Dr. Mildred Arucan-Masunaga

960 Center Street. Room #5
Wahiawa, HI 96786
PH: (808) 622-0001

Patient: _____ _____
Last **First** **M.I.** **Preferred Name**

Responsible Party: (if someone other than the patient)

_____
Last **First** **M.I.**

Address: _____ **City, State, Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Birth date: _____ **Social Security #:** _____ **Drivers Lic#:** _____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: _____ **City, State, Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Sex: ○ Female ○ Male **Marital Status**: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: _____ **Social Security #:** _____ **Drivers Lic#:** _____

E-mail: _____ □ I would like to receive email correspondences

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time **Referred By:** _____

Primary Insurance Information:

Name of Insured: _____ **Relationship to Insured:** ○**Self** ○**Spouse** ○**Child** ○ **Other**

Insured Social Security #: _____ **Insured Birth date:** _____

Employer: _____ **Insurance Company:** _____

Address: _____ **City, State, Zip:** _____

Secondary Insurance Information:

Name of Insured: _____ **Relationship to Insured:** ○**Self** ○**Spouse** ○**Child** ○ **Other**

Insured Social Security #: _____ **Insured Birth date:** _____

Employer: _____ **Insurance Company:** _____

Address: _____ **City, State, Zip:** _____

CONSENT FOR TREATMENT

I hereby authorize doctor or designated staff to take x-rays, models and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of your dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required proving proper care. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications. I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient/Responsible Party's Signature _____ **Date** _____