

Orthodontic Patient Transfer Form

Date / /

TO : _____
 FROM : _____
 Address : _____ Zip _____
 Tel : _____ Fax : _____ E-mail : _____

1. PATIENT'S NAME : _____ M/F
 Date of Birth : _____ Age : _____
 Address : _____ Zip _____
 Tel : _____ Fax : _____ E-mail : _____

2. CASE ANALYSIS : _____

 TREATMENT PLAN : _____

3. TREATMENT RECORDS :

Date	
/ /	
/ /	
/ /	
/ /	
/ /	

4. PRESENT TREATMENT : Active Treatment Retention Observation Other
 Technique : _____ Auxiliary appliance : _____
 Type of Bracket : (Manufacture, Slot size, Torque, Angulation, etc.)

Arch wire size : Upper _____ Lower _____

6	3	3	6
6	3	3	6

Estimated active treatment time : _____

5. PATIENT COOPERATION :

Appointments (excellent, good, poor) Oral hygiene (excellent, good, poor)
 Appliance (Headgear, Elastics, etc.) (excellent, good, poor)
 Patient attitude toward treatment (positive, negative)
 Suggestions for patient motivation _____

6. TRANSFER OF RECORDS :

No records were obtained Records being forwarded under separate cover
Contact our office after patient arrives and we will forward records

7. FINANCIAL CONTRACT : Copy enclosed

GENERAL REMARKS : _____

Signature : _____ Date : ____ / ____ / ____