American Association of Orthodontists
My Life. My Smile. My Orthodontist.®

AAO TRANSFER FORM
PATIENT IN ACTIVE TREATMENT

Date _______________

To ____

From ____

Phone ___________________ Fax __________________ Email: ____

Patient's name ____ Birth date ____________________ 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) ____

____

____

TREATMENT PROGRESS (Including chronology of treatment rendered)____

____

____

APPLIANCES

Fixed appliance:

Type_______________ Manufacturer _____________ Type of bracket: ☐ metal or ☐ non-metal Variations__________

Date bands and/or brackets placed: Max_______ Mand _______ Bonding Agent _______ Cementing Agent _________

Current archwire size and type: Max ______________ Mand _________________

Intraoral elastics: dates initiated, size and direction_____________________ Hours requested______________________

Extraoral appliance:

Type________________ and dates initiated______________________ Hours requested ____________________________

Removable appliance:

Type and dates initiated______________________________ Hours requested _________________________

Clear tray appliance:

Manufacturer ______________ Total trays ______ Trays delivered______ Change interval __________________________

Case/Patient number______________________

PATIENT COOPERATION

Oral hygiene ____ Headgear ____

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Elastics ________________________________ Clear trays ________________________________

Appointments ________________________________ Broken appliances ________________________________

Patient's attitude toward treatment ____

Suggestions for patient motivation ____

ACTIVE TX TIME ESTIMATES Original ____________________ Remaining _____ % of active treatment completed

RECOMMENDATIONS FOR CONTINUED TREATMENT ____

____

RECOMMENDATIONS FOR RETENTION ____

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 ______________

This patient/parent has been advised that orthodontic treatment fees 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______________________

(Orthodontist)

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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 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 Dr.____________________ to release all records of ____________________ (patient's name) for the purpose of continuation of treatment by Dr. ___________________(new provider's name).

Signature: ____Date_____________________
(Patient or Guardian)

Print Name ____________________________________

Relationship to Patient ___________________________

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