



Orthodontics & Dentofacial Orthopedics

# Orthodontic Information Form

This is a secure site, all personal information will remain confidential.

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\*denotes Professional Corporation

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_  
First Initial Surname

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
Month / Day / Year

Address: \_\_\_\_\_  
No. Street City/Town

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_  
Postal Code

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

### If patient is a minor, please give parent or guardian names:

May our office contact you at work?

Mother: \_\_\_\_\_ Work Number: \_\_\_\_\_ Ext: \_\_\_\_\_  Yes  No

Father: \_\_\_\_\_ Work Number: \_\_\_\_\_ Ext: \_\_\_\_\_  Yes  No

## RESPONSIBLE PARTY INFORMATION

Name: \_\_\_\_\_  
First Initial Surname

Address: \_\_\_\_\_  
No. Street City/Town Province Postal Code

Relationship to patient: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Years employed: \_\_\_\_\_ Orthodontic Coverage?  Yes  No

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Years employed: \_\_\_\_\_ Orthodontic Coverage?  Yes  No

## EMERGENCY INFORMATION

Name of nearest relative not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
No. Street City/Town Province Postal Code

### How did you hear about our office?

Please feel free to check more than one.

- Phone Book
- Another Patient
- Dentist
- Transfer
- Employee of this office
- Other \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Email: \_\_\_\_\_

OFFICE USE ONLY DATE: \_\_\_\_\_

REC. \_\_\_\_\_ PAT. #: \_\_\_\_\_

PE: \_\_\_\_\_ LETT: \_\_\_\_\_