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Charlottesville VA
(434)977-3939
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Jack T. Kayton III DDS PLLC

jackkaytondds.com

Child Health History

Patient Name: ____ ____ ____ ____

Last First MI Preferred Name

Date of birth

School attending

Has your child ever seen a Dentist before today?

◯ Yes ◯ No

Is your child in good health?

◯ Yes ◯ No

If no, please explain any conditions:

Does your child have any allergies?

◯ Yes ◯ No

If yes, please list:

Please list any medication your child is taking:

Parent or Guardian Signature

Response Date: