



AAO TRANSFER FORM
PATIENT IN ACTIVE TREATMENT

(To be typewritten)

Date _____

To: _____

From: _____
Telephone _____ Fax _____

Patient's name: _____ Birthdate: _____ Age: _____ Sex: _____
Responsible Party: _____ Relationship: _____
Address: _____ City: _____ State/Prov: _____ Zip: _____

ANALYSIS:
Including
significant history
& TMJ

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: _____

