

The Importance of Early Orthodontic Assessment for Children

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Description:

Why children should see an orthodontist by age 7. Learn what early assessment looks for, when treatment helps, and how CSSC supports children's orthodontic care.

Details:

Collins Street Specialist Centre: The importance of early orthodontic assessment for children

Most parents assume orthodontic treatment belongs to the teenage years — braces at 13 or 14, off a couple of years later, done. In many cases, that timeline is entirely appropriate. But it isn't always the most clinically sound approach. At Collins Street Specialist Centre, our orthodontists and paediatric dentists recognise that in certain situations, an earlier assessment — and sometimes earlier intervention — can genuinely change the course of a child's dental development. Catching specific issues during the growth years can reduce the complexity of later treatment and, in some cases, prevent problems that would otherwise require considerably more involved management.

The Australian Society of Orthodontists and the Australian Dental Association both recommend that children receive an orthodontic assessment by age seven. At CSSC, our orthodontists and paediatric dentists work together to identify developing concerns early and determine the most appropriate course of action — whether that means timely intervention, or an equally informed decision to monitor and wait.

Why age seven?

The recommendation to assess at age seven can seem surprisingly early. Most seven-year-olds still have a mix of baby and permanent teeth, and their dental arches are far from fully developed. So what's the clinical reasoning?

By age seven, several important developmental milestones have typically occurred:

The first permanent molars have erupted. These back teeth establish the foundation of the bite, and their position tells the orthodontist a great deal about how the upper and lower jaws are developing relative to each other.

The permanent incisors are erupting or have already come through. This allows the orthodontist to assess alignment and evaluate whether there's adequate space for the permanent teeth still to follow.

The jaw relationship is becoming clinically apparent. By this stage, an orthodontist can begin to assess whether the upper and lower jaws are growing in appropriate proportion and in the right spatial relationship.

An assessment at this age doesn't mean treatment will start at this age. For most children, the orthodontist will recommend monitoring with periodic reviews, with comprehensive treatment beginning once most or all permanent teeth have erupted — typically around age 11 to 14. For a smaller group, however, early assessment reveals developing issues where earlier intervention carries a clear clinical

benefit.

What does an orthodontic assessment involve?

An orthodontic assessment for a child is a gentle, non-invasive process. Parents and children can expect three things.

First, a clinical examination, where the orthodontist assesses the child's teeth, bite, jaw relationship, facial profile, and oral habits through direct observation — nothing uncomfortable.

Second, diagnostic records. Depending on the findings, the orthodontist may recommend radiographs: a panoramic X-ray to visualise all developing teeth, or a lateral cephalometric X-ray to evaluate jaw relationships. At CSSC, digital radiography is used, which delivers very low radiation doses.

Third, a conversation with parents. The orthodontist explains the findings clearly, outlines whether any concerns are present, and discusses the recommended approach — whether that's early treatment, structured monitoring, or simple reassurance that development is on track.

The whole appointment typically takes 20 to 30 minutes, and most children find it straightforward.

What are orthodontists looking for?

During an early assessment, the orthodontist evaluates a range of dental and facial developmental factors.

Crossbites

A crossbite occurs when one or more upper teeth close inside the lower teeth rather than outside them. Crossbites can affect the front teeth or the back teeth.

A posterior crossbite — particularly one that causes the jaw to shift sideways on closing — can contribute to asymmetric jaw growth if left unaddressed. Correcting it early, often with a palatal expansion appliance, can guide jaw development into a more symmetrical pattern. This correction is considerably more straightforward in a young, growing child than in an adolescent or adult, where skeletal change becomes progressively more limited.

Crowding and spacing

The orthodontist assesses whether there's enough arch length for the permanent teeth to erupt in reasonable alignment. Significant crowding — a clear mismatch between tooth size and available jaw space — may benefit from early management to guide eruption and create room for the developing teeth.

Notable spacing can indicate missing teeth, delayed eruption, or other developmental concerns that warrant further investigation or monitoring.

Protruding upper front teeth (increased overjet)

Upper incisors that protrude significantly beyond the lower teeth carry a higher risk of dental trauma. A child who falls or takes a knock to the face is considerably more likely to fracture or lose protruding front teeth. Where the overjet is clinically significant, early treatment to reduce the protrusion can meaningfully reduce that risk.

Underbite (Class III skeletal or dental relationship)

An underbite — where the lower jaw or lower teeth sit in front of the upper jaw — may be skeletal in origin or dental. Certain underbites respond well to early intervention that uses the child's remaining growth to guide jaw development. Waiting until skeletal growth is complete can result in a more pronounced discrepancy that ultimately requires orthognathic surgery to correct.

Open bite

An anterior open bite presents as a gap between the upper and lower front teeth when the back teeth are together. Open bites are frequently associated with oral habits — thumb sucking, tongue thrusting, or prolonged dummy use — and early identification allows for timely management.

Habits: thumb sucking, tongue thrusting, and mouth breathing

Oral habits can have lasting effects on dental and skeletal development.

Persistent digit sucking beyond age four to five can cause the upper incisors to protrude, the upper arch to narrow, and an open bite to develop. Where the habit continues, early intervention — sometimes with a habit-breaking appliance — can allow normal developmental forces to resume.

Some children habitually push the tongue forward against or between the teeth during swallowing. This repetitive pressure can contribute to open bite development and spacing between the front teeth.

Chronic mouth breathing — commonly associated with enlarged adenoids or tonsils, allergic rhinitis, or nasal obstruction — can influence facial growth, contributing to a long, narrow facial form, constricted dental arches, and associated bite problems. Early identification allows for appropriate referral to an ear, nose, and throat specialist alongside orthodontic management where indicated.

Impacted or ectopic teeth

Radiographs taken during an early assessment can reveal developing teeth that are positioned abnormally and at risk of becoming impacted — unable to erupt into their correct position. After wisdom teeth, the upper canines are the most commonly affected. Early detection of an ectopic canine allows for timely action — such as strategic extraction of the baby canine to improve the eruption path of the permanent one — which can substantially reduce the likelihood of needing surgical exposure and complex orthodontic traction later.

Early or late loss of baby teeth

Baby teeth hold space for the permanent teeth developing beneath them. If a baby tooth is lost prematurely — through decay, trauma, or other causes — adjacent teeth may drift into the gap, compromising the eruption path of the permanent tooth. A space maintainer placed promptly can preserve the necessary space until the permanent tooth is ready to come through.

Baby teeth retained well beyond their expected loss time may indicate that the permanent successor is absent, impacted, or developing abnormally — all of which warrant further evaluation.

Phase 1 vs Phase 2 treatment

Orthodontic treatment in children is commonly described in two distinct phases.

Phase 1 (early or interceptive treatment)

Phase 1 treatment typically occurs between ages seven and ten, during the mixed dentition stage. It targets specific developing problems where early correction carries a clear clinical benefit. Common Phase 1 interventions include:

- **Palatal expansion** — widening the upper arch to correct a posterior crossbite or create additional space for erupting permanent teeth
- **Partial fixed appliances** — braces placed on the permanent incisors and first molars to address alignment issues, crossbites, or significant overjet
- **Space maintainers** — appliances that preserve arch space after premature loss of baby teeth
- **Habit-breaking appliances** — fixed or removable devices that interrupt thumb sucking or tongue thrusting
- **Functional appliances** — removable or fixed devices that influence jaw growth, particularly useful in managing developing underbites or encouraging forward development of a retrusive upper jaw

Phase 1 treatment is typically shorter than comprehensive orthodontic treatment — often six to eighteen months — and focuses on specific developmental concerns rather than achieving complete dental alignment.

Phase 2 (comprehensive treatment)

Phase 2 is the comprehensive orthodontic treatment most families associate with braces or clear aligners. It generally begins once most permanent teeth have erupted, typically around age 11 to 14. Phase 2 aligns the full dentition, refines the bite, and aims for a stable, functional, and aesthetically satisfactory result.

For children who have completed Phase 1, Phase 2 may be shorter or less complex, because the foundational skeletal and developmental concerns were addressed during the growth years. In some cases, early intervention can also reduce or eliminate the need for tooth extractions during Phase 2.

When to wait — not every child needs Phase 1

Most children assessed at age seven will not need Phase 1 treatment. For the majority, the orthodontist will recommend a monitoring programme — periodic reviews every six to twelve months — to track dental development and identify the right time to begin comprehensive treatment.

Phase 1 is recommended only where there's a clear clinical reason for early action: preventing a progressive crossbite, reducing trauma risk from significantly protruding incisors, or facilitating the eruption of an ectopic tooth. Intervening without a specific clinical rationale can result in unnecessarily prolonged overall treatment time, patient fatigue, and treatment that could have been handled more efficiently as a single comprehensive phase.

This is where the expertise of a registered specialist orthodontist matters most. A specialist is trained to distinguish between situations that genuinely benefit from early treatment and those better managed with well-timed comprehensive intervention. Parents arranging an orthodontic assessment for their child should confirm they're seeing a practitioner registered with AHPRA as a specialist orthodontist, which can be verified through the AHPRA public register.

The CSSC paediatric and orthodontic team

At Collins Street Specialist Centre, children benefit from close collaboration between our paediatric dentists and orthodontists.

Paediatric dentists monitor overall dental development, provide preventive care and decay management, and identify potential orthodontic concerns during routine appointments. When a developing issue is identified, an orthodontic assessment can be arranged within the same centre — no external referral needed.

Orthodontists provide specialist assessment, diagnosis, and treatment planning, working in close communication with the paediatric dentists to ensure orthodontic care is well coordinated with the child's broader dental management.

For children requiring oral surgical intervention — such as surgical exposure of impacted teeth or extraction of supernumerary teeth — CSSC's oral and maxillofacial surgeons are available within the same building. This integrated model means the coordination of surgical and orthodontic care is seamless, with clear communication across treating specialists.

The result is that your child's dental development is monitored comprehensively, the right specialists are involved at the right time, and nothing falls through the gaps.

Practical guidance for parents

Arrange an orthodontic assessment by age seven, even where a child's teeth appear to be developing normally. Some significant developing issues aren't visible to the untrained eye and can only be identified through specialist assessment.

Don't wait for all permanent teeth to erupt. The purpose of early assessment is to identify issues during the mixed dentition stage, when growth modification and interceptive treatment are still viable options.

Address persistent oral habits. If your child continues to suck their thumb or use a dummy beyond age four to five, raise this with your dentist or orthodontist so appropriate guidance can be provided.

Mention concerns about breathing. If your child habitually breathes through their mouth, snores, or has disrupted sleep, bring this to your dental team's attention. Chronic mouth breathing can carry real orthodontic and medical implications.

Consider family history. If parents or siblings have had significant orthodontic concerns — severe crowding, underbites, impacted teeth — early assessment is particularly advisable, as many orthodontic traits have a recognised genetic component.

Book an orthodontic assessment at CSSC

A specialist assessment gives you the information needed to make well-informed decisions about your child's dental development, with no obligation to proceed with treatment unless there's a clear clinical reason to do so. Whether your child needs intervention now, later, or not at all, you'll leave the appointment knowing where things stand.

Contact Collins Street Specialist Centre to arrange an orthodontic assessment for your child.

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