CANADIAN ASSOCIATION OF ORTHODONTISTS

PATIENT TRANSFER FORM

cao / aco

DATE:

TO: Name:
Address:
Postal Code:
Telephone: ( )
Email:

FROM: Name:
Address:
Postal Code:
Telephone: ( )
Email:

Patient Name *(print)* Age:
Responsible Party:
Address:
Case Analysis:
Treatment Plan:
Estimated treatment time: Active: Retention:
Appliance: Bracket Slot Sizes:
Date Bands and/or brackets cemented:
Current Archwire Sizes: Upper: Lower:
Headgear: Type: Hours requested:
Intraoral elastics: force direction and size: Hours requested:
Removable appliance: Type: Hours requested:
Retainers: Type: Hours requested:
Retention Instructions:

Patient Co-operation:
Oral Hygiene: Headgear: Elastics: Appointments:
COMMENTS:
Progress to date:
Future treatment objectives:

Financial Arrangements

Estimated Fee:
How arranged:
Total amount paid before transfer:
Unpaid amount owing:

Transfer Records:

Contact our office, we will forward records ☐
Records being forwarded under separate cover ☐
Our records include:
Models ☐ Ceph ☐ Tracings ☐
Panorex ☐ Photos ☐ Other ☐

Patient has been informed that office policies, treatment procedures and fees may vary.