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 PAGE 2

Patient Name: ____ Date: ____________________

Occupation: ____

1. **I give Abdallah Karam, MD, my consent to check my prescription pharmacy history.**

   YES _____ NO _____

   What is the name and phone number of your local pharmacy?

   Pharmacy Name: ____

   Address: ____

   Phone Number: ___

   Mail Order Pharmacy Name: _________________________________ Phone: ____________________

2. **I give Abdallah Karam, MD, my consent to report immunizations to the State of Illinois Immunization Registry.**

   YES _____ NO _____

3. **Do you have a written Advanced Directive/Living Will or Healthcare Power of Attorney in place?**
   If yes, please plan to bring a copy with you to your next appointment for us to scan into your record.

   YES _____ NO _____

   If no, would you like information regarding your patient rights in making healthcare decisions?
   YES _____ NO _____

4. **What is your race?**

   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Native Hawaiian/Other Pacific Islander
   - ☐ Black or African American
   - ☐ White
   - ☐ Hispanic
   - ☐ Other: ________________________________

5. **What is your Ethnicity?**

   - ☐ Hispanic or Latino
   - ☐ Not Hispanic or Latino
   - ☐ Refused to Report

6. **Is English your primary language?**

   YES _____ NO _____

   If no, what is your primary language? ____

Patient Signature: ____ **Date**: ____________________