315 Old Ivy Way, Suite 101
Drkaytonteam@gmail.com
Charlottesville VA
(434)977-3939
drkaytonteam@gmail.com

Jack T. Kayton III DDS PLLC

jackkaytondds.com

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Women only: Are you pregnant? Due Date?

◯ Yes ◯ No

Have you experienced any of the following?

☐ High Blood Pressure	☐ Murmur	☐ Excessive Bleeding
☐ Tuberculosis	☐ Joint Replacement	☐ Thyroid
☐ Heart Disease	☐ Valve Replacement/ Repair	☐ Hepatitis
☐ Epilepsy	☐ Cancer	☐ Diabetes
☐ Heart Attack/ Stroke	☐ Blood Disease	☐ HIV / AIDS
☐ Fainting/ Dizziness	☐ Asthma	☐ Eating Disorders

Do you have any allergies to medications, latex or environmental? Please list any.

Please list any other condition we should be aware of:

Have you been hospitalized within the last 5 years? If yes, please explain.

Please list all prescription and over the counter medications you are taking:

Do you or have you used any tobacco products? If so, please elaborate.

Have you had any adverse reactions to dental treatment in the past? Please explain.

Response Date: