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

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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

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:_____

Employer Address: _____

Pharmacy: _____ Address & Phone:_____

Primary Care Physician:_____ Other Treating Physician: _____

Referred by: ☐Internet Search ☐ Family/Friend ☐Physician ☐Other. Please Specify _____

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

*Please indicate if you have ever 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:**