CLEAR DENTAL
DR. GAVIN FORSYTH INC.

New Patient Information

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? _____

ABOUT YOU

Name: _____ I prefer to be called: _____ ☐ Male ☐ Female
Birthdate: _____ Age: ____ Care Card: _____ DL/ID_____
Home Address: _____
City: _____ Prov: _____ Postal Code: _____
Home Phone: _____ Work: _____ ext. _____Cell: _____
E-mail Address: _____
Preferred contact method:

Telephone: ◯ Home ◯ Cell ◯ Work
◯ Text ◯ Email

Employer: _____ Occupation: _____
Employer's Address: _____ City: _____ Prov: ____ Postal Code: _____

PERSON RESPONSIBLE FOR ACCOUNT

◯Same as above
Name: _____ Birthdate: _____ Relation: _____
Billing Address: _____ City: _____ Prov: _____ Postal Code: _____
Home Phone:_____ Work: _____ ext. _____Cell: _____
Employer's Address: _____ City: _____ Prov: ____ Postal Code: _____

DENTAL INSURANCE INFORMATION

Primary Insurance
InsuranceCo Name: _____ Phone: _____ Group/Policy#: _____
Insured's Name: _____ Insured's Birthdate: _____ Relation: _____
ID/Certificate or Employee #: _____ Insured's Employer: _____

Secondary Insurance
InsuranceCo Name: _____ Phone: _____ Group/Policy#: _____
Insured's Name: _____ Insured's Birthdate: _____ Relation: _____
ID/Certificate or Employee #: _____ Insured's Employer: _____

APPOINTMENT POLICY

When you make an appointment with our office, we consider this a mutual commitment and reserve appropriate facilities and staff exclusively for you. Our office policy states that patients must give us 2 business days or 48 hours notice if they cannot keep an appointment. Appointment changes with less than 2 days notice are subject to a service fee based on the number of staff members and the amount of time that was reserved for you.

FINANCIAL POLICY

Payment in full is due the day of treatment, or on upon the start of major treatment. Should a patient have dental insurance with assignment to Dr. Gavin Forsyth Inc, the estimated patient portion will be the amount due.

Payment Options

1. For your convenience we accept Cash, Debit, Visa, MasterCard.
2. We also offer short-term financing options but interest charges will apply. All arrangements must be made in advance and are subject to an approval process.

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service. Therefore, the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. **You are ultimately responsible for all costs incurred regardless of what your dental insurance covers!**

Finance Charge and Fees

- Balances in excess of 30 days are subject to a finance charge of 2% per month (24% per annum).
- Returned checks are subject to a $25 accounting fee.

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Gavin Forsyth or an Associate of Clear Dental. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Clear Dental to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Gavin Forsyth Inc and Associates.

I understand and will comply with office **Appointment Policy.**
I understand and will comply with the office **Financial Policy**.
I understand and agree to the **General Consent to Treatment.**
I authorize the **Release of Information.**
I authorize the **Assignment of Insurance Benefits.**

X _____ Date: _____

Signature of patient, parent, or guardian