ℬ Burke Orthodontics

TRANSFER IN SUMMARY

PATIENT NAME:

DOES ANYTHING NEED TO BE REPAIRED TODAY?

WHEN WERE YOU LAST SEEN BY AN ORTHODONTIST?

PREVIOUS ORTHODONTIST NAME:

PREVIOUS ORTHODONTIST ADDRESS:

DATE TREATMENT WAS INITIATED:

ANTICIPATED DATE OF COMPLETION:

SPECIAL CONSIDERATIONS REGARDING YOUR CARE:

ARE YOU WEARING RUBBER BANDS?

ARE YOU WEARING ANY TYPE OF GROWTH APPLIANCE?

IF YES, HOW MANY HOURS A DAY?

HAVE YOU FOUND A NEW FAMILY DENTIST?

WHAT WERE YOUR PREVIOUS FINANCIAL ARRANGEMENTS?

SIGNATURE:

DATE: