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?	☐	☐
I give Little Urban Smiles permission to perform dental treatment on my child	☐	☐

Signature _____ Date _____