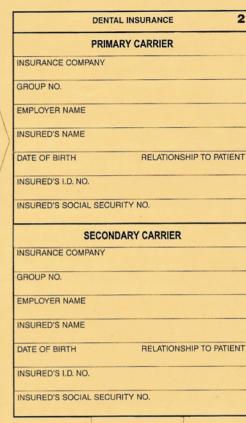
## **KENNETH B. SIEGEL, D.M.D**

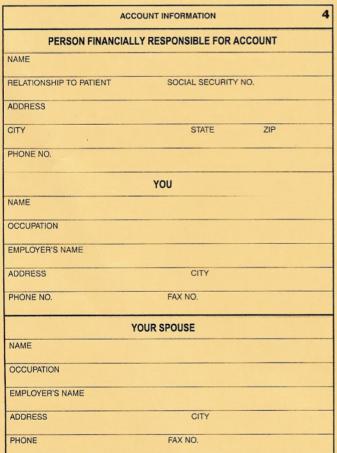
Dental Excellence of Blue Bell

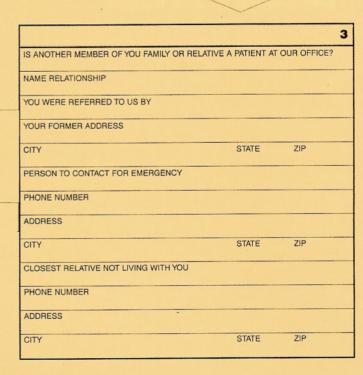
706 DeKalb Pike • Blue Bell, PA 19422 • 610-272-0828

## PATIENT REGISTRATION

	DATE			1	7	
	LAST NAME		FIRST	M.I.		
IF THIS	PREFERS TO BE CALLED BY					
APPOINTMENT	ADDRESS					
IS FOR YOU, START HERE	CITY STATE ZIP			ZIP		
	HOME PHONE NO.					
	BIRTH DATE	AGE	MALE	FEMALE		
	MARRIED	SINGLE	DIVORCED	WIDOWED		
,	SOCIAL SECURITY NO.					
	DATE					
	LAST NAME		FIRST	M.i.		
	PREFERS TO BE CALLED BY					
IF THIS	ADDRESS					
APPOINTMENT	CITY STATE ZIP					
IS FOR YOUR CHILD,	HOME PHONE NO.					
START HERE	BIRTH DATE	AGE	MALE	FEMALE		
	SCHOOL GRADE					
	SOCIAL SECURITY NO.					
V		IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO				
	ACCOUNT INFORMAT	TION	4			







## **CONSENT FOR TREATMENT**

1.	hereby authorize doctor and designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) 's dental needs.					
2.	Upon such diagnosis, I authorize doctor to perform upon by me and to employ such assistance as requ					
3.	I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.					
4.	I agree to be responsible for payment of all services. I understand that payment is due at the time of serving the event payments are not received by agreed a charge (18% APR) may be added to my account. I credit history may be made.	vice unless other arraupon dates, I unders	angements are made. tand that 1 1/2% late			
Patient's	Signature	Date	Witness			
		Deletionsk	in to Potiont			
Patient/R	Responsible Party's Signature	Relationsh	ip to Patient			