Little Urban Smiles

Patient Registration

Parent/Guardian Name _____

Child's Name _____ Birthdate _____

Last Medical Exam _____ Physician _____

Reason for Appointment _____

Does child have or previously had any of the following?

	Yes	No
Anemia _____	☐	☐
Diabetes _____	☐	☐
Allergies: _____	☐	☐
to Penicillin _____	☐	☐
to local anesthetic _____	☐	☐
Other If yes, please list _____ _____	☐	☐
Abnormal heart conditions _____	☐	☐
Abnormal bleeding from a cut _____	☐	☐
Rheumatic fever _____	☐	☐
Heart murmur/Micro-valve _____	☐	☐
Asthma _____	☐	☐
Taking any medicine _____	☐	☐
If yes, please list _____ _____		
Any other health conditions of which we should be aware? _____ _____ _____ _____	☐	☐

Signature _____ Date _____