



AAO TRANSFER FORM  
PATIENT IN ACTIVE TREATMENT

(To be typewritten)

Date \_\_\_\_\_

To: \_\_\_\_\_

From: \_\_\_\_\_  
Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Patient's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Prov: \_\_\_\_\_ Zip: \_\_\_\_\_

ANALYSIS:  
Including  
significant history  
& TMJ

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_

**PATIENT IN ACTIVE TREATMENT**

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 \_\_\_\_\_ Process \_\_\_\_\_  
 Check appropriate status of records:  
 Record duplicates available upon request at extra charge \_\_\_\_\_  
 Records enclosed \_\_\_\_\_ Under separate cover \_\_\_\_\_

Orthodontist's Signature: \_\_\_\_\_

**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) (Patient's Name)  
 for the purpose of continuation of treatment by another orthodontist.

\_\_\_\_\_  
 (Signature of Patient or Guardian)

\_\_\_\_\_  
 (Date)

\_\_\_\_\_  
 (Print Name)

\_\_\_\_\_  
 (Relationship to Patient)