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 _____

Elastics : 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 : / /

The Japanese Begg Society of Orthodontics