American Association of
Orthodontists

AAO TRANSFER FORM
PATIENT IN ACTIVE TREATMENT

Date ________

To ________

From ________

Phone (________) ________ - ________ Fax (________) ________ - ________

Patient's name ________ Birth date ________ Age ________ 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) ________

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 ______________________________

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