# Gary B. Solomon, DDS, MAGD

**Welcome to our practice!** Like friends welcoming friends, we will make every effort to see that your dental experience is as comfortable as possible.

In order for us to respect each other's time, please:

1. Send your completed patient forms to the office 2 days prior to your appointment. This will allow the doctor a chance to prepare for any special needs you may have during this initial examination, gather x-rays or documentation from referring or previous dentists, and verify your insurance benefits to those applicable.
2. You will want to arrive 5-10 minutes early. This will allow our business team to address any questions or concerns you may have before your appointment begins. We kindly request that all phones are turned off during your entire dental appointment.
3. The initial appointment (except in cases of emergencies) is spent conducting a thorough examination which includes a visual examination of the mouth, tissues and teeth, a set of necessary x-rays and diagnostic models. We will review your dental and health history, perform a visual oral cancer screening, and examine your existing dental restorations; looking to insure no damage is evident.
4. Following the completion of your soft tissue examination, our hygienist will determine and perform the type of dental cleaning or therapy appropriate for you.
5. At the conclusion of this comprehensive examination the doctor will usually provide an explanation of his findings and discuss with you any treatment you may need.
6. Your treatment room will be reserved exclusively for you. If for some unforeseen reason you find it impossible to keep this scheduled appointment, please verbally let us know 48 business hours in advance so that another patient may use the time which was reserved for you.

We want you to know we will do everything to make your appointment relaxed and pleasant. Our knowledgeable staff reflects the finest in care and skill in dentistry today. Our commitment to continuing education is ongoing through the year and our techniques and equipment represent the latest, safest and best... always with you in mind.

**Welcome to our practice, we all look forward to meeting you soon!**

*Dr Gary Solomon & Staff*

Gary B. Solomon, DDS, MAGD

# The Six Important Things We All Need to Know....

1. The following are infections and contagious. They usually don't hurt.
   - Periodontal Disease
   - Tooth Decay
2. Tooth pain at times will come and go away completely. When pain disappears, it gives a false sense of security that the tooth is normal, and upon return it will intensify each time. The first sign of discomfort is the right time to contact your dentist. Waiting could result in irreversible damage.
3. Our teeth can shift within a 24 hour period. This is one of contributing reasons night guards won't fit when not worn each night.
4. Over the counter mouth rinses can contain as high as 20% alcohol, leading to dry gum tissue causing pain and dissolving the bonding in fillings, onlays, inlay and veneers.
5. Do you know what is lurking beneath your gums?
   - At home, we are only able to clean the first 3mm of gum tissue by brushing, flossing and water irrigators (WaterPik, etc).
   - Periodontal pockets of 3mm or less often indicate healthy gum tissue. Periodontal pockets of 4mm and deeper indicate periodontal involvement and require a dental hygienist to access.
   - Bacteria in periodontal pockets of 4mm and deeper re-infect every 3 months following dental cleanings.
   - Periodontal pockets left untreated may progress to bone loss, a periodontal abscess, and possibly heart disease.
   - While pregnant, women should have their teeth cleaned every 3 months.
6. Wearing dentures does not eliminate the future need to see your dentist. Annual examinations are necessary for oral cancer screenings, to check your bite, and to check for mold and yeast that will infect and irritate your gum tissue. We look for cracks or fractures early on and we check for shrinkage in your bone and tissue, which can contribute to uncomfortable sore spots.

# Gary B Solomon, DDS, MAGD

## MEDICAL HISTORY

Patient's Name ______________________________ Birth Date ____/____/____ SS#_______ - _______ - _______

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently.
INCORRECT INFORMATION CAN BE DANGEROUS TO YOUR HEALTH
**Write the answer to each question in the space provided**

Name of Physician: ____________________________________________ Phone # ( ____ ) _______ - _________

Address ___________________________________________________ Date of Last Visit ______ / ______ / ______

Reason for Last Visit ______________________________________________________________________________

1. Are you currently under the care of a Physician?.................................................................( )Yes ( )No

   If "YES", for what reason or condition? ___________________________________________________

2. Are you currently taking any medications?...........................................................................( )Yes ( )No

   If "YES", what medication, and for what reason or condition?

   ______________________________________________________________________________

   ______________________________________________________________________________

   ______________________________________________________________________________

**HAVE YOU EVER HAD TREATMENT FOR:**

3. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease?.....( )Yes ( )No
4. Heart trouble, heart attack, Angina, heart surgery, a pacemaker, or irregular beats? .......( )Yes ( )No
5. Have you ever taken Phen Phen?..........................................................................................( )Yes ( )No
6. Abnormal blood pressure, excessive bleeding, or Anemia?................................................( )Yes ( )No
7. Breathing problems, Asthma, Tuberculosis, or Hay Fever?................................................( )Yes ( )No
8. Cancer, radiation treatments, or chemotherapy?..............................................................( )Yes ( )No
9. Diabetes?..........................................................................................................................( )Yes ( )No
10. Hepatitis, Jaundice, or Liver Disease?..............................................................................( )Yes ( )No
11. Kidney problems or Renal Dialysis?....................................................................................( )Yes ( )No
12. AIDS?..................................................................................................................................( )Yes ( )No

13. Arthritis or Rheumatism?........................................................................................( )Yes ( )No

14. Allergic reactions to medications?.........................................................................( )Yes ( )No

15. Have taken steroids in the last year?.......................................................................( )Yes ( )No

16. Have you ever had surgery?.....................................................................................( )Yes ( )No

    If "YES", explain.________________________________________________________________

17. Have you ever had a serious injury to your head or neck?...............................................( )Yes ( )No

    If "Yes", explain.________________________________________________________________

18. Do you smoke?........................................................................................................( )Yes ( )No

19. Have you consulted or been treated by a psychiatrist, psychologist, or counselor?...........( )Yes ( )No

    If "Yes", explain.________________________________________________________________

20. Are there any other problems about your health of which you are aware?........................( )Yes ( )No

    If "Yes", explain.________________________________________________________________

21. FOR WOMEN: Are you pregnant?.............................................................................( )Yes ( )No

22. **Emergency Contact Information**:
    Contact #1 Name :______________________________ Phone # ( ____ )________ - ________
    Relationship to Patient: __________________
    Contact #2 Name :______________________________ Phone # ( ____ )________ - ________
    Relationship to Patient: __________________

Blood Pressure taken in office: ______________________

**NOTE:** A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, all the questions on this form have been accurately answered. I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or other health practitioners.

| ______________________________ | ______________________________ |
|---|---|
| Signature of responsible party | Date Form Signed & Completed |
| ______________________________ | ______________________________ |
| Print Name | Relationship, if other than patient |

I give the dentist permission to take photographs to use for educational and promotional purposes.

| ______________________________ | ______________________________ |
|---|---|
| Signature of Patient | Date |
| ______________________________ | ______________________________ |
| Signature of Dr. | Date |

**Gary B Solomon, DDS, MAGD**
**18383 Preston Rd, Suite 207**
**Dallas, TX 75252**
**(972) 931-1777**

# REGISTRATION

Last Name ______________________ First ______________________ MI ______

Nickname ______________________ Birth Date _____ / _____ / _______ Age _____ Sex: M ____ F ____

Social Security # _______ / _______ / _______ Driver's License # ________________ State Issued _______

Home Address ______________________________________________

City ______________________________ State ____________ Zip ________

Home Phone: ( ____ ) _____ - ______ Work Phone: ( ____ ) _____ - ______ Cell: ( _____ ) _____ - ______

E-Mail ______________________________ May we e-mail messages to you? ______________

Employer ________________ Address ______________________ Occupation ____________

Who may we thank of referring you to our practice: ______________________________

Spouse's Name ______________________________________________

## ACCOUNT INFORMATION

**Person Responsible for Account** (If different than patient):

Last Name ______________________ First ______________________ MI ______

Relationship to Patient ______________ Birth Date _____ / _____ / _______ Age ______ Sex: M ____ F ____

Home Address ______________________ City______________ State _______ Zip_________

Home Phone: ( ____ ) _____ - ______ Work Phone: ( ____ ) ______ - ______ Cell: ( ____ ) ______ - ______

Social Security # _______ / _______ / _______ Driver's License # ________________ State Issued _______

Employer ______________________________ Occupation ____________________

Employer's Address ______________________________________________

## DENTAL INSURANCE INFORMATION

Insurance Company ______________________________ Phone # ( _____ ) ______ - ______
Insured Name: ______________________________ Self / Spouse / Parent
Insured SS# and ID # ______ - ______ - ______ Insured DOB _______ / _____ /_______
Employer Group Name ______________________ Group # ____________________

I authorize the Dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also authorize release of any information concerning my (or my child's) health care, medical history, advice and treatment to another dentist of if applicable, an insurance company. Since appointment times are reserved exclusively for me, I understand that charges will occur if I give less than 24 hours notice of an appointment change or cancellation.

Signature ______________________________ Date ______________________

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, ______________________________________________________, have received a copy of this office's Notice of Privacy Practices.

______________________________________________________

Signature

______________________________________________________

Date

______________________________________________________

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign.

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

______________________________________________________

______________________________________________________

______________________________________________________

# Gary B Solomon, DDS, MAGD

## Practice Policies

We are honored you have chosen us to provide your dental care. We are here to help you and below are some general guidelines for our office

General

- Patients are seen by appointment only.
- Office hours are Monday through Thursday 8:00 – 4:00, and we are closed for lunch from 12:00 – 1:00.
- If you should need to cancel or reschedule your appointment, please verbally notify us at least 48 business hours in advance, as other patients are waiting for your appointment time. We do not accept changes to the schedule on our voicemail system. Please call us and speak directly to our administrative team. Not giving us 48 hours notice will result in a $100 cancellation fee.
- As a courtesy to you, all appointments will receive a 2 week reminder from our office. At that time, we ask that you confirm the appointment, and update our office of any changes in your contact information, or insurance information.

Payments

- We offer a 5% accounting courtesy discount for all pre-payments of treatment exceeding $5,000. This does not apply to credit card payments, or third party financing.
- We accept American Express, Master Card, Visa and Discover
- For your convenience, our office offers third party financing through Care Credit Corporation and 12 Month No Interest is available.
- Payments for services are to be paid at the time services are rendered.

Insurance

- To better assist you, we do require all insurance information and verification 48 hours prior to your appointment time.

________________________________ ________________________
Patient Name Date

________________________________
Patient Signature

# Gary B Solomon, DDS, MAGD

New Patient Questionnaire

Patient Name: ________________________________ Date: __________________________

**Please tell us what type of oral hygiene products you use at home:**
Electric Toothbrush: ___________________________
Toothpaste:__________________________________
Floss: _____________________________________
Mouth Rinse: ________________________________
Other Home Care Products: ______________________

**Please check all the procedures below that you are interested in?**
☐ Check up, Cleaning, X-Rays ☐ Second Opinion ☐ Dentures or Partials ☐ Cosmetic Consultation ☐ Teeth Whitening ☐ Porcelain Veneers ☐ Crowns ☐ Tooth Colored Fillings ☐ Dental Implants ☐ Full Mouth Reconstruction/Rehabilitation ☐ Sedation Dentistry ☐ Night Guard
☐ Other ______________________________________________________________

**How much do you know about these procedures you are interested in?**
☐ I've just begun researching the procedure
☐ I've been researching for the last few months
☐ I know someone who has had the procedure already
☐ I am ready to begin treatment

**How soon are you planning to begin treatment?**
☐ I am ready to begin
☐ Within 1-3 months
☐ Within 3-6 months
☐ After 6 months

**Would you like information about interest free financing?**
☐ Yes
☐ No

**What is your Gender?**
☐ Male
☐ Female

**What is your age range?**
☐ 18-29 ☐ 30-39 ☐ 40-49 ☐ Above 50

**Briefly explain your current dental situation and what you would like to improve.**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**What are you most concerned about?**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________