

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

DENTISTRY 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 \_\_\_\_\_

School Attending \_\_\_\_\_ Referred By \_\_\_\_\_

Child's Physician & Phone \_\_\_\_\_

	<u>Father</u>	<u>Mother</u>
Parent's Name	_____	_____
Date of Birth	_____	_____
Social Security Number	_____	_____
Occupation	_____	_____

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
(Parent)

Insurance Carrier \_\_\_\_\_

Have any of your children been seen in this office?  yes  no

Please list their names \_\_\_\_\_

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

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