

Advanced Heart Care Group  
Dr. Omar Almousalli M.D.  
4600 Memorial Drive, W3 Belleville, IL 62226  
618-222-8900 Fax 618-222-8950

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**Patient Registration Form**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sex: Male/Female Marital Status: Single/Married, Social Security # \_\_\_\_\_

Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone Number :(\_\_\_\_\_) \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

**Primary Insurance Information**  
(Please make sure we get a copy of card)

Name of Insurance: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policyholder's Relationship to Patient: \_\_\_\_\_

**Secondary Insurance Information**  
(Please make sure we get a copy of card)

Name of Insurance: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policyholder's Relationship to Patient: \_\_\_\_\_

**Consent to Payment**

I have listed all health insurance plans from which I may receive benefits. I hereby authorize payment of medical benefits billed to my insurance to Dr. Omar Almousalli. I hereby accept responsibility for payment for any service provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if Dr. Omar Almousalli does not participate with my insurance. I agree to pay all co-payments, coinsurance, and deductibles at the time of services are rendered. I hereby authorize Dr. Omar Almousalli to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations.

I understand that while this consent is voluntary, if I refuse to sign this consent, Dr. Omar Almousalli can refuse to treat me.

\_\_\_\_\_  
Signature of Patient or Patient's Representative /Relationship

\_\_\_\_\_  
Date