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)