THE HEART AND VASCULAR SPECIALISTS

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

Name_______________________________________DOB ________________ M or F

SSN ___________________Address____

City_____________________________ State _________________ Zip ____________

Primary Phone______________________ Secondary Phone_________________________

Emergency Contact____

Phone ___________________________Relation to Patient _______________________

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 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

Signature ______________________________________ Date ______________________

********PARENT/GUARDIAN MUST SIGN FOR PATIENT UNDER THE AGE OF 18***********