LoPOUR & ASSOCIATES DDS
SMILES BY DESIGN
Family and Cosmetic Dentistry

D. Greg LoPour, DDS
505 298.7475 505 323.0997 info@SmilesByDesign.biz
5110 Masthead St NE, Suite A - Albuquerque, NM 87109

Welcome to our practice. We are a general and cosmetic dental practice serving families of all ages for over 26 years. We also specialize in the management (diagnosis and treatment) of **obstructive sleep apnea (OSA)**, **snoring** and **TMJ issues**. As a locally owned and operated small business, we have the privilege and the ability to serve our patients with the highest level of skill and integrity. Our patients' health and well-being is at the center of all we do. We are also deeply invested in our community and are proud to be a LEED Gold Certified business helping reduce stress on the environment through energy and resource efficiency.

Dentists have become an integral part of a person's approach to their overall total health. Now more than ever we understand that the benefits of a healthy smile are not just related to appearance and function but are directly related to a person's overall total health. Here at LoPour & Associates, DDS, we address issues of active disease related to teeth and gums, routinely assess the head, neck and jaw looking for abnormalities, both muscular and neurological. We screen for oral cancer, chronic diseases, and routinely monitor blood pressure. We also diagnose and treat obstructive sleep apnea (OSA) and snoring. As patients often visit the dentist more than they do their primary care doctor, we offer the opportunity to address many health issues that might otherwise go unobserved due to a complex medical system and long waiting periods for appointments.

We believe in authenticity and full disclosure. If there is a diagnosed problem, Dr. LoPour will provide all the treatment options available, all treatment costs and any costs covered by insurance coverage (if applicable) so that you can make a well informed decision regarding how you would like to proceed. Aesthetically, Dr. Greg LoPour and his team will take the time to listen to aspects of your smile you may not be happy with and discuss what kind of smile you desire. Voted Albuquerque's Top Dentist by his peers, Dr. Greg LoPour is well known for his integrity, excellent clinical skills and aesthetic eye. His exceptional attention to detail and his artistic talent allow him to create beautiful natural looking--and natural functioning--smiles that blend seamlessly with the face behind the smile.

Dr. Greg LoPour graduated with honors from Baylor College of Dentistry, Dallas, Texas in 1995. After practicing in Dallas for a few years, he and his wife, Paige moved to Albuquerque, New Mexico in 1999 to build a life and a dental practice together. In addition to consistently ranking among America's 100 Top Dentists, Dr. Greg LoPour has also been voted by his peers as Albuquerque's Top Cosmetic Dentist year after year and is featured on the cover of this year's Albuquerque The Magazine as Albuquerque's Top Cosmetic Dentist 2021. Nominated for the Ethics in Business Award, Dr. Greg LoPour served as 114th president of the New Mexico Dental Association, served on the Advisory Board, co-chaired the New Mexico Mission of Mercy, served as mentor for the Pre-Dent Society and continues to serve both the New Mexico Dental Society and the American Dental Association in various capacities. Dr. Greg LoPour has been the official dentist of The Albuquerque Isotopes minor league baseball organization since their inception in 2003. Having been invited to join the VIP Network, many of Hollywood's elite have placed the care of their smiles in the skilled hands of Dr. Greg LoPour and his team.

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Patient and Insurance Information

In a complicated world full of information overload and freely flowing promises it can be stressful to find a dental office that feels comfortable and a dentist in whom to place your trust. Our number one priority is to create a positive pleasant experience while providing exceptional care and always speaking the truth. We want you to look forward to your visits with us! **Please complete the following forms and send back to us prior to your first appointment.**

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____ Preferred Name: _____
Date of Birth: ___ /___ /____ SS#:_____ Sex: Male____ Female____ Unspecified____ Primary Language: English___ Spanish___ Other ___
Home Address: _____ City/State: _____ Zip: _____ >Preferred Ph#: _____
Is this a mobile number? Yes____ No____ May we text you about your dental appointments and dental appointment information? >Yes ____No____
E-mail Address: _____ May we email you about your dental appointments & dental information? >Yes___ No ___
Emergency Contact Name: _____ Relationship: _____ Emergency Ph#: _____

Responsible Party

First Name: _____ Middle Name: _____ Last Name: _____
Date of Birth: ___ /___ /____ SS#:_____ Sex: Male____ Female____ Unspecified____ Primary Language: English___ Spanish___ Other ___
Street Address: _____ Zip: _____ City: _____ State: _____ Country: _____
>Responsible Party Signature: _____ >Date: _____ /_____ / _____

Primary Dental Insurance

*Is the Subscriber the same as the Patient? Yes___ No___ Patient relationship to subscriber: _____
Subscriber First Name: _____ Middle Name: _____ Last Name: _____
Street Address: _____ Zip: _____ City: _____ State: _____ Country:_____
Employer Name: _____ Insurance Company: _____ Insurance Phone Number: _____
Subscriber ID#: _____ Group #: _____ Date of Birth: ___ /___ /____ Subscriber SS#: _____
>Responsible Party Signature: _____ >Date: _____ /_____ / _____

Secondary Dental Insurance

*Is the Subscriber the same as the Patient? Yes___ No___ Patient relationship to subscriber: _____
Subscriber First Name: _____ Middle Name: _____ Last Name: _____
Street Address: _____ Zip: _____ City: _____ State: _____ Country: _____
Employer Name: _____ Insurance Company: _____ Insurance Phone Number: _____
Subscriber ID#: _____ Group #: _____ Date of Birth: ___ /___ /____ Subscriber SS#: _____
>Responsible Party Signature: _____ >Date: _____ /_____ / _____

I affirm the information given is correct to the best of my knowledge. I further acknowledge it is my responsibility to inform this office of any changes in my medical status, any changes in my dental and medical insurance and any changes to my contact information. I certify that I have the dental insurance coverage listed above and I assign directly to ***D. Greg LoPour DDS, Smiles By Design, PA*** all insurance benefits, otherwise payable to me. I understand that I am ultimately financially responsible for all fees related to dental services and materials rendered at this office. I understand that if I carry dental insurance, the office will assist me in filing my dental claims once I have provided the necessary information. I authorize the release of the necessary information relating to my dental insurance claims as permitted under applicable law. I authorize the use of this signature of all my insurance submissions whether manual or electronic. I authorize this office to perform the necessary services I may need.

> _____ > _____
Signature of Patient or Responsible Party Today's Date

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Patient Information and Cancellation Policy

LoPour & Associates DDS is your Healthcare Advocate: Your dental insurance carrier is NOT your healthcare provider. In our practice, your insurance is considered supplemental and does not dictate the quality of care we provide. As a courtesy, we will bill your dental insurance but we do not render treatment based on your insurances' limitations. If you have questions or concerns regarding your plan, our team is more than willing to help you maximize your benefits, but any specific insurance related questions should be addressed with your carrier. Payments are due at time services are rendered and are nonnegotiable. >Initial_____

Diagnosed Treatment and Fees: After X-rays and an examination, should treatment be needed we will provide you with a detailed treatment and our treatment fees. All treatment plans and associated fees are based on conditions viewed at the time of diagnosis. Despite the most diligent care and precaution, unanticipated complications or unintended results, although rare, may occur. Our treatment plans are based on the best evidence available during the examination. There is no guarantee that this plan will not change. During treatment, it may be necessary to change or add procedures because of conditions that were not evident during original examination but found in the course of treatment. For example some teeth may have hidden decay or affected nerves that will require additional x-rays and additional dental treatment resulting in additional fees. If this is the case, we will provide the additional treatment and treatment costs to you at that time. >Initial_____

For Patients Utilizing Dental Insurance: We strive to help inform our patients regarding the complexities of insurance eligibility and insurance benefits. We will estimate (to the best of our ability) how much we think an individual's insurance plan will pay toward the recommended treatment. This is not a guarantee. Please always provide us with your most current insurance information prior to your appointment so that we may verify active coverage. >Initial_____

Payment Plans: We provide all our patients a **Financial Agreement** if any dental treatment is to be performed. This allows our patients the advantage of a detailed treatment plan along with our treatment fees. If insurance plan(s) are involved, we will take the time to look up insurance information and provide **estimated insurance coverage.** Finally, we will provide the estimated total dollar amount for which our patients are responsible. It is standard to collect the patient portion of the treatment on the day dental services are rendered. We are a small locally owned business and we ask that you please keep your account current. If your account becomes 90 days past due, we reserve the right to assess a late fee and if account remains past due we reserve the right to begin the debt collection process. >Initial_____

Cancellation Policy: In order to provide you with the care you need and deserve, appointment times are reserved and assigned specific clinical staff and materials. Commitment to this reserved time is absolutely necessary. Appointment times with Dr. LoPour are in high demand and we value advance notice from our patients who are unable to keep their scheduled appointments. Short notice cancellations and no-shows also result in unnecessary costs related to staffing and supplies. We require that all cancellations and changes to your appointments (with us) must be made during our normal working business hours and that you contact us at least TWO FULL BUSINESS DAYS before your scheduled appointment. Our business hours are Mondays through Wednesdays 8:00am -5:00pm and Thursdays 7:00am-3:00pm, We understand emergency's can and do occur without warning. NO FEE will be assessed for such instances. Outside of these unforeseen emergencies, all "short-notice" cancellations/changes to your scheduled appointment(s) will be subject to the following fee: $55 for Hygiene >Initial _____ and fee of up to a 20% of the cost of scheduled treatment with Dr. LoPour >Initial _____. If a third no-show/short notice cancellation occurs, we reserve the right to terminate the doctor-patient relationship and assess any FEES associated.

By signing below, you acknowledge that you have read this Patient Information form and understand its content, agree to its content including the cancellation policy.

>_____ >_____ >___/___/_____

Print Patient Name | Signature of Patient or Responsible Party | Today's Date

_____ _____

Signature of Dr. D. Greg LoPour or Authorized Representative | Today's Date

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Dental History

Full Name: _____ Preferred Name: _____ DOB: ___ / ___/ _____
How would you rate the condition of your mouth? Excellent:_____ Good: _____ Fair:_____ Poor:_____ Not sure:_____
I routinely see my dentist every: 3months_____ 4months_____ 6months_____ 12months___ Not routinely _____

What is your immediate dental concern today: _____

Please answer **YES** OR **NO** to the following if applicable:

1. Are you fearful of dental treatment?	Yes	No
How fearful, on a scale of 1(least) to 10 (most) [_____]		
2. Have you had an unfavorable dental experience in the past?	Yes	No
3. Have you ever had complications from past dental treatment?	Yes	No
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	Yes	No
5. Did you ever wear braces, have orthodontic treatment or have your bite adjusted?	Yes	No
6. Have you had any teeth removed?	Yes	No

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing?	Yes	No
8. Have you ever been treated for gum disease or lost bone around your teeth?	Yes	No
9. Have you noticed an unpleasant taste or odor in your mouth?	Yes	No
10. Is there anyone with a history of periodontal disease in your family?	Yes	No
11. Have you ever experienced gum recession?	Yes	No
12. Have any of your teeth become loose on their own (without an injury)?	Yes	No
13. Have you experienced a burning sensation in your mouth?	Yes	No

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?	Yes	No
15. Do you have a dry mouth or do you have difficulty swallowing food?	Yes	No
16. Are any teeth sensitive to hot, cold, biting, sweets?	Yes	No
17. Have you ever broken teeth, chipped teeth, had a toothache or a cracked filling?	Yes	No
18. Do you frequently get food caught between any teeth?	Yes	No

BITE AND JAW JOINT

19. Any problems with your jaw joint? (pain, sounds, limited opening, locking, popping)?	Yes	No
20. Have you ever been treated for TMJ or joint pain?	Yes	No
21. Do you have difficulty chewing gum, carrots, nuts, bagels, protein bars/other foods?	Yes	No
22. Have your teeth changed in the last 5 years: Become shorter, thinner or worn?	Yes	No
23. Are your teeth becoming more crooked, crowded, or overlapped? Spaces?	Yes	No
24. Do you have more than one bite or shift your jaw to make your teeth fit together?	Yes	No
25. Do you place your tongue between your teeth or rest teeth against your tongue?	Yes	No
26. Do you chew ice, bite your nails or use your teeth to hold objects?	Yes	No
27. Do you clench your teeth in the daytime?	Yes	No
28. Do you have any problems with sleep (i.e., restlessness) or wake up with headaches?	Yes	No
29. Do you wear or have you ever worn a bite appliance?	Yes	No

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SMILE CHARACTERISTICS

30. Is there anything about the appearance of your teeth that you would like to change? Yes No
31. Have you ever whitened (bleached) your teeth? Yes No
32. Have you felt uncomfortable or self conscious about the appearance of your teeth? Yes No
33. Have you been disappointed with the appearance of previous dental work? Yes No

>Patent's Signature _____ **Date >**___/ ___ / _____

Doctor's Signature _____ **Date** _____

Medical History

DO YOU HAVE or HAVE YOU EVER HAD:

1. Hospitalization for illness or injury? Yes No
   Please explain: _____

2. An allergic reaction to any of the following:
   _____ aspirin, ibuprofen, acetaminophen, codeine/other narcotics
   _____ barbiturates, sedatives, sleeping pills, shellfish, iodine
   _____ penicillin
   _____ erythromycin
   _____ tetracycline
   _____ sulfa
   _____ local anesthetic
   _____ fluoride
   _____ metals (nickel, gold, silver, other) If yes, please explain: _____
   _____ latex
   _____ other: _____
3. Heart problems, or cardiac stent within the last 6 months Yes No
4. History of infective endocarditis Yes No
5. Artificial heart valve, repaired heart defect (PFO) Yes No
6. Pacemaker or implantable defibrillator Yes No
7. Orthopedic implant (joint replacement) Yes No
8. Rheumatic or scarlet fever Yes No
9. High or low blood pressure Yes No
10. A stroke (taking blood thinners) Yes No
11. Anemia or other blood disorder Yes No
12. Prolonged bleeding due to a slight cut (INR>3.5) Yes No
13. Emphysema, shortness of breath, sarcoidosis Yes No
14. Tuberculosis, measles, chicken pox Yes No
15. Asthma Yes No
16. Breathing or sleep problems (i.e. SLEEP APNEA, SNORING, SINUS) Yes No
    If YES, please explain: _____

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17.	Kidney disease	Yes No
18.	Liver disease	Yes No
19.	Jaundice	Yes No
20.	Thyroid, parathyroid disease, or calcium deficiency	Yes No
21.	Hormone deficiency	Yes No
22.	High cholesterol or taking statin drugs	Yes No
23.	Diabetes (HbA1c= _____)	Yes No
24.	Stomach or duodenal ulcer	Yes No
25.	Digestive disorders (i.e. celiac disease, gastric reflux)	Yes No
26.	Osteoporosis/osteopenia (i.e. taking bisphosphonates)	Yes No
27.	Arthritis	Yes No
28.	Autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)	Yes No
29.	Glaucoma	Yes No
30.	Contact lenses	Yes No
31.	Head or neck injuries	Yes No
32.	Epilepsy, convulsions (seizures)	Yes No
33.	Neurologic disorders (ADD/ADHD, prion disease)	Yes No
34.	Viral infections and cold sores	Yes No
35.	Any lumps or swelling in the mouth	Yes No
36.	Hives, skin rash, hay fever	Yes No
37.	STI/STD/HPV	Yes No
38.	Hepatitis (type___)	Yes No
39.	HIV/AIDS	Yes No
40.	Tumor, abnormal growth	Yes No
41.	Radiation therapy	Yes No
42.	Chemotherapy, immunosuppressive medication	Yes No
43.	Emotional difficulties	Yes No
44.	Psychiatric treatment	Yes No
45.	Antidepressant medication	Yes No
46.	Alcohol/recreational drug use	Yes No

ARE YOU:

47.	Presently being treated for any other illness	Yes No
48.	Aware of change in your health in the last 24 hours (i.e. fever, chills)	Yes No
49.	Taking medication for weight management	Yes No
50.	Taking dietary supplements	Yes No
51.	Often exhausted or fatigued	Yes No
52.	Experiencing frequent headaches	Yes No
53.	A smoker, smoked previously or use smokeless tobacco	Yes No
54.	Considered a touchy/sensitive person	Yes No
55.	Often unhappy or depressed	Yes No
56.	Taking birth control pills, hormones, hormone replacement therapy	Yes No
57.	ARE YOU or COULD YOU be pregnant	Yes No
58.	Under treatment or have been treated for prostate disorders	Yes No

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Describe any current medical treatment, impending surgery, genetic/development delay or other treatments that may possibly affect dental treatment performed by **LoPour & Associates DDS** (i.e. Botox, Collagen Injections, Sex reassignment Surgery (SRS or GRS):

List all medications, supplements, and or vitamins taken within the last two years.

Drug	**Purpose**	**Drug**	**Purpose**

When a health care worker is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases to include Hepatitis B and C Virus and Human Immunodeficiency Virus (AIDS). > **Initial:** _____

HIPAA: I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

> Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
> Obtaining payment from third party payers (e.g. my insurance company);
> The day-to-day healthcare operations of your practice.
> I give permission for Doctors and staff to discuss my medical information with the following person(s) listed below:
Please place check mark next to each you would like shared: TREATMENT ____ FINANCIALS____

Full Name of Person: _____ Full Name of Person: _____

The information I have given is true and accurate to the best of my knowledge.

>_____ >_____
Signature of Patient or Responsible Party **Today's Date**