Your Name and Practice Information

Transfer of retention

Patient name: ____ Date: ___________________

Treating Orthodontist: ____________________________

Type of orthodontic treatment:

___ Fixed appliances (conventional braces)

___ Aligner treatment (such as Invisalign)

___ Other, please describe briefly:

Treatment was completed (approximate date) ______________________

Retention method currently used:

___ Removable retainers

___ Fixed (bonded) retainers

___ Other

Do you have any questions or concerns about the fit or effectiveness of your retainers?

___ No

___ Yes, please describe:

___ I understand that Dr. X's agreement to monitor my current retainers does not imply any opinion with regard to my treatment result, nor is it a guarantee against future relapse.

___ I understand that future dental treatment may render my current retainers ineffective or unusable. Should this occur, it may be necessary to modify or replace my current retainers, and that I have the option of having this done with Dr. X or an orthodontist or other dentist of my choice.

___ I do not wish to have my retention monitored.

Patient signature (or signature of patient's representative):______________________________