AAO TRANSFER FORM
PATIENT IN RETENTION

Date _____

To _____

From _____ Phone _____ Fax _____ Patient's

name _____ Birth date: _____

What sex was the patient assigned on their birth certificate? ☐Male ☐Female

What is the patient's current gender identification? ☐Male ☐Female ☐Other

What are the patient's preferred pronouns_____ Social Security # _____ Phone _____

Responsible party _____ Relationship: _____

Home address _____City _____State/Province _____ Zip code _____

ORIGINAL DIAGNOSIS _____

TREATMENT CHRONOLOGY _____

RETENTION DELIVERED _____

Maxillary Date placed _____ Type _____ Hours _____

Mandibular Date placed _____ Type _____ Hours _____

Headgear/facebow/chincup, myofunctional, etc. _____

LIMITATIONS

Limitations imposed by complexity of orthodontic problem [i.e., diseases (including periodontal) growth pattern, joint problems, dysfunctions – dental, bone, muscle, nerve, etc.] and cooperation by patient and parent.

Limitations _____

GUIDANCE RECOMMENDATIONS

Maxillary _____

Mandibular _____

THIRD-MOLAR RECOMMENDATIONS _____

RETENTION PHASE FINANCIAL

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. Often the fee for a transfer patient in the retention phase of treatment is determined on a per visit basis.

Any comments pertinent to original arrangement or current retention guidance arrangements and recommendations.

☐ Included with active TX fee (if separate $_____)

☐ Separate retention fee $ _____

☐ Per office call $_____

☐ Replacement retainer charge if quoted $_____

Other _____

ADDITIONAL COMMENTS _____

TRANSFER OF RECORDS (Enter dates)

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 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 important 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.

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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 _____