106 N. Dean Rd Suite 140
Orlando, Florida, 32825
407.614.6161
info@mynulifedental.com
myNuLifeDental.com

Patient Information

Circle One: Dr/Mr/Mrs/Ms/Miss

First:_____Middle:_____ Last:_____ Jr/Sr:_____

Street:_____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____

Email address:_____

May we contact you via text message and/or email: ☐ Yes ☐ No

Patient Social Security:_____Patient Date of Birth:_____Sex: ☐M ☐F

Emergency Contact:_____ Relationship:_____Phone:_____

Preferred Pharmacy:_____Phone:_____

How did you hear about us? ☐Facebook ☐Instagram ☐Google ☐Referral ☐Other:_____

Insurance Information

Do you have dental insurance ☐Yes ☐No Do you have secondary Dental insurance? ☐Yes ☐No

Primary Insurance		Secondary Insurance	
Subscriber Name		**Subscriber Name**	
Subscriber SSN		**Subscriber SSN**	
Date of Birth		**Date of Birth**	
Relationship to Subscriber	☐Self ☐Spouse ☐Child	**Relationship to Subscriber**	☐Self ☐Spouse ☐Child
Employer Name		**Employer Name**	
Employer Phone		**Employer Phone**	
Insurance Company		**Insurance Company**	
Insurance Group #		**Insurance Group #**	
Insurance Phone #		**Insurance Phone #**	
Please present your insurance card to our patient service representative to be photocopied			

Authorization for Release of Health Records to External Parties

I authorize the disclosure of information from my treatment records to:

Name of Recipient:_____

Relationship to Patient:_____

I give authorization to disclose the following information:

☐ All treatment information

☐ Information specifically related to these treatment dates

Starting Date:_____ End Date:_____

I understand that I may withdraw or revoke my permission at any time, by notifying NuLife Dental and Med Center

Signature of Patient (or Representative) _____ Date: _____