American Association of Orthodontists®
My Life. My Smile. My Orthodontist.®

# 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 _____

Case/Patient number_____

## PATIENT COOPERATION

Oral hygiene _____ Headgear _____



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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

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 _____

This patient/parent has been advised that orthodontic treatment fees 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)



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## 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. 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).

Signature: _____Date_____
(Patient or Guardian)

Print Name _____

Relationship to Patient _____



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