James H. Ku DDS

9316 Montgomery Blvd NE
Albuquerque, NM 87111
(505) 800-5050

Welcome to Our Dental Office Family!

Thank you for choosing James Ku, DDS for your dental care. We look forward to taking care of your oral healthcare needs such as helping you develop and/or maintaining healthy gums and nice smile. We appreciate you choosing our dental practice and are honored that you have given us this opportunity. Our office policies and procedures are designed for your best long-term interests and keep you informed regarding the dental care you may receive at our office. All of our patients and/or guardians must complete, agree to, and sign our office policy forms prior to any treatment.

General Information Consent to Dental Treatment

By signing this form, you do hereby consent to be a patient of James H. Ku, DDS and receive treatment and also agree that your initial visit may require radiographs and gum probing, which may require additional charges, in order to complete the examination, diagnosis, and treatment plan. Accurate medical histories are essential for the delivery of safe and appropriate dental treatment; therefore, you agree to provide a thorough and complete medical history, supply a full list of your medications with accurate dosage amounts, and consent to our office personnel communicating with any medical or other dental practitioner(s) to inquire about any aspect(s) of your medical and/or dental health history. You do hereby agree and understand that although our office providers strive very hard to perform predictable and comfortable dental treatment, no guarantees can be made about dental treatment outcomes, the longevity of restorations, and/or the prognosis of any oral healthcare condition due to the extreme variability of patients' DNA, overall health conditions, diet choices, and oral hygiene habits. Consequently, by signing below, you hereby understand that any dental treatment you receive at this office can have unanticipated results and the practitioner(s) and the associated costs may change at any time due to such unanticipated results or due to any updated information regarding your medical or dental health conditions(s). For example, the removal of deep tooth infections (cavities) my sometimes cause a tooth to become sensitive and need endodontic therapy (a root canal) to correct such sensitivity, which is an additional charge or that the extraction of teeth may sometimes cause a gum infection needing further treatment and expense to resolve. Consequently, by signing below, you agree to accept these types of risks associated with dental treatment.

We welcome and encourage you to ask questions about any aspects of your recommended care.

An adult parent or guardian must accompany minor patients, which is anyone under the age of 18 or who is not mentally competent if older than 18 years of age. If a patient is accompanied by a non-guardian, a signed note authorizing dental treatment must be provided by the guardian stating the name of the other adult (with their photo ID) who is bringing the minor patient along with an immediate contact phone number. By signing below, you agree to NOT leave your children or any minors that you are responsible for alone or unattended in our office.

I have read and fully understand these policies, and I fully agree to them.

Patient Signature _____ Printed Name _____ Date _____

Guardian Signature_____ Printed Name _____Date _____
(if patient is a minor)

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Get-Acquainted Questionnaire

In order for us to better serve you, please fill in the following information completely:

PATIENT'S NAME _____Date of Birth _____
Last First Middle
Residence Address _____Home ( ) _____Cell ( )_____

City _____ State _____ Zip _____

Email _____ Is an appointment reminder via text ok? YES NO

____Married (Name of spouse) _____ ___Single ____Widow ____Divorced ___Separated

Former Dentist _____ Date of last dental visit _____

Whom may we thank for referring you to this office? _____
Person responsible for payment of account _____

YOUR EMPLOYER _____ SPOUSE EMPLOYER _____
Business address _____Business address _____
City _____City _____
Business Phone _____Business phone _____

Purpose of visit _____

Please complete the following information if patient is covered by dental insurance:
Please provide proof of insurance.
Name of person carrying insurance _____ Social Security Number ____-_____-____
Name & address of insurance company _____
Group Plan # _____ Member ID# _____Banner ID # (if any) _____

If there is secondary insurance, please complete the following:
Name of person carrying insurance _____ Social Security Number ____-_____-____
Name & address of insurance company _____
Group Plan # _____ Member ID# _____ Banner ID # (if any) _____

For your benefit; a thorough examination, usually including dental X-RAYS is necessary before an intelligent and efficient analysis of your dental problems can be made. The receptionist can advise you of the fee for these services which is usually covered by insurance if you have it.

After thorough diagnosis, your dental problems can be intelligently discussed; treatment can be planned, and your investment in this health plan understood and arranged.

It is a pleasure to survey your dental needs and discuss these problems with you. Please be assured that the most thorough, conscientious service will be dedicated to you. All facilities and personnel of this office are expressly here to serve you and your health.

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Your Health History

The following questions are all associated with the proper management of your dental health.
Physician _____ Address _____
Approximate date of last physical examination _____

1.	Are you now under current medical treatment?	YES	NO
2.	Has a physician ever informed you that you had a heart ailment?	YES	NO
3.	Has a physician ever informed you that you had high blood pressure?	YES	NO
4.	Has a physician ever informed you that you had a respiratory disease?	YES	NO
5.	Has a physician ever informed you that you had diabetes?	YES	NO
6.	Has a physician ever informed you that you had rheumatic fever?	YES	NO
7.	Has a physician ever informed you that you had rheumatism or arthritis?	YES	NO
8.	Has a physician ever informed you that you had any tumors or growths?	YES	NO
9.	Has a physician ever informed you that you had blood diseases?	YES	NO
10.	Has a physician ever informed you that you had kidney or liver disease?	YES	NO
11.	Has a physician ever informed you that you had stomach or intestinal disease?	YES	NO
12.	Have you had any major operations?	YES	NO
13.	Have you ever had serious accident involving head injuries?	YES	NO
14.	Are you allergic to any known materials resulting in hives, asthma, etc.?	YES	NO
15.	Are you now taking drugs or medication?	YES	NO
16.	Have you had any adverse response to drugs?	YES	NO
17.	Are you now on any kind of special diet?	YES	NO
18.	Do you have a history of fainting?	YES	NO
19.	Have you ever had any x-ray or radiation treatment (other than diagnostic?)	YES	NO
20.	Are you in good health at this time?	YES	NO
21.	Are you now pregnant? (woman) Expected delivery date_____	YES	NO
22.	Are there now any unhealed injuries or inflamed areas in or around mouth?	YES	NO
23.	Are there now any growths or sore spots in your mouth?	YES	NO
24.	Do you chew on only one side of your mouth?	YES	NO
	If so, why? _____		
25.	Do you have pain in or near your ears?	YES	NO
26.	Do you habitually clench or grind your teeth during the day or night?	YES	NO
27.	Have you had any difficult extractions in the past?	YES	NO
28.	Do you now have bleeding gums?	YES	NO
29.	When was your last full mouth x-ray taken? _____		
30.	Do you have any present dental complaints? _____		

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his staff and assume financial responsibility. Professional services are usually paid for when rendered.

Signature _____ Date _____

++++++++++++++++++++++++++++For Doctor's Use ++

Changes in health _____ Date _____
Changes in health _____ Date _____

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Financial Policies and Arrangements

We accept cash, checks (subject to approval), and major debit and credit cards such as Visa, MasterCard and Discover with a valid form of ID.

Full payment or estimated insurance copays are due at time of service. Estimates are provided as a courtesy to you but are based on general information provided by your insurance company, which indeed is **ONLY AN ESTIMATE AND NOT A GUARANTEE OF COVERAGE. Your insurance policy is a contract between you and the insurance company. We are not party to that contract; therefore, we can only estimate your copay portion based on the information they provide to us at time of treatment planning, which is often only generalized information and not specific enough to guarantee coverage or determine the precise amount of your financial responsibility.**

If you need major dental care, extended payment plans are available with prior credit approval through third-party-lenders such as Care Credit. Our office does not offer in-house extended payments. All financial arrangements for dental treatment must be made in advance with the office manager prior to any appointments. Please feel free to ask us any questions regarding your financial responsibility.

Insurance Payment(s) Policies & Your Ultimate Financial Responsibility

At this time, we are providers for Delta Dental, United Concordia, Met Life, Cigna & Aetna. All other insurance companies are considered out-of-network but we will submit your insurance claims and accept assignment of benefits for most out-of-network insurance plans.

However, in order for us to accept assignment of benefits, we require that you pay any deductibles (or provide proof that you have done so) and pay the estimated portion of your bill at the time of service. **If your insurance company has not paid within sixty (60) days, and/or all efforts to collect from them have been exhausted, the unpaid balance will become your liability and you will be responsible for payment, regardless of any insurance company's analysis of the unpaid services or arbitrary determination or coverage of non-coverage of dental treatment.** All charges are due **in full** within 60 days from date of service regardless of any disputed or pending insurance matter(s).

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By signing below, you understand and agree that any balance over 60 days past due will be assessed a monthly finance charge of 1.5% APR and that any remaining accounts **over 90 days past due are subject to collection proceedings** by third parties outside of our control and you further agree to pay for any and all such collection related expenses and to have any outstanding financial balances reported to any credit monitoring agencies over 90 days past the date of service regardless of any insurance related decisions.

By signing below, you authorize James H. Ku DDS to release any information requested, including medical and dental information, to any insurance company, employer, third party payer or administrator for the purposes of processing your dental claims.

Additionally, by signing below, you further agree to **pay in full any estimated insurance copayments at the time of service** and to be held liable for any balances owed per the financial policies as described above. **I have read and fully understand these policies and I fully agree to comply with them.**

_____ Date ____/____/__

Patient Signature Printed Name

_____ Date ____/____/__

Guardian Signature Printed Name
(if patient is a minor)

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Missed/Late Appointment Policy

Thank you for choosing James H. Ku D.D.S. for your dental care. We value your time and want your experience at our office to be positive in every way. It is our pledge to care for your dental needs in as timely a manner as possible. When you schedule your appointment, we have reserved this time especially for you; therefore, we expect for you to **keep your appointment(s)** and to **be on time** so that we may be able to offer timely care to all of our patients, including you. Therefore, we must **strictly enforce this policy** even when there are good reasons for cancelling appointments or being late.

If you must cancel or change your appointment, we require that you contact us by phone at least 24 hours in advance. If you do not keep your appointment and have not contacted us to cancel or reschedule, you will be charged a missed appointment fee of $50.00. If you are late to your appointment by more than 10 minutes, we reserve the right to automatically cancel your appointment fee to your account. Multiple missed appointments will result in a dismissal from our practice, and any balance not paid within 30 days will be sent to collections.

As a courtesy, our staff will attempt to reach you via text messages, phone calls and/or emails asking you for a confirmation of your appointment several weeks and days ahead of time to help remind you; however, in the event that our staff is unable to do so, you are still responsible to keep, and be on time for your appointment.

Thank you for taking the time to review, and agree to, our missed/late appointment policy, which is in the best interest of all of our patients. We hope that by making these policies very clear, we can eliminate any possible misunderstandings in the future. Thank you for reading and agreeing to our policies. Please let us know if you have any questions or concerns.

I have read the policy; I understand and agree to it.

_____ _____ Date _____/_____/_____

Patient Signature Printed Name

_____ _____ Date _____/_____/_____

Guardian Signature Printed Name
(if patient is minor)