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 you and discuss what can be done to achieve the 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.

LoPOUR & ASSOCIATES DDS
SMILES BY DESIGN
Family and Cosmetic Dentistry

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Patient and Dental Plan 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.**

Patient Information

First Name: ________________ Middle Name: ____________ Last Name: _____________________ Preferred Name: ____________
Date of Birth: ___ /___ /____ SS#:__________ Sex: Male______ Female______ Unspecified______ Status: Married___ Single___ Other___
Home Address: ______________________________ City/State: _____________ Zip: ________ Language: English___ Spanish___ Other___
>Preferred Ph#: ________________ Is this a mobile number? Yes____ No____ E-mail Address: ______________________________
May we TEXT / EMAIL you about your appointments? >Yes ____No____ How did you hear about us? ____________________________
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 Plan

*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: ___________________ Dental Plan Name: ______________________ Dental Plan Phone #: _________________
Subscriber ID#: ____________________ Group #: _______________ Date of Birth: ___ /___ /____ Subscriber SS#: ___________
>Responsible Party Signature: ______________________________ >Date: ______ /______ / ______

Secondary Dental Plan

*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: ___________________ Dental Plan Name: ______________________ Dental Plan Phone #: _________________
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 plan and and any changes to my contact information. I certify that I have the dental plan coverage listed above and I assign directly to ***D. Greg LoPour DDS, Smiles By Design, PA*** all dental plan 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 have dental plan coverage, 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 plans claims as permitted under applicable law. I authorize the use of this signature of all my dental plan 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, Treatment Cost and Cancellation Policy

LoPour & Associates DDS is your Healthcare Advocate: We are dental professionals specializing in the diagnosis, prevention, and treatment of diseases and conditions that affect your gums, teeth, jaw and mouth. We also specialize in aesthetics, dental surgery and restorations directed at removing active disease and creating beautiful healthy smiles. We are passionate about dentistry and focused solely on providing our patients with the best treatment options, materials and techniques available. WE ARE NOT a dental insurance company nor do we directly benefit from dental plans carried by our patients. Modern day dental insurance companies are not owned by dentists but by stockholders, investment bankers and other firms for the sole purpose of making a profit. Thus, many dental plans often dictate a patient's treatment based on maximizing a profit rather than supporting (financially) the treatment recommended by the attending professional dentist. **Please be aware your dental plan may refuse to pay for all or some of the treatment. Your dental plan is considered supplemental and does not dictate what treatment we recommend, nor will we allow dental plans to lower the quality of care we provide to our patients.** As a courtesy, we will bill your dental plan, but we do not render treatment based on your dental plan's 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 dental plan related questions should be addressed with your carrier. Payments are due at time services are rendered and are nonnegotiable. **>Initial**___________

Diagnosed Treatment and Fees: All recommended treatment 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. Recommended treatment is based on the best evidence available during the patient 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 Plans: We strive to help inform our patients regarding the complexities of eligibility and benefits. We will estimate (to the best of our ability) how much we think an individual's dental plan will pay toward the recommended treatment. This is not a guarantee. Please always provide us with your most current dental plan information prior to your appointment so that we may verify active coverage. **>Initial**____________

Payment: We provide all our patients with a detailed treatment plan and associated fees. If dental plan(s) are involved, we will take the time to look up insurance information and provide **estimated dental plan 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: Patient appointments are reserved time with Dr. LoPour. These appointments have assigned clinical staff and materials ordered ahead of time. Commitment to this reserved time is absolutely necessary. We require that all cancellations and changes to your appointments be made at least TWO FULL BUSINESS DAYS before your scheduled appointment. We ask you please contact us during our working business hours to make changes. Business hours are Mondays through Wednesdays 8:00am - 5:00pm and Thursdays 7:00am-3:00pm, We understand emergencies can and do occur without warning and in such cases NO FEE will be assessed. **All other "short-notice" cancellations/changes/ no shows to your scheduled appointment(s) will be subject to the following fee: $55 for Hygiene and fee of up to a 20% of the cost of scheduled treatment with Dr. LoPour. If a third no-show/short notice cancellation occurs, we reserve the right to terminate the doctor-patient relationship and assess any FEES associated.** **>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**

____ ________________

Signature of Dr. D. Greg LoPour/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 dental plan carrier or medical 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**