PATIENT RECORDS ORDER AND TRANSFER FORM

Please take this form to your dentist – or the dentist of your choosing. They will gather diagnostics required to create your clear aligner treatment plan

WHY YOU ARE RECEIVING THIS

We have determined that the patient you are seeing may be a candidate for clear aligner treatment. Our doctors have examined certain 2D photographs that the potential patient provided through our website. In order to make a final determination about this patient's course of treatment we need to examine comprehensive diagnostic information. This patient is here to see you to get those diagnostics completed.

Upon completion of diagnostics please send them all via our secure, encrypted email
diagnostics@clearbluesmiles.com
After this information is received, we will pay you for this transfer.

Of course, you have a duty to diagnose any problematic dental issues presented in the patient and should inform them of such. Clear Blue Smiles LLC is not positioned to provide preventative or restorative dental care. Any continuing doctor/patient relationship that arises is not of concern to Clear Blue Smiles LLC.

WE ARE CLEAR BLUE SMILES, NICE TO MEET YOU!

Clear Blue Smiles LLC is an orthodontic management company that has contracted with dental professionals for the coordination of treatment for certain patients seeking orthodontic care.

YOUR TIME IS VALUABLE

We recognize this request takes time and there are administrative costs involved. As such, we will compensate you $525 for the successful completion and transmission of these records.

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REQUESTED DIAGNOSTICS

The orthodontists in our network vigorously evaluate all potential patients and insist that certain diagnostics be taken before any treatment is prescribed. Since the patients we help to treat desire the convenience of remote orthodontic treatment, we require that they visit a dental office qualified to take the required diagnostic exams, including:

- Panoramic radiographic image
- A comprehensive oral evaluation
- Digital diagnostic casts (i.e., iTero scan or similar)
- Comprehensive periodontal evaluation, and
- Clinical photos showing multiple angles of the potential patients' bite/facial profile

PRETTY EASY, RIGHT?

If you would like to explore a contractual relationship with Clear Blue Smiles LLC and continue to be compensated for your work, please visit www.clearbluesmiles.com/affiliates for more information. There is no cost to an affiliation, and you benefit in three ways:

1. You will be listed on our doctor locator page for future potential patients seeking diagnostic exams;

2. Your existing patient base will be aware of your affiliation with Clear Blue Smiles LLC, thereby allowing you to offer diagnostic exams to them and receive revenue from us; and,

3. You may advertise, if all relevant statutes and regulations allow, that your office can help to coordinate orthodontic treatment to your patients, thereby offering your patients easy, convenient, affordable, expert orthodontic care.

Thank you, and please do not hesitate to contact Clear Blue Smiles LLC, at: dentists@clearbluesmiles.com if you have any questions.

Sincerely,

The Clear Blue Smiles Team

AUTHORIZATION TO RELEASE DENTAL INFORMATION

The execution of this form does not authorize the release of information other than that specifically described below

RELEASE TO: CLEAR BLUE SMILES LLC, PO BOX 407, ST. LOUIS, MO 63040
diagnostics@clearbluesmiles.com

Patient Name:________________________________ DOB:________________ SSN: ____________________

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes the following information:

INFORMATION REQUESTED:

- DENTAL PANORAMIC RADIOGRAPHIC IMAGE
- 3D DIGITAL CAST (.STL FILE)
- CLINICAL PHOTOS
- COMPLETE PERIODONTAL CHART
- COMPREHENSIVE DENTAL EXAMINATION WITH CARIES ASSESSMENT

DATE OF EXAMINATION: ____/____/______

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED: Examination pursuant to patient's desire for orthodontic clear aligner therapy.

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it.

PERSON AUTHORIZED TO SIGN FOR PATIENT NAME (If patient is minor):

Print: _____________________________ State How Authorized (i.e., "Parent"): _________________________

Sign: _____________________________ Date: ____________

PATIENT

Print: _____________________________

Sign: _____________________________ Date: ____________

RECORDS ORDER AND TRANSFER FORM
INVOICE

Upon successful completion of diagnostic records and transmission, please complete and submit this invoice to: dentists@clearbluesmiles.com, or print and mail to: Clear Blue Smiles LLC, PO Box 407, St. Louis, MO 63040.

All invoices will be paid within 30 days upon receipt.

DENTAL OFFICE INFORMATION

PRACTICE NAME: ____________________

PRACTICE LOCATION: ____________________

DENTIST NAME: ____________________

DENTIST LICENSE NUMBER: ____________________

DATE RECORDS SUBMITTED: ____________________

PATIENT NAME: ____________________

PREFERRED METHOD OF PAYMENT

- ☐ Credit/Debit Card
- ☐ Check

Thank-you, a member of our team will be contacting you soon!