CARDIAC SURGICAL ASSOCIATES
An Affiliate of Osceola Regional Medical Center
720 w. Oak Street Suite 360, Kissimmee, FL 34741
Phone: (407) 846-0090 ● Fax: (407) 846-0072

PATIENT REGISTRATION FORM

Today's Date: _____

Last Name: _____ First Name: _____ M.I. _____

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

Emergency Contact

Name: _____ Relationship: _____

Primary Phone: _____ Secondary Phone: _____

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: _____ Fax: _____

Guarantee of Payment: For services rendered, the undersigned does hereby to agree to guarantee and promise to pay Cardiac Surgical Associate 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:** _____