Abdallah Karam, M.D., S.C.
2101 South Arlington Heights Road, Suite 100 | Arlington Heights, Illinois 60005
Telephone: (847) 427-2100 | Fax: (847) 427-2111

PATIENT REGISTRATION FORM

Date _____ ***Home Phone*** (_____) _____ ***Cell Phone*** (_____) _____

PATIENT INFORMATION

_____
Last Name ***First Name*** ***Middle Initial***

Address _____ Patient Employer _____

City _____ Employer Address _____

State _____ Zip _____ _____

Sex ☐ M ☐ F Birthday _____ /_____ /_____ Phone (_____) _____

Soc. Sec. # _____ Whom may we thank for referring you?

☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Dr. _____

☐ Single ☐ Partnered for _____ years ☐ Family ☐ Friend ☐ Hospital ☐ Website

Occupation _____ ☐ Other _____

Emergency Contact and Phone Number (Required) _____

PRIMARY INSURANCE

_____
Subscriber Last Name ***First Name*** ***Middle Initial***

Relation to Patient _____ Subscriber Soc. Sec. # _____

Address (if different from patient's) _____ Insurance Company _____

_____ Contact # _____ Group # _____

City _____ Subscriber # _____

State _____ Zip _____ Phone (_____) _____

Sex ☐ M ☐ F Birthday _____ /_____ /_____ Employer Phone (_____) _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ YES ☐ NO Contact # _____ Group # _____

Additional Insurance Company _____ Subscriber # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Karam all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient