THE HEART AND VASCULAR SPECIALIST

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

Name ______________________________ **DOB** ____/____/____ **M or F**

Address ____

City ______________________________ **State** __________ **Zip** __________

(Phone) Home ______________ **Cell** ______________ **Work** ______________

Spouse Name ____________________ **DOB** __________ **Phone** ______________

Emergency Contact ______________________________ **Phone** ______________

Referring Physician ____________________ **Primary Care Physician** ____________________

How did you hear about us? ______________________________________

Do you consent to a medical examination and any other procedures or tests deemed medically necessary by Dr. Bellur ? Yes No

Do you wish Dr. Bellur to release medical information to your Primary Care Physicians and/or to the Physician who referred you to our office? Yes No

Do you consent to our leaving messages on your answer machine or voice mail regarding your appointments and/or test results? Yes No

Occasionally a Resident Physician or a Medical Student will do a Cardiology Medical Rotation in this office. Do you consent to this Physician or student's presence during your examination with Dr. Bellur? Yes No

Signature ______________________________ Date: ____________________

************UNDER 18 YEARS OLD MUST HAVE A PARENT/GUARDIAN SIGN ************