Nebraska Myofunctional Specialties, LLC

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PATIENT REGISTRATION

First Name: _____Last Name: _____Middle Initial:_____
Preferred Name: _____ Patient is: ___Policy Holder ___Responsible Party

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Responsible Party (if someone other than the patient)
First Name: _____Last Name: _____Middle Initial: _____
Address: _____Address 2: _____
City, State, Zip: _____Home Phone: _____
Work Phone: _____ Ext: _____Mother's cell: _____Father's cell: _____
Birth Date: _____Soc. Sec. _____ Drivers Lic: _____

___Responsible Party is also a Policy Holder for Patient ___Primary Insurance Policy Holder ___Secondary Insurance Policy Holder

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Patient Information
Address:_____
Address 2: _____
Home Phone: _____Work Phone: _____Ext: ____Cellular:_____
Sex: ___Male ___Female Marital Status: ___Married ___Single ___Divorce ___Separated ___Widowed
Birth Date: _____Age _____Soc. Sec. _____Drivers Lic:_____
E-Mail: _____ ____I would like to receive correspondences via e-mail

Section 2 _____

I have received a copy of the "Notice of Privacy Practices" in compliance with HIPAA guidelines, (Health Insurance Portability and Accountability Act)

Signature_____Date_____

Authorization for Release of Information: This authorization or photocopy hereof, will authorize Patricia L Brinkman-Falter, COM to obtain and furnish pertinent information it may have regarding the condition of _____ while under her observation or treatment. This information may be obtained from and/or released to:

Dentist:_____
Address_____ Phone_____
Orthodontist:_____
Address_____Phone_____
Other:_____
Address_____Phone_____

Signature:_____Date_____

Comments: