Little Urban Smiles

Orthodontic Patient Registration

Parent/Guardian Name ______________________________

Child's Name ______________________________ Birthdate __________

Last Medical Exam ____________________ Physician ______________

United Health Care/Missouri Care/HomeState (please circle one) Member ID# ______________

Describe any previous orthodontic treatments or consultations ______________________________
____

Does your child have or previously had any of the following?

	Yes	No
Anemia ______________________________	☐	☐
Diabetes ______________________________	☐	☐
Allergies: ______________________________	☐	☐
to Penicillin ______________________________	☐	☐
to local anesthetic ______________________________	☐	☐
Please list any other allergies ______________________________		
Abnormal heart conditions ______________________________	☐	☐
Abnormal bleeding from a cut ______________________________	☐	☐
Rheumatic fever ______________________________	☐	☐
Heart murmur/Micro-valve ______________________________	☐	☐
Asthma ______________________________	☐	☐
Any other health condition of which we should be aware? __________	☐	☐
If yes, please list ______________________________		
Taking any medicine? ______________________________	☐	☐
If yes, please list ______________________________		
______________________________		
I give Little Urban Smiles permission to perform orthodontic treatment on my child ______________________________	☐	☐

Signature ______________________________ Date ______________