NEBRASKA
MYOFUNCTIONAL SPECIALTIES

PAT BRINKMAN-FALTER, BSDH, MS, COM
BOARD CERTIFIED OROFACIAL MYOLOGIST
LICENSE #613 TIN 26-3623727 NPI 1639505092

PATIENT REGISTRATION

First Name: ____________________________________Last Name: ___________________________Middle Initial:______
Preferred Name: ____ Patient is: ___Policy Holder ___Responsible Party

____

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

____

Patient Information
Address:____Address 2:
____
Home Phone: ______________________Work Phone: _____________________Ext: ____Cellular:_____________________
Sex: ___Male ___Female Birth Date: ___________________Age ______Soc. Sec. _______________________
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 the above named patient while under her observation or treatment. This information may be obtained from and/or released to:

Dentist:____Phone_________________________
Address____State_______________Zip_______________

Orthodontist:____Phone_________________________
Address____State________________Zip__________________

Medical Doctor:____Phone_________________________
Address:____State_______________Zip__________________

Other: ____Phone_________________________
Address____State________________Zip__________________

Signature:____**Date**__________________

7701 PACIFIC STREET, SUITE 319, OMAHA, NE | 8911 WHISPERING WIND ROAD, LINCOLN, NE
(402)759-1762 OR (402)882-2MYO