Coastal Bend Pain Management

Jason B Baney, FNP-C
Family Nurse Practitioner
Board Certified
by the American Academy of
Nurse Practitioners

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

Madeline Benavidez, FNP-C
Family Nurse Practitioner
Board Certified
by the American Academy of
Nurse Practitioners

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

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: _____

Insurance Coverage Information

If you are NOT the insured, please fill out the requested information below.

Primary Insurance:

Insurance Co Name: _____ _Phone: _____

Member ID: _____Group ID: _____

Name of Insured: _____ Relation to Patient: _____

Insured's SSN: _____ Insured's DOB: _____

Secondary Insurance:

Insurance Co Name: _____ Phone: _____

Member ID: _____ Group ID: _____

Name of Insured: _____Relation to Patient: _____

Insured's SSN:_____Insured's DOB:_____

Signature: _____ **Date:**