DENTAL WELLBEING
HEALTHY SMILES. CONFIDENT LIVES.

NEW PATIENT INFORMATION

Welcome! We're glad you're here.

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: (circle one) Guarantor Dependent Preferred Name: _____

Address: _____ City, State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ E-Mail: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic#: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other

Employer: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

RESPONSIBLE PARTY (if other than patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City, State and Zip: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

PRIMARY INSURANCE INFORMATION

Name of the Insured: _____ Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured ID or Soc. Sec: _____ Birth Date of Insured: _____

Address of Insured: _____ City, State and Zip: _____

Insurance Company: _____ Insurance Phone: _____

Insurance Address: _____ City, State and Zip: _____

SECONDARY INSURANCE INFORMATION

Name of the Insured: _____ Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured ID or Soc. Sec: _____ Birth Date of Insured: _____

Address of Insured: _____ City, State and Zip: _____

Insurance Company: _____ Insurance Phone: _____

Insurance Address: _____ City, State and Zip: _____

Thank you for choosing Dental Wellbeing!

Please complete all information to help us better serve you. If you have any questions, our team is happy to assist you.

OFFICE USE ONLY

Chart #: _____ Date: _____

Referred By: _____

Reviewed By (print name): _____

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MEDICAL HISTORY

Patient's Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions that you have, or medications that you may be taking, could have an important interrelationship with the dentistry that you will be receiving.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please indicate: _____

Physician's Name: _____

Address: _____ Phone: _____

1. Have you ever been hospitalized or had major operations? ☐ Yes ☐ No If yes, please indicate: _____
2. Have you ever had a serious head or neck injury? ☐ Yes ☐ No
3. Are you taking any medications? ☐ Yes ☐ No If yes, please list all medications below:

_____

4. Do you use tobacco products? ☐ Yes ☐ No
5. Do you, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No
6. Do you bruise easily? ☐ Yes ☐ No
7. Have you ever had abnormal bleeding? ☐ Yes ☐ No
8. Have you ever required a blood transfusion? ☐ Yes ☐ No
9. Have you ever used a controlled substance? ☐ Yes ☐ No
10. Have you had recent weight changes? ☐ Yes ☐ No
11. Are you wearing contacts? ☐ Yes ☐ No
12. Do you have a persistent cough or throat clearing NOT associated with illness? ☐ Yes ☐ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

(CIRCLE ALL THAT APPLY)

Penicillin	Metal	Codeine	Acrylic	Sulfa Drugs	Local Anesthetics
Aspirin	Latex	Barbiturates	Sedatives	Sleeping Pills	

Please list any other allergies: _____

It is my responsibility to inform the dental office of any changes in my medical status.

Please Sign:

Patient/Guardian Signature: _____ Date: _____

Thank you!

We look forward to caring for you.

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MEDICAL HISTORY

Do you have any of the following? (Circle all that apply)

AIDS/HIV Positive	Anaphylaxis	Alzheimer's Disease	Anemia
Emphysema	Epilepsy or Seizures	Hives or Rash	Hypoglycemia
Irregular Heartbeat	Kidney Problems	Breathing Problems	Lung Disease
Chest Pains	Heart Murmur	Pacemaker	Psychiatric Care
Cortisone Medicine	Diabetic	Herpes	High Blood Pressure
Scarlet Fever	Shingles	Sickle Cell Disease	Sinus Trouble
Arthritis/Gout	Low Blood Pressure	Thyroid Disease	Excessive Bleeding
Heart Attack/Failure	Ulcers	Fainting/Dizzy Spells	Stroke
Hemophilia	Hepatitis A	Hepatitis B or C	Liver Disease
Rheumatic Fever	Rheumatism	Artificial Heart Valve	Stomach/Intestinal
Artificial Limbs	Asthma	Blood Disease	Swelling of limbs
Chemotherapy	Osteoporosis	Tumors or Growths	Mitral Valve Prolapse
Convulsions	Radiation Treatment	Heart Disease/Trouble	Cancer
Renal Disease	Angina	Congenital Heart Disorder	

To the best of my knowledge, the questions on this form have been answered accurately.
I understand that providing incorrect information can be dangerous to my (or patient's) health.
It is my responsibility to inform the dental office of any changes in my medical status.

Signature of patient / Parent or Guardian: _____ Date: _____

Thank you!

We appreciate you taking the time to complete this information.
It helps us provide you with the best care possible!

Revised by C.L 2026

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PATIENT'S DENTAL HISTORY

ABOUT YOUR VISIT

Reason for this visit: _____

What was done? _____

When was your last dental visit? _____

When was your last cleaning? _____

How often do you visit the dentist? _____

DENTAL HEALTH

When was your last set of full x-rays? _____

How often do you brush? _____

How often do you floss? _____

Do you drink water with fluoride? _____

Previous dentist name: _____

Phone: _____

Address: _____

City, State and Zip: _____

PLEASE CHECK YES OR NO

		YES	NO
1.	Do your gums bleed while brushing/flossing?	☐	☐
2.	Do you have frequent headaches?	☐	☐
3.	Are your teeth sensitive to hot or cold?	☐	☐
4.	Do you clench or grind your teeth?	☐	☐
5.	Do you bite your lips or cheeks frequently?	☐	☐
6.	Are our teeth sensitive to sweet/sour food or drinks?	☐	☐
7.	Have you noticed your teeth are becoming loose?	☐	☐
8.	Does food tend to get caught between your teeth?	☐	☐
9.	Do you have any mouth pain?	☐	☐
10.	Do have any sores or lumps in or around your mouth?	☐	☐
11.	Have you ever had periodontal treatment? (gums)	☐	☐
12.	Have you had head and/or neck jaw injuries?	☐	☐
13.	Have you ever worn a night guard?	☐	☐
14.	Have you had difficult extractions in the past?	☐	☐
15.	Have you ever had prolonged bleeding following extractions?	☐	☐
16.	Do you wear dentures or partials? If yes, how long? _____		

17. Have you experienced any of the following problems with your jaw? (circle all that applies)

☐ Clicking ☐ Pain (joint, ear, side of face) ☐ Difficulty with opening or closing

18. If there was anything you could change about your smile, what would you change?

_____

_____

SIGNATURE

Signature of patient / Guardian _____

Date _____

OFFICE USE ONLY

Reviewed by: _____ Date: _____

Reviewed by (print name): _____

Notes: _____

_____

Thank you for trusting us with your care!

Revised by C.L 2026

DENTAL WELLBEING
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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: _____

_____

_____

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: _____