# PATIENT TRANSFER FORM ITERO SCAN

This Patient Transfer Form serves as official notification and authorization for Align Technology, Inc. and its representatives, successors, assigns, and agents (collectively referred to as "Align") to facilitate the transfer of electronic Medical Records (as detailed below) to the designated New Treating Provider specified herein. This transfer is conducted in accordance with applicable privacy laws and regulations to ensure continuity of care for the patient.

Please complete the form below and save it to your computer before attaching it and sending to Blue Pearl Dental Care by email at: **info@bluepearldental.com**.

If you have difficulty completing this form, please enter data manually, print and post the completed form to: **Blue Pearl Dental Care 126A Seven Sisters Road, London N7 7NS.**

## Patient Information

**Title:** Ms. **Patient's name:**

**Patient's address:** **Postcode:**

**Date of Birth:** **Gender:**

**Tel:** **Mobile:**

**Email:** **Referral Date:**

**Patient Medical Records.**

Medical History: Please indicate any relevant medical conditions, allergies, or medications.

## Referring Dentist Details

**Dentist's name:**

**GDC No:**

**Practice address:** **Postcode:**



126a Seven Sisters Road London N7 7NS
Tel +44 20 7263 5484 – info@bluepearldental.com – www.bluepearldental.com

**Email:**

# Reason for referral

Please indicate the specific reason for the iTero scan referral (check all that apply):

| | |
|---|---|
| ☐ | Comprehensive orthodontic evaluation |
| ☐ | Treatment planning for orthodontic therapy |
| ☐ | Evaluation for Invisalign® treatment |
| ☐ | Restorative dentistry planning |
| ☐ | Implant planning |

Other (please specify):

# For the patient

For the patient - Patient request and authorisation for transfer.

This Patient Transfer Form authorises correspondence with Align and any provider named above, verbally or in writing, regarding Medical Records and the transfer thereof, or other related information that may be (i) considered confidential under a national or state health, safety, or privacy code or (ii) otherwise considered individually identifiable health information.

I will not, nor shall anyone on my behalf, have any rights of approval, claims of compensation, or seek or obtain legal, equitable, or monetary damages or remedies arising out of use of my Medical Records that comply with the terms of this Patient Transfer Form. A copy of this Patient Transfer Form shall be considered as effective and valid as the original. This authorisation shall be valid three years from the date I sign below.

☐ If the patient does not have a digital version of their signature available, with authorization of the patient, please type their name in the signature area to the Left and check the box above to acknowledge the inclusion of all data required for us to proceed.

Patient Signature



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# Please tell us your preferences

**Please Note:**

- You will receive an email confirming that we have received your referral, and we can provide the service.
- Once the referral is accepted, we will contact the patient to schedule the appointment.
- If you have any questions or need further assistance, please contact our office directly at the provided phone number or email address. Thank you for choosing to collaborate with us for your patient's care.

**Important information**: it is essential that you complete all sections of this form in full.

The referring practice will be responsible for ensuring the clinical evaluation takes place and is properly recorded.

**Signature of referring dentist:**

☐

If you do not have a digital version of your signature available, please type your name in the signature area to the Left and check the box above to acknowledge the inclusion of all data required for us to proceed.



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