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 (family) and cosmetic dental practice with over 20 years of experience. Now more than ever, we as a society realize the benefits of a healthy smile are not just related to appearance and function, but extend to the overall health of the entire body. Dentists have become an integral part of a person's approach to their overall "total health." We not only address issues of active disease related to teeth and gums, but we 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. Patients often visit the dentist more than they do their primary care doctors so we are able to help assist in preventing many complications through early detection.

In a complicated world full of information overload, freely flowing promises and so many choices, finding a dentist you can trust and with whom you feel comfortable can be extremely stressful. We are excited and honored you have given us the opportunity to meet your expectations and to build a trusting relationship. 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!

We believe in authenticity. If there is a diagnosed problem, Dr. LoPour will provide all the options available along with their pros and cons so that you can make a well informed decision regarding how you would like to proceed. Aesthetically, Dr. 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. Dr. LoPour is well known for his integrity, 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 itself.

We love what we do and only know one way to do it…the right way. We are not the most expensive nor are we the cheapest, but you have our 100% guarantee that we are here to serve YOU. Our goal is to help you prevent major dental complications by diagnosing problems sooner rather than later; to provide excellent dental maintenance supporting optimal oral health as well as overall total body health; and to address any aesthetic concerns you have now or may have in the future. You only have one set of teeth. They are one-of-a-kind and they are true to you. Investing in them through routine maintenance and repair the way you invest in other valuables is important whether you have dental insurance or not. People do not have oil insurance however they do routinely change the oil in their car so that the engine continues to run efficiently. Never replacing the oil in a car leads to loss of the entire engine and is expensive to replace. Similarly, dentistry is not expensive, neglect is.

We ask that you take a few minutes to review and complete the following forms. Please bring them with you to your first appointment.

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Please complete these forms and bring them with you to your appointment. Thank you.

About You

First Name: _____ MI:___ Last Name: _____ Male / Female
Preferred Name: _____ Birth Date: _____/_____/_____ SS#: _____
Home Address: _____ City/State: _____ Zip: _____
Cell Phone: _____ Alt number you can be reached: _____
May we text/email you about appointments and appointment reminders? Yes / No
E-mail Address: _____
*We use *Rhinogram* which is a secure texting program recommended by HIPPA

Marital Status: Single Married Widowed
Name of Spouse: _____ Spouse Birth Date: _____/_____/_____
Names of Children: _____
Whom may we thank for referring you to our practice? _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Reason for today's visit? _____
Date of last dental visit? _____ Are you happy with your smile? Yes / No
Are you currently under the care of a physician for any conditions? Explain: _____
_____
Physician Name: _____ Phone: _____

Insurance Information

Insurance: **Yes** or **No** (please circle one). If yes, please hand insurance card to front desk
Subscriber Name: _____ SSN or Alt ID#: _____
Insurance Company: _____ Employer: _____
Insurance Phone Number: _____ Group#: _____
Secondary Insurance: _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I certify that I have dental insurance coverage 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 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.

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

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

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Patient Information

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 believe in helping our patients receive the dentistry they need so if there are financial constraints we do offer payment plans. 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 cancellations must be made during normal business hours on workdays and at least TWO FULL BUSINESS DAYS before the scheduled appointment. We understand emergency's can occur without warning and no fee will be assessed for these instances nor will we charge for the first missed/short notice cancelled appointment. If a second appointment is missed/short notice cancelled a $55 charge will be billed. If a third no-show/short notice cancellation occurs, we reserve the right to terminate the doctor-patient relationship and assess another $55 charge. **Initial**_____

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

_____ _____

Dr. D. Greg LoPour/Authorized Representative | Today's Date

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Dental History

Name_____ DOB: _____
How would you rate the condition of your mouth? ____Excellent ____Good ____Fair ____Poor
I routinely see my dentist every: ____3mo. ____4mo ____6mo. ____12mo. ____Not routinely
What is your immediate concern: _____

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

1. Are you fearful of dental treatment?	Yes	No
How fearful, on a scale of 1(least) to 10 (most) [____] Info: _____		
2. Have you had an unfavorable dental experience?	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
24. Have your teeth changed in the last 5 years: Become shorter, thinner or worn?	Yes	No
25. Are your teeth becoming more crooked, crowded, or overlapped? Spaces?	Yes	No
26. Do you have more than one bite or shift your jaw to make your teeth fit together?	Yes	No
27. Do you place your tongue between your teeth or rest teeth against your tongue?	Yes	No
28. Do you chew ice, bite your nails or use your teeth to hold objects?	Yes	No
29. Do you clench your teeth in the daytime?	Yes	No
30. Do you have any problems with sleep (i.e. restlessness) or wake up with headaches?	Yes	No
31. Do you wear or have you ever worn a bite appliance?	Yes	No

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SMILE CHARACTERISTICS

32. Is there anything about the appearance of your teeth that you would like to change?	Yes	No
33. Have you ever whitened (bleached) your teeth?	Yes	No
34. Have you felt uncomfortable or self conscious about the appearance of your teeth?	Yes	No
35. 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? Please explain: Yes No

_____

2. An allergic reaction to
   - _____ aspirin, ibuprofen, acetaminophen, codeine/other narcotics
   - _____ Barbiturates, sedatives, sleeping pills, shellfish, iodine
   - _____ penicillin
   - _____ erythromycin
   - _____ tetracycline
   - _____ sulfa
   - _____ local anesthetic
   - _____ fluoride
   - _____ metals (nickel, gold, silver, _____)
   - _____ 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

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14. Tuberculosis, measles, chicken pox	Yes	No
15. Asthma	Yes	No
16. Breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	Yes	No
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

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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. FEMALE - taking birth control pills	Yes	No
57. FEMALE - pregnant	Yes	No
52. Male - prostate disorders	Yes	No

Describe any current medical treatment, impending surgery, genetic/development delay or other treatment that may possibly affect your dental treatment. (i.e. botox, collagen injections)

_____

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 to Doctors and staff to discuss treatment with _____(relative).

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

_____ _____

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