BICKNELLEMG
NERVE & MUSCLE TESTING SINCE 1988
J. Eric BICKNELL, M.D.

7823 YOUREE DRIVE | SHREVEPORT, LA 71105 | P: 318.798.6833 | F: 318.798.6835

Patient's Name/Last: _____ First: _____Middle:_____ SSN:_____

Residence Address: _____ City: _____State:_____Zip:_____

Mailing Address: (Check here if same as above) ☐ _____

Home Telephone:_____Cell Telephone: _____ Email:_____

Date of Birth/Month:_____Day:_____Year:_____ ☐ Male ☐ Female Race:_____Ethnicity:_____ ☐ Hispanic/Latino ☐ Non Hispanic

Employer's Name: _____Work Telephone #:_____ Ext:_____

Language: ☐ English ☐ Spanish ☐ Other:_____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Have you ever been treated by J. Eric Bicknell in the past?_____

Name of Referring Physician:_____

RESPONSIBLE PARTY *(Check here if same as above)* ☐

Name/Last: _____ First: _____ Middle: _____Responsible Party's SSN:_____

Mailing Address:_____ City:_____State:_____Zip:_____

Home Telephone:_____ Relationship to Patient: _____DOB:_____

Employer's Name: _____Work Telephone #:_____ Ext:_____

Responsible Party's Spouse's Name (if applicable): _____ SSN:_____

IN CASE OF EMERGENCY, WHO MAY WE NOTIFY *(OTHER THAN SOMEONE LIVING WITH YOU)*

Name:_____ Relationship to Patient: _____ Telephone #:_____

Address:_____City:_____State:_____Zip:_____

INSURANCE COVERAGE: Is your illness/injury due to an Auto/Work Accident? Yes No

INSURANCE NAME	POLICY NUMBER	NAME OF POLICY HOLDER
Primary		
Secondary		

(Company Name) **AUTHORIZATION/ RELEASE OF INFORMATION**

I hereby authorize my insurance benefits to be paid directly to Dr. J. Eric Bicknell. I understand that I am financially responsible for non-covered services. I also authorize release of my medical records to my insurance carrier, other physicians, and healthcare personnel as regulated by HIPAA and outlined in our Notice of Privacy Practice.

Signed By: _____ Date:_____

☐ Patient ☐ Parent ☐ Guardian ☐ Other

**If Patient is under 18 years of age, signature of Parent or Guardian is required to authorize exam.*

(Signature) _____

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PATIENT MEDICAL HISTORY

NAME:_____ **AGE:** _____ **DATE**:_____

OCCUPATION:_____ **SEX:** ☐ Male ☐ Female RIGHT OR LEFT HANDED?

REFERRING PHYSICIAN: _____

ALLERGIES: _____

MEDICAL HISTORY: Have you had any of the following? (Check all that apply)

☐ Arthritis	☐ Poor Circulation	☐ Ulcer/ Stomach Problems
☐ Stroke	☐ Heart Problems	☐ Colon Problems
☐ Cancer	☐ Lung Problems	☐ Diabetes
☐ Thyroid Problems	☐ High Blood Pressure	☐ Other

Are you currently taking a blood thinner medication? YES NO

If yes, please list:_____ Most recent lab:_____

SURGICAL HISTORY: (List any operations you have had and approximate date)_____

_____

SOCIAL HISTORY: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

ALCOHOL USE? YES NO Frequency:_____ **TOBACCO USE?** YES NO Frequency:_____

List any immediate family with same or similar symptoms:_____

PRESENT ILLNESS HISTORY:_____

CHIEF COMPLAINT:_____

DATE OF ONSET:_____ ☐ Work related ☐ Accident ☐ MVA

DESCRIBE SYMPTOMS:

☐ Numbness	☐ Tingling	☐ Paresthesias (pins and needles)	☐ Stabbing
☐ Burning	☐ Weakness	☐ Pain	☐ Bowel or bladder dysfunction

Are symptoms:	☐ Constant	☐ Intermittent	☐ Nocturnal
	☐ Mild	☐ Moderate	☐ Severe

Aggravated by: (most uncomfortable position) _____

Relieved by: (most comfortable position) _____

Does discomfort radiate? YES NO If yes, where? _____

Have you had: ☐ Myelogram ☐ CT scan ☐ MRI ☐ EMG ☐ Plain Spine X-rays

If so, please list when and where_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please PRINT your name here

_____

Signature

_____

Date

If you are not the patient, indicate your relationship below.

- ☐ Parent or legal guardian of the minor
- ☐ Spouse
- ☐ Personal representative of the patient
- ☐ Other

Name:_____ Address:_____

Phone:_____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details)

_____

_____

*Employee signature*_____ *Date*_____

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ALTERNATIVE CONTACT AND TREATMENT FORM

We at Bicknell EMG take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff members to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

☐ *I do not authorize anyone to receive information regarding my medical care.*

☐ *I authorize my physician and the employees of this clinic to speak with:*

1. Person: _____ Relationship: _____

Phone number(s) _____

☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

2. Person: _____ Relationship: _____

Phone numbers(s) _____

☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

3. Person: _____ Relationship: _____

Phone number(s) _____

☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

Alternate means of contacting me are:

Answering machine/voice mail/pager: (_____)_____

Cell Phone: (_____)_____

Email: (_____)_____

Fax number: (_____)_____

Other: (_____)_____

This authorization will remain in effect unless changed by me while I am a patient at this office.

It is my responsibility to notify this office of changes and to complete a new form.

I agree that should I desire to revoke this authorization, I will give written notice.

PATIENT SIGNATURE:_____

PATIENT/ GUARDIAN SIGNATURE: _____

WITNESS SIGNATURE: _____

DATE: _____ TIME: _____

Patient Name: _____

Mark these drawings according to where you hurt. (If the back of your neck hurts, mark the drawing on the back of the neck, etc.) If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.

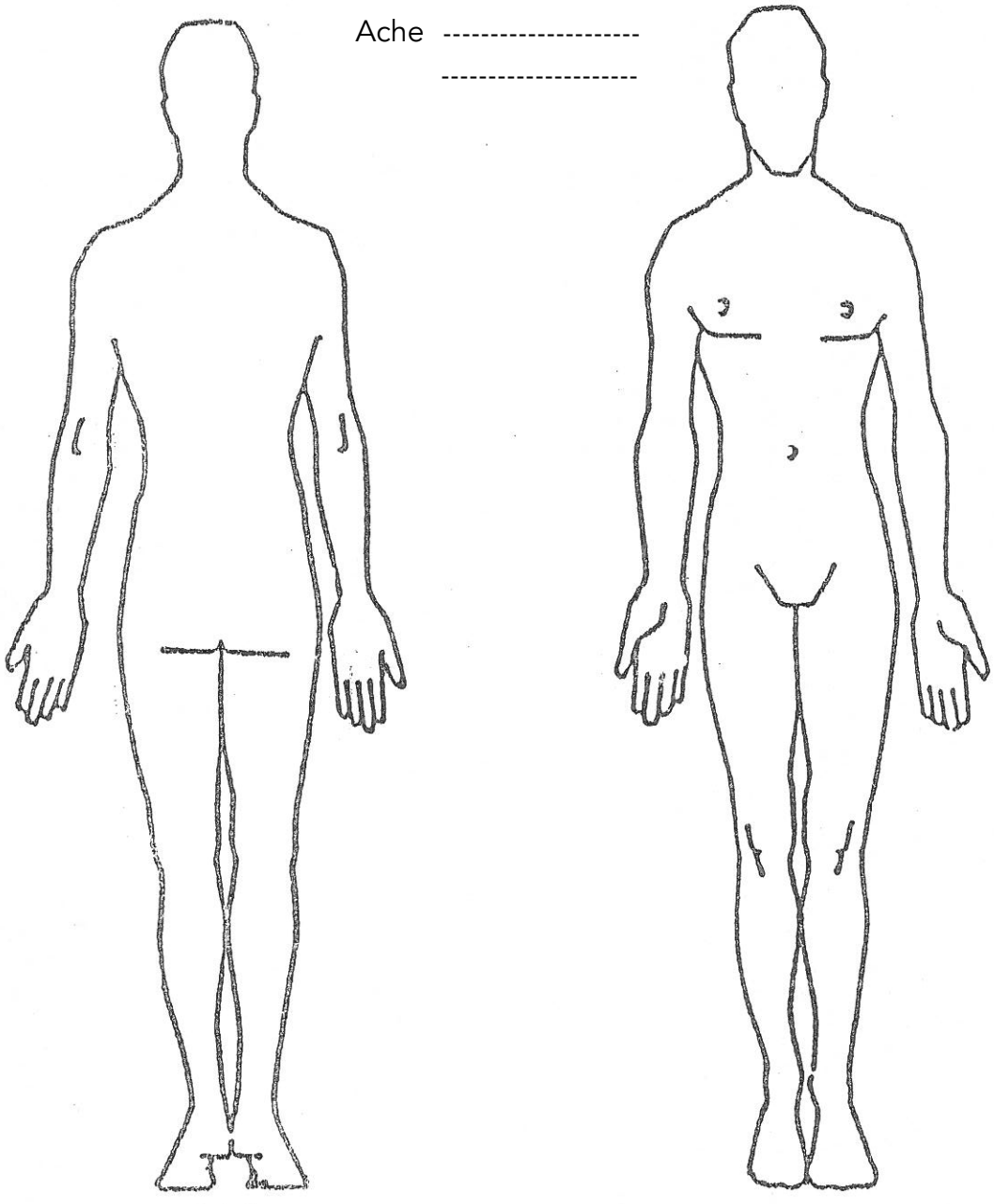
Numbness =======
=======

Pins and Needles oooooooo
oooooooo

Burning x x x x x x x
x x x x x x x

Stabbing ///////////////
///////////////

Ache ----------



BACK FRONT

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MEDICATION LIST

NAME:_____ **DATE**:_____

Please list any medications you are currently taking, including any over the counter medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____
25. _____