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

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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