CHARLES J. PILLAR, D.D.S., P.C.

DENTISTRY FOR CHILDREN AND ADOLESCENTS

ARI M. PILLAR, D.D.S.

ORTHODONTICS FOR CHILDREN AND ADOLESCENTS

146A MANETTO HILL ROAD

PLAINVIEW, NY 11803

(516) 931-7171

CHILD'S HISTORY & INFORMATION

(Please print clearly)

Child's Name____________________ Nickname__________ Age______ Birth Date ________

Last Name First Name

Home Address/Town______________________________ Phone ____________

Email ____________________ Mom's Cell ____________________ Dad's Cell ____________________

School Attending____________________ Referred By ____________________

Child's Physician & Phone ______________________________

	Father	Mother
Parent's Name		
Date of Birth		
Social Security Number		
Occupation		

Business Address (Parent) ______________________________ Phone ____________

Insurance Carrier ______________________________

Have any of your children been seen in the office? ☐ Yes ☐ No

Please list their names ______________________________

DOES YOUR CHILD HAVE OR HAS HE/SHE EVER HAD (Please circle)

1. Heart murmer/problem .... yes no
2. Rheumatic fever .... yes no
3. Behavior / Sensory issues .... yes no
4. Nervous disorder .... yes no
5. Asthma .... yes no
6. Bleeding disorders .... yes no
7. Anemia .... yes no
8. Allergies .... yes no
9. Latex allergy .... yes no
10. Diabetes .... yes no
11. Tuberculosis .... yes no
12. Convulsions .... yes no
13. Kidney involvement .... yes no
14. Liver involvement .... yes no
15. Blood transfusions .... yes no
16. Is your child allergic to penicillin, aspirin or any other medicine .... yes no
17. Is your child taking any medication at the present time .... yes no
18. Is your child under medical care now .... yes no
19. Has your child ever had an unfavorable reaction from previous dental or medical care .... yes no
20. Any previous hospitalizations? .... yes no
21. Date of last medical examination ______________________________
22. Date of last dental exam ______________________________

IF ANY OF THE ABOVE ANSWERS ARE YES, PLEASE EXPLAIN:

____

____

____

I hereby authorize Dr. Charles J. Pillar, and/or his associates to render any services deemed necessary in the treatment of____________________ after consent by parent.

Date: ______________________________

Signature of Parent or Guardian

The policy in our office is the parent who requests treatment for the child is responsible for all fees for services rendered.

CHARLES J. PILLAR, D.D.S., P.C.

DENTISTRY FOR CHILDREN AND ADOLESCENTS

ARI M. PILLAR, D.D.S.

ORTHODONTICS FOR CHILDREN AND ADOLESCENTS

146A MANETTO HILL ROAD
PLAINVIEW, NY 11803
(516) 931-7171

Every member of our office is proud to be a part of a team whose primary mission is to deliver the finest and most comprehensive pediatric dental services available today. In order to assist you with the investment in your child's dental health, we are providing the following options from which you can select a plan that best meets your needs.

Initial Payments.
The policy in our office is, the parent who requests treatment for the child is responsible for all fees for services rendered. Payment is expected at the time services are rendered.

Payment Options.

We accept the following forms of payment : Cash, Check, or Credit Card.

- It is office policy that a credit card is left on file as most insurance policies have deductibles. Your insurance company determines the exact amount after we have submitted your claim for payment. We will charge your card for the amount which is your responsibility after we have received your insurance payment.

- Your signature below provides authorization for our office to process payment(s) to this card for reasons as outlined above.

I,______________________ have read the above disclaimer and fully understand my financial responsibilities to Pillar Pediatric Dentistry and Orthodontics.

Patient/Guardian Signature : ____________________________ Date ___________

Credit Card: Visa ______ Mastercard ______ American Express ______

Credit Card # ___________________ Expiration Date _________ Security Code _____

Please feel free to discuss any of the above with our office manager.

____
Signature of Parent or Guardian