

ORTHODONTICS 5TH YEAR SC PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

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Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	15

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. What is the magnitude of the extraoral force applied on the superior arch as described in the source?**
 - A. 100 g
 - B. 200 g
 - C. 400-500 g
 - D. 1000 g
- 2. What describes the mandible closing path in functional terms?**
 - A. Rectilinear Sliding of 0.3–0.8 mm in the Sagittal Plane
 - B. Path from Rest Position to Habitual Occlusion
 - C. Path During Mastication
 - D. Incisal Edge Sliding on Palatal Surface
- 3. What is the term for the vertical movement of a tooth away from the occlusal plane?**
 - A. Extrusion
 - B. Intrusion
 - C. Protrusion
 - D. Retransmission
- 4. Indicate what does the electro-myography study.**
 - A. it is a method which studies the movement of the lower jaw during mastication.
 - B. the muscular tonus during contraction
 - C. perfusing of TMJ
 - D. registers the bio-potential of the muscles during contraction
- 5. Which of the following is a general indication for space maintainers?**
 - A. General or partial anodontia
 - B. Tooth extraction 1 year earlier of physiological change
 - C. Aesthetic defects combined with speech problems
 - D. Everything mentioned above

- 6. What is the most common functional factor in the etiology of vertical inoclusion?**
- A. Infant-type swallowing
 - B. Physiological swallowing
 - C. Nasal breathing
 - D. Mixed breathing
- 7. What is the tendency for the teeth that bound a space gap in primary and mixed dentition?**
- A. Bodily move to the space gap
 - B. Incline the crowns to the space gap
 - C. Do not change their position
 - D. Rotation around their axis
- 8. Which combination accurately reflects what should be described in space gaps diagnosis?**
- A. Etiology
 - B. Morphological description
 - C. Functional description
 - D. Etiology, morphological and functional description
- 9. Infantile swallowing normative age?**
- A. 6-9 years
 - B. 0-6 months
 - C. 4-6 years
 - D. 5-6 years
- 10. Which regulator type is indicated for mesial bite?**
- A. Functional regulator Type I
 - B. Functional regulator Type II
 - C. Functional regulator Type III
 - D. Crossbite

Answers

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1. D
2. B
3. B
4. D
5. D
6. A
7. A
8. D
9. B
10. C

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Explanations

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1. What is the magnitude of the extraoral force applied on the superior arch as described in the source?

- A. 100 g
- B. 200 g
- C. 400-500 g
- D. 1000 g**

In this context, extraoral forces used to influence the maxilla with headgear are applied in an orthopedic range, not just for dental tooth movement. The force must be large enough to affect skeletal growth centers while still being tolerable for the patient. The source describes the force magnitude on the superior arch as about 1000 g, or roughly 9.8 N. This level is considered sufficient to produce skeletal changes at the sutures of the maxilla when the appliance is worn for the recommended duration, whereas lower forces tend to yield mainly dental tipping rather than skeletal effects. So 1000 g is the stated magnitude because it achieves the intended orthopedic impact on the maxillary complex while balancing tissue tolerance and clinical practicality.

2. What describes the mandible closing path in functional terms?

- A. Rectilinear Sliding of 0.3–0.8 mm in the Sagittal Plane
- B. Path from Rest Position to Habitual Occlusion**
- C. Path During Mastication
- D. Incisal Edge Sliding on Palatal Surface

The closing path describes how the mandible moves from a relaxed rest position into the position of habitual occlusion, where the teeth first contact during normal closure. This path reflects the coordinated action of muscles and the joint, guided by the condyles and the occlusion, and it isn't a simple straight-line slide. It ends when habitual occlusion is achieved, not during chewing or anterior guidance movements. The other options describe different phases or types of movement (such as the chewing cycle, incisal edge interaction, or a fixed rectilinear slide) that don't define the actual functional closure from rest to intercuspalion.

3. What is the term for the vertical movement of a tooth away from the occlusal plane?

- A. Extrusion
- B. Intrusion**
- C. Protrusion
- D. Retransmission

Intrusion is the vertical movement of a tooth toward the apex, away from the occlusal plane. This movement lowers the tooth into the bone and reduces the vertical dimension, which is useful for correcting deep bites or bringing supra-erupted teeth back into alignment. It's the opposite of extrusion, which moves a tooth upward toward or beyond the occlusal plane, increasing the vertical height. Protrusion is a forward (horizontal) movement of teeth, not a vertical change relative to the occlusal plane. The other term listed isn't a standard orthodontic term.

4. Indicate what does the electro-myography study.

- A. it is a method which studies the movement of the lower jaw during mastication.
- B. the muscular tonus during contraction
- C. perfusing of TMJ
- D. registers the bio-potential of the muscles during contraction**

Electromyography measures the electrical activity generated by muscle fibers when they contract. Muscles produce bio-potentials as motor units fire, and EMG captures these signals with electrodes to show how actively a muscle is working, when it activates, and how the activity is coordinated. This makes EMG the best description for what the study records—the bio-potential of the muscles during contraction. The other ideas describe movement, resting muscle tone, or blood flow, which EMG does not directly measure.

5. Which of the following is a general indication for space maintainers?

- A. General or partial anodontia
- B. Tooth extraction 1 year earlier of physiological change
- C. Aesthetic defects combined with speech problems
- D. Everything mentioned above**

Space maintainers are used to preserve the space in the dental arch when a tooth is lost prematurely or eruption timing changes, so that the remaining teeth don't drift and there's room for the permanent successor or a future prosthetic. General or partial anodontia means teeth are missing, which can lead to shifting of adjacent teeth and loss of arch length; maintaining space helps preserve the correct alignment and leaves room for future replacement. If a tooth is extracted earlier than intended due to physiological changes, a space maintainer prevents mesial drift of adjacent teeth and protects the eruption path of the neighboring tooth. Aesthetic defects with speech problems arise when spacing affects appearance and function, so keeping the space helps maintain aesthetics and phonetics until definitive rehabilitation is achieved. All these scenarios are valid indications for space maintainers.

6. What is the most common functional factor in the etiology of vertical inoclusion?

- A. Infant-type swallowing**
- B. Physiological swallowing
- C. Nasal breathing
- D. Mixed breathing

The influence of swallowing habits on the vertical dimension of the dentition is the key idea. Infant-type swallowing involves a forward tongue thrust where the tongue presses against the anterior teeth and the palate during swallowing, with incomplete lip seal. This creates a persistent vertical component of force on the front teeth. If this pattern is habitual, it can alter tooth eruption and tipping in a way that changes the vertical relationship of the arches, contributing to a vertical occlusion problem such as a deep bite. This makes it the most commonly implicated functional factor in vertical occlusion. Physiological swallowing corresponds to the normal pattern and nasal or mixed breathing can affect facial growth more generally, but they are not as directly tied to the vertical occlusion pattern as an abnormal, habitual tongue-thrust swallow is.

7. What is the tendency for the teeth that bound a space gap in primary and mixed dentition?

- A. Bodily move to the space gap**
- B. Incline the crowns to the space gap
- C. Do not change their position
- D. Rotation around their axis

When a space exists between two teeth in primary or early mixed dentition, the teeth that bound that gap tend to move as a unit toward the space. This bodily movement, where the entire tooth—crown and root—shifts forward into the gap, is driven by the natural mesial drift forces during eruption and the way the periodontal ligament allows translation under changing occlusal contacts. The result is closure of the space by translating the teeth rather than merely tipping the crowns toward the gap or rotating around their axis. This pattern explains why premature loss of primary teeth often leads to space loss: the adjacent teeth drift into the space to maintain occlusion and arch harmony.

8. Which combination accurately reflects what should be described in space gaps diagnosis?

- A. Etiology
- B. Morphological description
- C. Functional description
- D. Etiology, morphological and functional description**

A complete space gaps diagnosis integrates three interconnected pieces: what started the gaps (etiology), the physical characteristics of the gaps (morphology), and how functional factors influence or propagate them (functional description). Etiology explains the underlying cause—such as tooth-size–arch-length discrepancy, missing teeth, or habits—that sets up the spacing pattern. Morphology tells you where the gaps are, how wide they are, their shape, and whether they're single or multiple, in the anterior or posterior region. Functional description examines how the gaps behave in function and what habits or occlusal dynamics might be maintaining them—tongue thrust, atypical swallowing, lip incompetence, or other parafunctional activities. Putting all three together gives a full, clinically useful picture and guides treatment planning, so including etiological, morphological, and functional descriptions is the best approach.

9. Infantile swallowing normative age?

- A. 6-9 years
- B. 0-6 months**
- C. 4-6 years
- D. 5-6 years

Infantile swallowing reflects the reflexive suck–swallow pattern seen in early infancy, tightly linked to breastfeeding or bottle feeding. In this stage, the tongue works with the lips and jaw in rapid, rhythmic cycles without the mature tongue-tip seal against the palate or the teeth coming into contact. Neuromuscular control is still developing, so this reflexive pattern is considered normal for the first months of life. By about six months, many infants show changes in oral motor control as solids are introduced and coordination advances, signaling a transition toward a more mature swallow. If the infantile pattern persists beyond early infancy, it can be a clue to tongue thrust or other orofacial motor issues that may influence future dentoalveolar development. So, the normative window for infantile swallowing is from birth to about six months.

10. Which regulator type is indicated for mesial bite?

- A. Functional regulator Type I
- B. Functional regulator Type II
- C. Functional regulator Type III**
- D. Crossbite

When a mesial bite is present, the goal is to correct the anterior crossbite by rebalancing muscle forces and guiding jaw growth so the upper teeth can occlude ahead of the lowers in a stable way. Functional regulators achieve this by altering how the lips, cheeks, tongue, and jaws interact during function, encouraging the jaws to assume a more favorable, Class I relationship as growth proceeds. Functional regulator Type III is the most appropriate choice for a mesial bite because its design specifically addresses the muscle balance and jaw position associated with that pattern. It provides the right balance of guiding forces and space to allow the maxilla to advance and the mandible to settle into a more posterior, cooperative position during function, helping to correct the crossbite and establish a more normal overjet as the patient grows. In contrast, Type I and Type II are geared toward other patterns of malocclusion or less severe needs, and a crossbite is not a regulator type itself.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://orthodontics5thyrsc.examzify.com>

We wish you the very best on your exam journey. You've got this!

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