Cardiac Surgical Associates

PATIENT REGISTRATION FORM

PLEASE PRINT

Today's Date: _____

Last Name:_____ **First** Name:_____ MI _____

Primary Address:_____

City:_____State:_____Zip:_____

Local Address: (if applicable)_____

City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email: _____

Date of Birth:_____ Gender: ❑Male ❑Female SS#: _____

Marital Status: ❑Single ❑Married ❑Divorced ❑Other

Race: ❑African American ❑White ❑Asian ❑Hispanic ❑Other

Language: ❑English ❑Spanish ❑Other

Physicians

Primary/Family Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Cardiologist: _____ Phone: _____

Employer Information

Employed: ❑Full Time ❑Part-time ❑Unemployed ❑Disabled ❑Retired ❑Military

Employer:_____Job Title: _____

Phone: _____

Pharmacy

Name: _____ Phone: _____

Emergency Contact

Name:_____ Relationship:_____

Home Phone:_____ Work Phone:_____

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Insurance (Please present card to photocopy)

Primary Insurance _____	**Secondary** Insurance _____
Member ID# _____	Member ID# _____
Group# _____	Group# _____
Phone# _____	Phone# _____
Subscriber's Name _____	Subscriber's Name _____
SS# _____	SS# _____
Date of Birth _____	Date of Birth _____

Guarantee of Payment: For services rendered, the undersigned does hereby agree to guarantee and promise to pay Cardiac Surgical Associates all charges incurred in the treatment of the name patient, including the expenses not covered by any insurance presently in force. If any action at law or inequity is brought to enforce this agreement, Cardiac Surgical Associates shall be entitled to reasonable attorney's fees, court costs and any other cost of collection incurred. I understand that all bills are payable and become due upon presentation.

Receipt of Notice of Privacy Practices: By my signature on this document, I acknowledge receipt of the Notice of Privacy Acts.

I hereby authorize Cardiac Surgical Associates to release all or part of my medical records to Medicare and/or any other companies, if requested, without any liability to CSA. I hereby authorize Medicare and/or my insurance companies to pay directly to CSA any payments, assignments or benefits due me.

Patient Signature_____Date: _____