ORLAND PARK ORTHODONTICS
Exceptional care & Excellent results

AAO TRANSFER FORM
PATIENT IN ACTIVE TREATMENT

Date_____

Patient's name _____

Cell phone _____

To _____ From _____

Phone _____ Email _____

PATIENT INFORMATION

Secondary Phone _____ Responsible party _____ Relationship _____

Home address _____ City _____ State/Province _____ Zip code _____

Patient's Birth date _____ Patient's preferred pronouns? _____

Patient's sex assigned on their birth certificate? ☐ Male ☐ Female

Current gender identification? ☐ Male ☐ Female ☐ Other

Special health or history concerns _____

Patient/Parent concerns RE TX _____

Oral Hygiene issues with patient ☐ Yes ☐ No Patient Appointment Issues _____

Patient's attitude toward treatment? _____

TREATMENT TO DATE

Analysis (Including significant history & TMD)

Treatment Plan (Including chronology of treatment rendered)

Treatment Progress (Including chronology of treatment rendered)

_____

Original Planned Completion date _____ Estimated % of Treatment Remaining _____

Any discrepancy between original estimated completion date and current projected completion date? ☐ Yes ☐ No

If yes, reasoning? _____

APPLIANCES

Date bands and/or brackets placed _____ Slot Size ☐ 0.22 ☐ 0.18 ☐ bidimensional

Bracket type and RX _____ Current archwire size & type Max _____ Mand _____

Intraoral elastics dates initiated, size and direction _____ Hours requested _____

Extraoral appliance Type _____ Dates initiated _____ Hours requested _____

Removable appliance Type _____ 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 # _____

Any Broken appliances during treatment? ☐ Yes ☐ No

Appliance Notes _____

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FINANCIAL

Third party payment _____

Total charges before transfer _____ Total amount paid before transfer _____

Unpaid amount still owed transferring office _____

Balance 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 _____

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 nearly 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 _____