American Association of Orthodontists

Date:

AAO TRANSFER FORM
PATIENT IN ACTIVE TREATMENT

To: ____

From: _____
Telephone: _____ Fax: _____

Patient's name: _____ Birthdate: _____ Age: _____ Sex: _____

S.S.N./S.I.N.: _____ Phone: (_____) _____ - _____

Responsible party: _____ Relationship: _____

Address: _____

City: _____ State/Province: _____ Zip/Postal 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:

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)

Print Name _____

Relationship to Patient _____