

### Coastal Bend Pain Management

**Michael E. Tschickardt, M.D., Medical Director**  
*Board Certified in Pain Medicine  
by the American Board of Anesthesiology  
Fellowship Trained in Pain Medicine*

**Ricardo Taboada, M.D.**  
*Board Certified in Pain Medicine  
by the American Board of Anesthesiology  
Fellowship Trained in Pain Mediciner*

**Madeline Benavidez, FNP-C | KeiKei Robinson, FNP-BC**

#### Demographics | Patient Information | Initial

**Patient Name:** \_\_\_\_\_ **Provider Name:** Michael E. Tschickardt, M.D.  
**Date of Birth:** \_\_\_\_\_ **Date of Service:** \_\_\_\_\_  
SSN: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Language Spoken: \_\_\_\_\_  
Gender:  M  F Dominant Hand:  Right  Left  
Address: \_\_\_\_\_  
Street City State Zip

**Please enter your information and check your preferred method of contact:**

Cell Phone: \_\_\_\_\_  Home Phone: \_\_\_\_\_  Work Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_ **Is it okay to leave a detailed message?**  Yes  No  
Do you have VIDEO capabilities?  Yes - FaceTime  Yes - Skype  Yes - Duo  No  Unsure  
VIDEO Contact Number: \_\_\_\_\_  
Marital Status:  Single  Married  Separated  Divorced  Widowed  
Spouse's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ OK to discuss medical issues?  Yes  No  
Employment Status:  Full-Time  Part-Time  Retired  Disabled  Home-maker/other  Student  
Place of Employment/School: \_\_\_\_\_ Job Position: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_ Address & Phone: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Other Treating Physician: \_\_\_\_\_

**Referred by:**

Internet Search  Family/Friend: \_\_\_\_\_  
 Physician: \_\_\_\_\_  Other: \_\_\_\_\_  
Emergency Contact 1: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Emergency Contact 2: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Please advise if OK to release or discuss medical issues with your emergency contact:**  Yes  No

Have had a Spinal Cord Stimulator or Pain Pump implanted: \_\_\_\_\_

**Is this a Work Related Injury?**  Yes  No **If yes, please provide DOI and adjuster contact:** \_\_\_\_\_

**Is this a Motor Vehicle accident injury?**  Yes  No **If yes, please provide date of accident:** \_\_\_\_\_

**Text Opt-In Message**

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**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_