually apart due to –

Proclination of incisors

Facial muscle contraction

Nasal obstruction

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Fracture

Horizontal position of lips

199. Incompetent lips form due to –

Facial muscle expansion & mandible in rest position

Increased vertical distance between the lips

Disproportion between soft tissues & bony framework

Abnormally large lips

Nasal obstruction

200. Incompetent lip behavior depends on –

A. degree of incompetence

Muscle of facial expressions

Mandibular position

Lips posture

Lips morphology

201. Anterior oral seal means –

Instinctively & reflexly produced sealing off anterior end of digestive tract

Instinctively & reflexly produced sealing off

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Properly sealing off anterior end off the digestive tract

Sufficiently sealing off anterior end off the digestive tract

Sealing off posterior end of digestive tract

202. Moderately incompetent lip seal is maintained by –

Sustained contraction of the circum oral muscles

Sustained relaxation of the facial muscles

Resting mandible

Tongue

Circum oral muscle contraction

203. Adaptive habit postures are maintained by –

Tongue & lip in functional posture

Mandible & tongue in rest posture

Tongue, mandible & lips, rest & function as an integrated unit

Circum oral muscles

By maintain anterior oral an seal

204. In case of more incompetency the posterior oral seal is maintained –

Contact between posterior teeth & tongue

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Soft palate & ventral surface of tongue

Soft palate & dorsum of tongue

Lower lip & tongue

Dorsum of tongue & soft palate

205. On class II dental base with severe incompetency occur due to –

Increased overjet & decreased overbite

Lower lip may lie completely behind the upper lip

Increased overjet & increased incomplete overbite

Increased openbite

Reversed overjet

206. Strap like lower lip behaviors –

Lower lips retracts excessively during expressive behaviors

Lower lips rest in normal position

Lower lips contract excessively

Lower lips expand excessively

Active lower lip excessively retracted

207. Strap like lip causes –

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Proclination of lower incisors

Retroclination of upper incisors

Retroclination of lower incisors

Class II malocclusion

Class III malocclusion

208. In severe incompetency of lip anterior oral seal is maintained by –

Hard palate 7 tongue

Upper lip & tongue

Lower lip & tongue

Lingual segment & tongue

Ventral surface of tongue & lower lip

209. Everted lip morphology is associated with –

Proclination of upper incisors

Bimaxillary proclination

Proclination of upper & lower labial segment

Retroclination of lower incisors

Proclination of lower incisors

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210. When lips are competent but habitually apart due to proclination of teeth, it's called –

Incompetent lip

Potentially competent lip

Competent lip

Everted lip

Potentially incompetent lip

211. Macroglossia may cause –

Proclination of upper incisors

Bimaxillary proclination with crowding

Bimaxillary proclination with spacing

Retroclination of lower incisors

Proclintion of upper & lower anterior segment

212. When of the roof tongue held very high it causes –

Upper arch wide & lower arch narrow

Both arches wide

Cross bite

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Open bite

Traumatic bite

213. In relax position, tongue –

Lies on the roof of the mouth

On the floor of the mouth

Over the teeth

Behind the lingual aspect

Below the anterior segment of upper incisor

214. Deep palate are most commonly found in –

Mesocephalic patients

Dolichocephalic patient

Euryprosopic patient

Normal face form

Narrow dental arch

215. Abnormal function of lip 7 facial muscle is seen in case of –

Macroglossia

Microglossia

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Tongue thurst

Tongur tie

216. Horizontal distance between lips may seen in case of –

Skeletal II cases

Skeletal III cases

Skeletal I cases

Open bite cases

Normal face

217. Maxillary labial frenum can be –

Thick, fibrous & high attached

Thin, bony & low attached

Thick, fibrous & low attached

Thin, fibrous & low attached

Shortly attached, thick & fibrous

218. The inter labial gap is about –

1 – 2 mm

0 – 1 mm

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0.5 – 1 mm

2 – 3 mm

1.5-2 mm

219. Color & texture of active low lip –

Bright & rigid

Light & chapped

Reddish & rigid

Pinkish & chapped

Light reddish & chapped

220. On class I dental base with mild incompetency may cause –

Proclination of upper incisors

Incomplete overbite

Open bite

Increased overjet

Cross bite

221. How many postures of tongue are described by ballard –

3

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2

0

1

4

222. Full & everted lip produce –

Proclination

Retroclination

Bimaxillary proclination

Class III malocclusion

spacing

223. How post oral seal maintains –

Lip & tongue

Hard palate & tongue

Ventral of tongue lip

Dorsum of tongue & soft palate

Hard palate & dorsum of tongue

224. Hypertonic lips may cause –

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Retroclination

Proclination

Crowding

Spacing

Open bite

225. How anterior oral seal produce –

By contact between lips

Contact between tongue & lower lip

Contact between lip & soft palate

Contact between lip & teeth

Soft palate & hard palate

226. Effect of strap like lips is –

Lower anterior teeth may retroclined & crowded

Anterior maxilla may be protruded

Lower anterior teeth may be proclined & spacing

Chin will be prominent

Bimaxillary proclination

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227. Macroglossia occur due to –

Muscular hypertrophy

Lymphnode obstruction

Critnism

Tonsillitis

Small size of anterior teeth

228. Clinical sign of macroglossia –

Crowding of anterior teeth

Indentation of teeth at the tip of tongue

Displacement of teeth

Indentation of teeth at the side of tongue

Proclination & generalized spacing

229. A very high tongue in the roof of the mouth may cause –

Cross bite

Reverse cross bite

Crowding

Median diastema

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Wide upper arch & narrow lower arch

230. Features of abnormal labial frenum –

Frenum is thin & hard

Frenum extend from upper lip to incisive papilla

Frenum is thick, wide & fleshy than normal

It passes between central incisors & run into incisive papilla

Thick, fibrous & attached.

231. In abnormal labial frenum radiographically seen –

A – V shaped notch

A – B shaped notch

A – S shaped notch

A – M shaped notch

A - L shaped notch

232. In abnormal labial frenum which test is done? –

Blassing test

Blanching test

Bisselled test

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Blaming test

Two finger test

233. In abnormal labial frenum which surgery is done –

Frenectomy

Frenotomy

Chilotomy

Fibrotomy

Frenumtomy

234. When lip in competency is seen,it may cause –

Increased overjet

Increased but incomplete overbite

Decreased overbite

Complete overbite

Decreased over jet

235. How can we get bucco ingual force –

By lips

By cheeks

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By tongue

By lips & cheeks

By tongue & cheeks

236. How can we get the occlusal force –

By opposing lips

By opposing teeth

By mesial surface of teeth

By distal surface of teeth

By cheeks

237. In severe class II dental base relationship how the anterior oral seal is maintained –

By tongue & soft palate

By tongue & upper lip

By tongue & lower lip

By the lips

By tongue

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238. When the lower lip line is high & firmly retracting type, then what type of malocclusion is produced –

Class III malocclusion

Class I malocclusion

Class II division 1 malocclusion

Class II division 2 malocclusion

Normal occlusion

Space gaining

239. Methods of gaining space are-

Proximal stripping

Extraction

Space maintainer

Expansion

Control of abnormal habit

240. Space is required for-

Correction of median diastema

Correction of crowding

Correction of open bite

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Retraction of proclined tooth

Correction of tongue thrusting

241. In case of proximal stripping which surfaces are reduced?

Mesial surface

Buccal surface

Occlusal surface

Distal surface

Lingual surface

242. Proximal stripping is also known as-

Slenderization

Distalization

Disking

Proclination

Reproximation

243. Proximal stripping are indicated in-

Severe crowding

Deep bite cases

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Space required is minimal

Spacing of teeth

Bolton's analysis show mild tooth material excess

244. Procedure of proximal stripping are-

Inverted cone bur

Use of metallic abrasive strips

Safe sided carborundum discs

Polishing burs

Long thin tapered fissure burs

245. Due to proximal stripping-

Creates roughness of teeth

Caries susceptibility increased

Periapical lesion may develop

Sensitivity of teeth may arise

Patient feels comfortable

246. Methods of distalization are-

Head gear

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Labial bow

Sagittal appliance

Frankel appliance

Use of open coil spring

247. Which of these are correct?

Derotation of posterior teeth occupy more space than normally placed posterior teeth

Derotation is not a method of space gaining

Derotation is corrected by palatal finger spring

Derotation of posterior teeth provides some amount of arch length

Derotation is done by fixed appliance incorporating springs or elastics

248. Which of these are correct?

Proclination are done by self supporting buccal spring

Proclination of retruded anterior teeth results in gain of arch length

Labial bow helps in proclination of teeth

Proclination of anterior teeth causes deep bite

Proclination of anterior teeth are done by ‘Z’ spring

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249. In case of sagittal appliance-

A split acrylic plate joined together by a jack screw

It is one of the extra oral methods of distalization

These appliances are retained using Adam's clasps on molars and premolars

Jack screw is not used in this appliance

It can distalize only one tooth at a time

250. Rapid maxillary expansion is also known as-

Distalization

Rapid palatal expansion

Reproximation

Split palate

Slenderization

251. Rapid maxillary expansion are indicated in case of-

Posterior cross bite association with relative maxillary deficiency

Class II div 1 cases

Cleft palate patients with collapsed maxillary arch

Open bite cases

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Class III malocclusion of dental or skeletal cause

252. Effects of rapid maxillary expansion are-

No change occurs in the mid palatal suture

Opening of the mid palatal suture

Decrease of intra nasal space occurs

Midline spacing between the two maxillary central incisors

Buccal tipping of maxillary molars

253. Tooth borne fixed appliances of rapid maxillary expansion are-

Derichweiler type

Hyrax type

Hass type

Herbst appliance

Isaacson type

254. Expansion is indicated in-

Correction of malocclusion where space necessary is less than 3mms

Correction of open bite

For correction of dental cross bite

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Correction of severe crowding

Correction of mouth breathing

255. Slow maxillary expansion is done by-

Coffin spring

Double cantilever spring

Quad helix appliance

Apron spring

'T' spring

256. Rapid maxillary expansion is contra indicated in-

Cleft palate patients with collapsed maxillary arch

True unilateral cross bite

Class III malocclusion of dental or skeletal cases

If maxilla is narrow and long associated with mandibular retrognathism

If more than half of the roots of deciduous teeth are absorbed

259. Expansion is checked by-

Clinically by appearance of midline diastema

Clinically by appearance of cross bite

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Clinically no spacing occurs

Radiographically no change on mid palatal suture

Radiographically sutural widening can be observed in occlusal radiograph

260. According to rapid expansion, which of these are correct?

Type of expansion are skeletal

Rate of expansion are slow

Greater force are used

Duration of treatment are long

It should be used before fusion of mid palatal suture

261. According to slow expansion, which of these are correct?

Greater forces are used

Types of expansion are mostly dental

Rate of expansion are rapid

Duration of treatment are long

It can be done in any age

262. Methods of serial extraction are-

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Nance method

Wilkinson method

Holm's method

Dewel's method

Tweed's method

263. Which sequels are correct about serial extraction?

Nance method- Extraction of D followed by 4 and C

Dewel's method- Extraction of C followed by D and 4

Tweed's method- Extraction of D followed by 4 and C

Nance method- Extraction of C followed by D and 4

Tweed's method- Extraction of C followed by 4 and D

264. Which of these are correct?

Balancing extraction refers to removal of another tooth on opposite side of same arch

Balancing extraction refers to extraction of teeth in opposite arch

Compensating extraction refers to extraction of teeth in opposite jaws

Compensating extraction refers to removal of teeth on opposite side of same arch

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Compensating extractions are carried out to preserve the buccal occlusal relationship

265. What are the reasons for extracting teeth as a part of orthodontic treatment?

Disproportion between arch size and tooth size

Generalized spacing

Abnormal forms and size of individual teeth

Class-I malocclusion cases

Correction of sagittal inter-arch relationship

Cephalometry

266. What is the value of SNB?

82

80

76

78

84

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267. When is SNA decreased?

When maxilla is progathic in relation to anterior cranial base.

When maxilla is retrogathic

When mandible is retrogathic

When mandible is prognathic in relation to anterior cranial base.

When maxilla is retrogathic in relation to anterior cranial base.

268. The value of SNB helps us to know the -

Anterior posterior position of the maxilla in relation to anterior cranial base.

Anterior posterior position of the mandible in relation to anterior cranial base.

Prognathic mandible

Prognathic maxilla

Retrognathic mandible

269. What is facial plane?

A line from nasion to sella turcica

A line from orbitale to porion

Nasion to pogonion

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Nasion to point B

Orbitale to porion

270. A plane joining the Nasion to sella turcica is

Used in Steinar analysis

Used in Downs analysis

Frankfurt (horizontal plane)

Maxillary plane

S-N plane

271. The angle formed by Y axis and FH plane indicated which type of growth?

Average

Horizontal

Vertical

All of the above

None of the above

272. Types of cephalostats are-

Wheelers type

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Broad bent type

Highleys type

Space cephalostat

Nance type

273. Broadbent type of cephalostat uses -

2 x ray sources

1 X ray sources

2 film holder

1 film holder

1 x ray sources and 2 film holder

274. A cephalometric apparatus consist of

Head holding device

Cassette holder

X ray source

Cephalostat

Geometry box

275. SNB helps us to know the anterior posterior relation of

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Mandible in relation to FH plane

Mandible in relation to anterior cranial base

Maxilla in relation FH plane

Maxilla in relation to anterior cranial base

Mandibular prognathism and retrognathism

276. When is SNB decreased?

When mandible is retrognathic in relation to anterior cranial base

When maxilla is prognathic in relation to anterior cranial base

When maxilla is retroclined

When mandible is prognathic in relation to anterior cranial base

When mandible is retrognathic

278. Which of these would you aspect to find in class II division 1 case?

an ANB angle of +8

an ANB angle of -8

an ANB angle of +2

SNA angle >84

SNB angle> 80

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279. If the norm of the cephalometric angle SNA is 82, a patient's reading 90, for SNA most likely indicates:

Maxillary protrusion

The patient's ethnic back ground

Protrusive maxillary incisors

Dysplasia of the anterior cranial base

Class II malocclusion

280. Which of the following is a unilateral landmark on a cephalogram

Orbitale

Basion

Porion

Gonion

Nasion

281. Which of the following land mark is not situated on the mandible

Point B

Gonion

Gnathion

ANS

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Porion

282. Hand and wrist Xrays predict

Timing of growth

Direction of growth

Amount of growth

Growth is retarded or not

All of the above

283. Facial photograph will not predict

Profile

Lip competency

Chin prominence

Anterior crossbite

Dental prominence

284. Almost 90-100% deep bite may be found in cases with which malocclusion

Angle’s class II division 1

Angle’s class II division 2

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Angle’s class I type 1

Increased inter incisor angle

Decreased inter incisor angle

285. In Angle’s class I malocclusion which of the following is not seen

Crossbite

Bimaxillary protrusion

Mandibular teeth overlapped by the buccal surface of maxillary teeth

Rotation and crowding

Curve of spee flat

286. In skeletal class III the value of ANB will be

0

+2

+4

-6

-4

287. A boy has ANB angle of -4, facial angle of 98 he is a case of

True class III

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Pseudo class III

Skeletal class III

Dental Class II

Dental Class III

288. Closed bite is seen in which type of malocclusion

Class I

Class II division 1

Class II division 2

Class III

Class II

289. Soft tissue profile of a thumb sucking patient is

Convex

Concave

Normal

Point A is ahead

Point B is ahead

290. Frontal cephalogram is used to

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Assess facial symmetry

Assess facial assymmetry

Deepbite

Openbite

Dental compensation in sagittal plane

291. Anterior teeth most likely to be fractured with which of the following mixed dentition malocclusion:

Proclined upper incisor

Retroclined upper incisor

Class II div.1.

Class II div.2.

ClassIII

N: B – Underlined are true.

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Dedicated To

My Mom, Zubaida Shaheen

My Dad, Md. Islam

&

My Only Son

Mohammad Sharjil

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