TEREDESAI, McCANN & ASSOCIATES, P.C.
HYPERTENSION & KIDNEY SPECIALISTS

PATIENT INFORMATION:

Physician who Referred you to TMA: ______________________________

Reason/Condition why you were referred:____

Primary Care Physician:___________________________________

Date of Birth _____/_____/_____

Marital Status M S D W Race___________ Sex M F

Home Phone# (______) _______-__________

Cell Phone# (______) ______-_______

Work Phone# (______) ______-_________

Other Phone# (______) ______-________

Email: ____

Occupation_______________________

Highest Level of Education: High School __ Bachelors__ PhD__ Vocational__

Are you able to pay for your medications? Always__ Most of the time__Sometimes__Never__.

Primary Pharmacy________________________ Phone# (____) _____-______

Secondary/MailOrder Pharmacy____________________ Phone # (_____) _____-______

Preferred Hospital for Procedures___________________________

Do you have medical insurance? Yes No

PLEASE BRING INSURANCE CARD(S) WITH YOU TO YOUR APPOINTMENT

PERSON TO CONTACT in case of emergency:

Name_________________________ Relationship to patient__________________________

Home Phone # (_______) _______-__________

Address (only if different from patient's)

____________________________ City ____________________ State ______ Zip ________

Please Checkmark and Sign:

______ I authorize payment of insurance benefits to Teredesai, McCann & Associates.

____ (Signature)

______ I also authorize release of any medical information necessary to process this claim.

____ (Signature)