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

Patient Registration Form

Name: ____Date of Birth_____________________

Sex: Male/Female   Marital Status: Single/Married, Social Security #_____________________________
Widowed/Divorced

Address:

____

____

Home Phone Number: (________) ___________________Work Phone (_________) _________________

E-mail address:___________________________________Cell Number(_________)__________________

Emergency Contact Person: ________________________Phone Number :(_________) _______________

Place of Employment: ____

Primary Physician: ____

Primary Insurance Information

Name of Insurance: ____

Policy Holder Name: ______________________________________Date of Birth: _________________

Insurance ID Number: ________________________________Group Number: _____________________

Policyholder's Relationship to Patient: ____

Policyholder's Social Security #____

Secondary Insurance Information

Name of Insurance: ____

Policy Holder Name: ______________________________________Date of Birth: _________________

Insurance ID Number: ________________________________Group Number: _____________________

Policyholder's Relationship to Patient: ____

Policyholder's Social Security #____

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.

X____ ____________________________

Signature of Patient or Patient's Representative /Relationship Date