DENTAL WELLBEING

HEALTHY SMILES. CONFIDENT LIVES.

7720 W. Sahara Ave. Suite 114
Las Vegas, NV 89117
(702) 648-1200
dentalwellbeinglv.com

EXISTING PATIENT
MEDICAL & DENTAL HISTORY UPDATE

To help us provide you with the safest and best possible care, please let us know if anything has changed since your last visit.

Today's Date: _____

Patient Name: _____

Date of Birth: _____

1. SINCE YOUR LAST VISIT, HAS ANYTHING CHANGED?

☐ No Changes

If yes, please check all that apply:

- ☐ New medical condition or diagnosis
- ☐ Hospitalization or surgery
- ☐ Pregnancy
- ☐ New medications
- ☐ Medication dosage changes
- ☐ Allergies
- ☐ Tobacco/Nicotine use
- ☐ Alcohol use
- ☐ Other: _____

Please explain any changes:

_____

_____

2. MEDICAL CONDITIONS

☐ No Changes

Have you been diagnosed with any of the following since your last visit? (Check all that apply.)

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Heart Valve Replacement
- ☐ Pacemaker
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Asthma/COPD
- ☐ Sleep Apnea
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Blood Disorder
- ☐ Autoimmune Disease
- ☐ Thyroid Disorder
- ☐ Other: _____

3. DENTAL HISTORY

☐ No Changes

Since your last visit, have you experienced:

- ☐ New dental treatment elsewhere
- ☐ Tooth pain
- ☐ Sensitivity
- ☐ Broken tooth or filling
- ☐ Swollen gums
- ☐ Bleeding gums
- ☐ Jaw pain / TMJ
- ☐ Grinding or clenching
- ☐ Other: _____

Please explain any dental concerns:

_____

_____

4. CURRENT MEDICATIONS

List any medications you are currently taking (including over-the-counter): _____

5. CURRENT ALLERGIES

Please list any medication, food, or environmental allergies: _____

PATIENT CERTIFICATION

I certify that the information provided above is true and complete to the best of my knowledge. I understand it is my responsibility to inform Dental Wellbeing of any changes to my medical or dental history.

Patient/Guardian Signature: _____

Date: _____

OFFICE USE ONLY

Reviewed by: _____ Date Reviewed: _____

Notes: _____

_____

Thank you!

WE APPRECIATE YOUR TRUST AND LOOK FORWARD TO CARING FOR YOU.

Revised by C.L 2026

DENTAL WELLBEING
HEALTHY SMILES. CONFIDENT LIVES.

HIPAA Privacy & Patient Acknowledgment (2026)

Dental Wellbeing
7720 W. Sahara Ave. Suite 114
Las Vegas, NV 89117
(702) 648-1200

NOTICE OF PRIVACY PRACTICES

Your Protected Health Information (PHI) may be used or disclosed for treatment, payment, healthcare operations, appointment reminders, insurance claims, and other purposes permitted by law. You have the right to receive copies of your records, request amendments, confidential communications, request restrictions, receive an accounting of eligible disclosures, and file a privacy complaint without retaliation. If applicable, records protected under 42 CFR Part 2 are handled in accordance with federal law and HIPAA.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have received or have been offered a copy of Dental Wellbeing's Notice of Privacy Practices. I understand how my protected health information may be used and disclosed for treatment, payment, healthcare operations, and other purposes permitted by law. I understand that I may request restrictions on certain uses or disclosures of my information, although Dental Wellbeing is not required to agree to every request.

Patient Name (Print): _____

Date of Birth: _____

If signed by someone other than the patient, relationship to patient:

_____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this NOTICE OF PRIVACY PRACTICES but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

_____

Patient Name: _____ Date of Birth: _____

DENTAL WELLBEING
HEALTHY SMILES. CONFIDENT LIVES.

APPOINTMENT CANCELLATION & NO-SHOW POLICY

We reserve appointment times specifically for each patient. Last-minute cancellations and missed appointments prevent us from offering that time to other patients who need care.

CANCELLATION POLICY

Please provide at least **48 hours'** notice if you need to cancel or reschedule your appointment.

Effective immediately:

- Appointments canceled with less than **48 hours'** notice may be subject to a **$65 cancellation fee.**
- Missed appointments (No-Shows) will also be charged a **$65 fee.**
- This fee is not covered by dental insurance and is the patient's responsibility.
- The cancellation fee must be paid before scheduling future appointments.

We understand that emergencies and unforeseen circumstances can happen.
Exceptions may be made at the doctor's discretion.

PATIENT ACKNOWLEDGMENT

I have read and understand Dental Wellbeing's Appointment Cancellation & No-Show Policy. I understand that if I fail to provide at least 48 hours' notice, or if I do not arrive for my scheduled appointment, I may be charged a $65 cancellation/no-show fee.

Patient Name (Print): _____

Date of Birth: _____

Signature: _____ Date: _____

TREATMENT AUTHORIZATION AND FINANCIAL AGREEMENT

I have requested the care of Dental Wellbeing, and I hereby authorize them to release any information to my insurance company as necessary to facilitate treatment or secure payment of services rendered. Information may include but is not limited to the following: diagnosis, treatment plan, x-rays, laboratory, consultation and follow up documentation. I also authorize and request that my insurance payer or third-party administrator pay service directly to Dental Wellbeing.

I understand that I am financially responsible for all services rendered and that the eligibility agreement is between my insurance company and me. As a courtesy to me, Dental Wellbeing will make an effort to secure payment from my insurance company before turning to me for payment. I understand that I am responsible for all cost shares (co-payments) and deductibles at the time of service. I can pay cash, check, or credit cards. However, should my check be returned by my bank for insufficient funds, there will be a $35 return fee added to my account.

I understand that Dental Wellbeing is entitled to contact me directly for payment should my insurance company deny coverage or not pay for services rendered. Unpaid balances are due monthly, and I will make arrangements to pay the balance, otherwise the unpaid balance will be turned over to a collection agency. Should the use of a collection agency be needed, I will also be responsible for the fees charged by the collection agency to collect my unpaid balance. I have been informed that the collection agency fee can be up to 35% of the unpaid balance amount, therefore increasing the balance originally owed. I also agree to keep the office up to date with my personal information relating to changes in insurance coverage, mailing address, medical history, medications, and any other changes that may affect the treatment and care rendered to me.

_____ _____
Patient/Guardian Signature Date

INFORMATION HEALTH POLICY

I have received a copy of Dental Wellbeing Information Practices detailing how my information may be used and disclosed as permitted under federal and state law. I understand that Dental Wellbeing may leave a message on my answering machine or with a third party regarding limited dental information, pending appointments, or other dental care related communications.

_____ _____
Patient/Guardian Signature Date

OFFICE USE ONLY

Reviewed by: _____ Date: _____

Reviewed by (print name): _____

Notes: _____

_____

_____