American Association of Orthodontists

AAO TRANSFER FORM
PATIENT IN ACTIVE TREATMENT

Date _____

To _____

From _____

Phone (_____) _____ - _____ Fax (_____) _____ - _____

Patient's name _____ Birth date _____ Age _____ 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) _____

APPLIANCES

Appliance (type, manufacturer, type of bracket–metal or non-metal, and variations) _____
Date bands and/or brackets placed: Max _____ Mand _____ Bonding Agent _____ Cementing Agent _____
Current archwire size and type: Max _____ Mand _____
Extraoral type and dates initiated _____ Hours requested _____
Intraoral elastics, dates initiated, size and direction _____ Hours requested _____
Removable appliance type and dates initiated _____ Hours requested _____

PATIENT COOPERATION

Oral hygiene _____ Headgear _____ Elastics _____
Appointments _____ Broken appliances _____
Patient's attitude toward treatment _____
Suggestions for patient motivation _____

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

ACTIVE TREATMENT RECOMMENDATIONS _____

RETENTION AND THIRD MOLAR RECOMMENDATIONS _____

ADDITIONAL COMMENTS _____

Transfer – Active 5/00
Reviewed 09/09

FINANCIAL

Closed _____ Open End (Fixed) _____ Other _____

Fees: Active _____ Extras _____

Terms _____

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 _____

TRANSFER OF RECORDS **(Enter date)** _____

Dates of our: Records _____

Casts _____ Articulator type _____

Cephalograms _____ Tracings _____

Intraoral radiographs _____

Facial photographs _____

Intraoral photographs _____

Transferring Duplicate ☐ Initial ☐

Original ☐ Progress ☐

Check appropriate status of records

Record duplicates available upon request at extra charge ☐Yes ☐No

Records enclosed ☐Yes ☐No

Under separate cover ☐Yes ☐No

Signature: _____Date_____

(Orthodontist)

PATIENT RECORDS RELEASE AUTHORIZATION

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

I authorize _____ to release all records of

(Orthodontist's Name)

_____ for the purpose of continuation of treatment by another orthodontist.

(Patient's Name)

Signature: _____Date_____

(Patient or Guardian)

Transfer – Active 5/00
Reviewed 09/09

Print Name _____

Relationship to Patient _____

Transfer – Active 5/00
Reviewed 09/09