THE HEART AND VASCULAR SPECIALISTS

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

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/Chavez 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**********