THE HEART AND VASCULAR SPECIALISTS

Shashi S Bellur M.D., P.A., F.A.C.C.

Name_____ DOB_____ M or F

SSN_____ Mailing address_____

City_____ State_____ Zip_____

Cell phone_____ Home phone_____

Work phone_____Email address_____

Race_____Ethnicity_____

Emergency Contact Name_____

Emergency contact phone number_____

Primary Relationship to patient_____

Do you consent to a medical examination and any other procedures or tests Deemed medically necessary by the doctor? □YES □NO

Do you wish Dr Bellur to release medical information to your primary care Physician, the physician who referred you to our office, and/or your insurance Company? □YES □NO

Do you consent to our leaving messages on your answering machine or voicemail Regarding your appointments and/or tests? □YES □NO

Occasionally, a resident physician or medical student will do a medical cardiology Rotation in this office. Do you consent to this physician or student's presence during your examination with the doctor? □YES □NO

Do you have an Advanced Directive (Advance directives are legal documents that outline a person's preferences for the type of end-of-life and/or medical care they would receive in the event that they become ill and cannot communicate their intentions directly). □YES □NO

Patient Signature_____ Date_____

Print Name _____

Guardian Signature_____Date_____

Print Name _____

PARENT/GUARDIAN MUST SIGN FOR PATIENT UNDER AGE 18