



AAO TRANSFER FORM PATIENT IN ACTIVE TREATMENT

Date _____
 To _____
 From _____
 Phone _____ Fax _____ Email: _____
 Patient's name _____ Birth date _____ Sex _____
 Social Security # _____ Phone _____
 Responsible party _____ Relationship: _____
 Home address _____ City _____ State/Province _____ Zip code _____

ANALYSIS (Including significant history & TMD) _____

PATIENT/PARENT CONCERNS RE: TX _____

SPECIAL HEALTH OR HISTORY CONCERNS _____

TREATMENT PLAN (Including chronology of treatment rendered) _____

TREATMENT PROGRESS (Including chronology of treatment rendered) _____

APPLIANCES

Fixed appliance:

Type _____ Manufacturer _____ Type of bracket: metal or non-metal Variations _____
 Date bands and/or brackets placed: Max _____ Mand _____ Bonding Agent _____ Cementing Agent _____
 Current archwire size and type: Max _____ Mand _____
 Intraoral elastics: dates initiated, size and direction _____ Hours requested _____

Extraoral appliance:

Type _____ and dates initiated _____ Hours requested _____

Removable appliance:

Type and dates initiated _____ Hours requested _____

Clear tray appliance:

Manufacturer _____ Total trays _____ Trays delivered _____ Change interval _____
 Attachments Placed Yes No IPR Completed Yes In progress to stage _____ No
 Refinements? Yes No # _____

Case/Patient number _____ Notes _____

PATIENT COOPERATION

Oral hygiene _____ Headgear _____

Elastics _____ Clear trays _____

Appointments _____ Broken appliances _____

Patient's attitude toward treatment _____

Suggestions for patient motivation _____

ACTIVE TX TIME ESTIMATES Original _____ Remaining _____ % of active treatment completed

RECOMMENDATIONS FOR CONTINUED TREATMENT _____

RECOMMENDATIONS FOR RETENTION _____

ADDITIONAL COMMENTS _____

FINANCIAL

Third party payment _____

Total charges before transfer _____

Total amount paid before transfer _____

Unpaid amount still owed transferring office _____

Balance of original quoted fee not yet charged _____ or overpaid at transfer _____

This patient/parent has been advised that orthodontic treatments vary widely throughout the country and the world and it is reasonable for them to expect that a transfer may increase treatment fees and may involve changes in payment policies. For most people who transfer during their orthodontic treatment, the total treatment cost is likely to increase.

AVAILABLE RECORDS FOR TRANSFER

Casts Initial Date _____ Progress Date _____ Articulator type _____

Ceph Initial Date _____ Progress Date _____

Tracings Initial Date _____ Progress Date _____

Panoramic Initial Date _____ Progress Date _____

CBCT Initial Date _____ Progress Date _____

Intra-oral scan files Initial Date _____ Progress Date _____

Intraoral x-rays Initial Date _____ Progress Date _____

Facial photos Initial Date _____ Progress Date _____

Intraoral photos Initial Date _____ Progress Date _____

Check appropriate status of records:

Record duplicates sent upon request (may be an additional charge to patient) Yes No

Records enclosed Yes No Records sent under separate cover Yes No

Signature: _____ Date _____

(Orthodontist)

REQUEST TO TRANSFER RECORDS TO NEW PROVIDER

When a patient moves, or, for other reasons, there is a necessity to change orthodontists during the course of ongoing orthodontic treatment, it is highly advantageous for all involved parties that the transfer be as prompt and convenient as possible. Of paramount importance is the identification of an orthodontist who will accept the patient and successfully complete the treatment.

The American Association of Orthodontists represents over ninety percent of the orthodontic specialists in the U.S. and Canada. Your current doctor is a member and will assist you in finding a qualified orthodontist.

It is necessary that your records be transferred to assure that the receiving orthodontist is knowledgeable of your orthodontic condition(s), orthodontic treatment goals, the current treatment plan, and related financial arrangements.

This patient/parent has been advised that orthodontic treatments vary widely throughout the country and the world and it is reasonable for them to expect that a transfer may increase treatment fees and may involve changes in payment policies. For most people who transfer during their orthodontic treatment, the total treatment cost is likely to increase.

To facilitate the transfer of these records, it is necessary that you complete the following:

I authorize Dr. _____ to release all records of _____ (patient's name) for the purpose of continuation of treatment by Dr. _____ (new provider's name)

Address/City/State/Province _____

Phone _____.

Signature: _____ Date _____
(Patient or Guardian)

Print Name _____

Relationship to Patient _____