# Coastal Bend Pain Management

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*Board Certified in Pain Medicine*
*by the American Board of Anesthesiology*
*Fellowship Trained in Pain Medicine*

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**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:** _____

**Patient Signature:** _____ **Date:**