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_____
Married _____ Single_____ Widowed_____

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

Name of Primary Care Physician_____
Address, phone and fax number_____
_____

Do you consent to our leaving messages on your answering machine or voicemail Regarding your appointments and/or tests? □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