Great Lakes
— PROSTHODONTICS

24600 Detroit Road, Suite 200 · Westlake, Ohio 44145
(440) 808-9809 · info@glppros.com · glppros.com
Anthony Deliberato, DDS · Christian Loo, DDS · Eric Guirguis, DDS, MSD

New Patient Registration

Type directly into the shaded boxes, then save the file. If a question does not apply, enter N/A. You may also print this and complete it by hand.

PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL

PREFERRED NAME | DATE OF BIRTH | SEX | MARITAL STATUS

STREET ADDRESS | APT / SUITE

CITY | STATE | ZIP

HOME PHONE | MOBILE PHONE | EMAIL

Best way to reach you: Mobile | Home phone | Email | Text message

EMPLOYER | OCCUPATION

SOCIAL SECURITY NUMBER (OPTIONAL) | DRIVER'S LICENCE NO.

RESPONSIBLE PARTY — IF OTHER THAN THE PATIENT

NAME | RELATIONSHIP TO PATIENT | DATE OF BIRTH

STREET ADDRESS | CITY / STATE / ZIP

PHONE | EMPLOYER

DENTAL INSURANCE

I do not have dental insurance

PRIMARY CARRIER | GROUP / POLICY NO. | CARRIER PHONE

SUBSCRIBER NAME | SUBSCRIBER DATE OF BIRTH | RELATIONSHIP TO PATIENT

SECONDARY CARRIER | GROUP / POLICY NO. | SUBSCRIBER NAME

EMERGENCY CONTACT

NAME | RELATIONSHIP | PHONE

REFERRAL

24600 Detroit Road, Suite 200 · Westlake, Ohio 44145
(440) 808-9809 · info@glppros.com · glppros.com
Anthony Deliberato, DDS · Christian Loo, DDS · Eric Guirguis, DDS, MSD

REFERRED BY (DOCTOR OR OFFICE)

THEIR PHONE

How did you hear about us? Referring dentist Another patient Family or friend Online search Our website Insurance list Other

NAME OF YOUR GENERAL DENTIST

DATE OF LAST DENTAL VISIT

FINANCIAL POLICY AND AUTHORISATION

Payment is due at the time of service unless other arrangements have been made in advance. We will submit claims to your insurance carrier as a courtesy, but the balance remains the responsibility of the patient or the responsible party. Estimates of insurance coverage are not a guarantee of payment. Accounts unpaid after 90 days may be referred for collection, and the responsible party agrees to pay reasonable costs of collection. We ask for 48 hours' notice to change or cancel an appointment; repeated missed appointments may incur a fee.

I certify that the information I have given is accurate and complete to the best of my knowledge. I authorise Great Lakes Prosthodontics to release information required to process insurance claims, and I assign to the practice the insurance benefits otherwise payable to me. I have read and accept the financial policy above.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

PRINT NAME

RELATIONSHIP TO PATIENT IF NOT THE PATIENT

Great Lakes
— PROSTHODONTICS

24600 Detroit Road, Suite 200 · Westlake, Ohio 44145
(440) 808-9809 · info@glppros.com · glppros.com
Anthony Deliberato, DDS · Christian Loo, DDS · Eric Guirguis, DDS, MSD

Medical & Dental History

Type into the shaded boxes and tick the boxes that apply, then save the file.
Your answers are used only to treat you safely. Tell us of any change at future visits.

PATIENT NAME | DATE OF BIRTH | TODAY'S DATE

PHYSICIAN

PHYSICIAN NAME | PRACTICE | PHONE

DATE OF LAST PHYSICAL EXAMINATION | REASON FOR THAT VISIT

CURRENT HEALTH

Are you in good health? Yes No

Has your health changed in the last year? Yes No

Are you under the care of a physician now? Yes No

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN

Have you been hospitalised or had a serious illness in the last five years? Yes No

IF YES, DESCRIBE AND GIVE APPROXIMATE DATES

MEDICAL CONDITIONS — PLEASE TICK ANYTHING YOU HAVE HAD

- ☐ Heart disease
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Artificial heart valve
- ☐ Pacemaker or defibrillator
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Angina
- ☐ Stroke
- ☐ Mitral valve prolapse
- ☐ Rheumatic fever
- ☐ Congenital heart defect
- ☐ Asthma
- ☐ Emphysema or COPD
- ☐ Tuberculosis
- ☐ Sleep apnoea
- ☐ Sinus trouble
- ☐ Shortness of breath
- ☐ Diabetes — Type 1
- ☐ Diabetes — Type 2
- ☐ Thyroid disorder
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Hepatitis A / B / C
- ☐ Anaemia
- ☐ Blood transfusion
- ☐ Bleeding or clotting disorder
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ Artificial joint or implant
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Epilepsy or seizures
- ☐ Fainting spells
- ☐ Neurological disorder
- ☐ Depression or anxiety
- ☐ Eating disorder
- ☐ HIV or AIDS
- ☐ Autoimmune disease
- ☐ Glaucoma
- ☐ Stomach or intestinal disease

Any other condition not listed? ☐ Yes ☐ No

24600 Detroit Road, Suite 200 · Westlake, Ohio 44145
(440) 808-9809 · info@glppros.com · glppros.com
Anthony Deliberato, DDS · Christian Loo, DDS · Eric Guirguis, DDS, MSD

IF YES, PLEASE DESCRIBE

MEDICATIONS, ALLERGIES AND BISPHOSPHONATES

LIST ALL MEDICATIONS, VITAMINS AND SUPPLEMENTS YOU TAKE, WITH DOSAGE

Allergic or sensitive to: Penicillin Other antibiotics Aspirin Codeine Local anaesthetic Latex Metals Sulfa drugs Iodine Acrylic No known allergies

OTHER ALLERGIES, AND WHAT REACTION YOU HAD

> **Important — bone medications.** Please tell us if you have ever taken a bisphosphonate or bone-density medication, by tablet or by infusion. These include Fosamax, Actonel, Boniva, Reclast, Zometa, Aredia, Prolia and Xgeva. These medicines affect how the jaw heals and directly change how we plan implant and surgical treatment.

Have you ever taken any of these medications? Yes No Not sure

WHICH MEDICATION | WHEN TAKEN (FROM / TO) | STILL TAKING?

FOR WOMEN

Pregnant Trying to become pregnant Nursing Taking oral contraceptives None of these

IF PREGNANT, DUE DATE | WEEKS

TOBACCO, ALCOHOL AND OTHER SUBSTANCES

Do you use tobacco or vape? Never Currently Formerly

TYPE AND AMOUNT PER DAY | IF FORMER, YEAR YOU STOPPED

Alcohol use: None Occasional Weekly Daily

Do you use recreational drugs? Yes No

DENTAL HISTORY

DATE OF YOUR LAST DENTAL VISIT | DATE OF LAST FULL-MOUTH X-RAYS | LAST CLEANING

24600 Detroit Road, Suite 200 · Westlake, Ohio 44145
(440) 808-9809 · info@glppros.com · glppros.com
Anthony Deliberato, DDS · Christian Loo, DDS · Eric Guirguis, DDS, MSD

Reason for today's visit: Consultation Second opinion Referred for treatment Emergency or pain
Failing existing work Implants Dentures or partials Crowns or bridges

IN YOUR OWN WORDS, WHAT WOULD YOU MOST LIKE US TO ADDRESS?

CURRENT DENTAL CONCERNS — PLEASE TICK ANY THAT APPLY

- Pain or sensitivity
- Bleeding gums
- Loose teeth
- Missing teeth
- Broken or chipped teeth
- Worn-down teeth
- Grinding or clenching
- Jaw joint pain or clicking
- Headaches on waking
- Denture does not fit
- Denture is loose
- Difficulty chewing
- Bad breath or taste
- Dry mouth
- Food catching between teeth
- Unhappy with appearance
- Teeth have shifted
- Sores in the mouth

Have you had orthodontic treatment? Yes No

Have you had periodontal (gum) treatment? Yes No

Have you had oral surgery or extractions? Yes No

Have you had dental implants placed? Yes No

PLEASE GIVE DETAILS OF ANY OF THE ABOVE, WITH APPROXIMATE DATES

Have you ever had a difficult or upsetting dental experience? Yes No

How would you describe your comfort at the dentist? Comfortable A little anxious Very anxious

SIGNATURE

To the best of my knowledge, the information on this form is complete and correct. I understand that giving inaccurate or incomplete information may be dangerous to my health, and that it is my responsibility to inform this practice of any change in my medical status or medications.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE

PRINT NAME

RELATIONSHIP IF SIGNING FOR THE PATIENT

FOR OFFICE USE — REVIEWED BY / NOTES

Great Lakes
— PROSTHODONTICS

24600 Detroit Road, Suite 200 · Westlake, Ohio 44145
(440) 808-9809 · info@glppros.com · glppros.com
Anthony Deliberato, DDS · Christian Loo, DDS · Eric Guirguis, DDS, MSD

HIPAA Acknowledgement & Consent for Treatment

Complete on screen and save, then print the last page to sign by hand.
A typed name is not a signature — the signed page must be returned to the office.

PATIENT NAME | DATE OF BIRTH | TODAY'S DATE

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

Great Lakes Prosthodontics maintains a Notice of Privacy Practices describing how your protected health information may be used and disclosed, and how you may obtain access to that information. A copy is available at our office on request. By signing below, you acknowledge that you have been offered a copy of that notice.

☐ I acknowledge that I was offered a copy of the Notice of Privacy Practices ☐ I would like a printed copy

PERMISSION TO SHARE INFORMATION WITH OTHERS

We will not discuss your care with anyone you have not named here, except as permitted by law. You may change this list at any time in writing.

NAME | RELATIONSHIP | PHONE

NAME | RELATIONSHIP | PHONE

You may leave a detailed message: ☐ On my mobile voicemail ☐ On my home voicemail ☐ With the people named above ☐ By email ☐ Please leave name and callback only

You may send appointment reminders by: ☐ Text message ☐ Email ☐ Phone call ☐ Post

CONSENT FOR EXAMINATION AND TREATMENT

I authorise Dr. Anthony Deliberato and the doctors and clinical staff of Great Lakes Prosthodontics to perform the examination, diagnostic imaging, and treatment procedures necessary or advisable to diagnose and treat my dental condition. I understand that:

- Dentistry is not an exact science and no guarantee has been made to me about the result of examination or treatment.
- The treatment plan and fees will be explained to me before treatment begins, and may need to change if conditions are found that were not apparent at the outset.
- Every procedure carries risks, which will be explained to me before I consent to that procedure. These may include discomfort, swelling, bruising, infection, bleeding, numbness that is usually temporary but may be lasting, injury to adjacent teeth or restorations, jaw joint symptoms, and — with implants — the possibility that an implant does not integrate and must be removed or replaced.
- Local anaesthetic will usually be used, and I have disclosed any allergy or prior reaction on my medical history form.
- I may ask questions at any time, and I may withdraw my consent before or during treatment.

RADIOGRAPHS AND PHOTOGRAPHS

I consent to dental radiographs, including 3D cone-beam imaging, and to intraoral scanning as needed for diagnosis and treatment planning. Clinical photographs may be taken as part of my record.

My photographs may also be used, without my name, for: ☐ Teaching and lectures ☐ The practice website ☐ No — records only

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges whether or not they are covered by insurance, and that the practice will submit claims on my behalf as a courtesy. I have been given the opportunity to discuss fees and payment options.

24600 Detroit Road, Suite 200 · Westlake, Ohio 44145
(440) 808-9809 · info@glppros.com · glppros.com
Anthony Deliberato, DDS · Christian Loo, DDS · Eric Guirguis, DDS, MSD

SIGNATURE

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE

PRINT NAME

RELATIONSHIP IF SIGNING FOR THE PATIENT

WITNESS — OFFICE USE

Please return all completed forms to the front desk, or bring them with you to your first appointment. If you would prefer to complete them here, arrive about fifteen minutes early and we will help. Questions? Call **(440) 808-9809**.