NEBRASKA
Myofunctional Specialties

Pat Brinkman-Falter, BSDH, MS, COM
Board Certified Orofacial Myologist
License #613 TIN 26-3623727 NPI 163950

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**_____

Omaha Office
11414 W Center Road, Suite 335, Omaha, NE 68114
Phone: (402)759-2561 or (402)882-2MYO

Lincoln Office
8911 Whispering Wind Road, Lincoln, NE
Phone: (402)759-2561 or (402)882-2MYO