Williams Eye Institute
6850 Hohman Avenue
Hammond, IN 46324-1410
USA

PATIENT INFORMATION

NAME (Last, First Middle)			MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP		REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS		ETHNICITY	
HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP		RACE	
MARITAL STATUS	STUDENT STATUS ☐Full-Time ☐Part-Time	SMOKER (Y/N)? N	VETERAN (Y/N)? N	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)			SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP			SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS ☐Full-time ☐Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
RELATIONSHIP TO PATIENT						

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
CITY, STATE ZIP	PHONE	DEDUCTIBLE	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT
CITY, STATE ZIP	PHONE		DEDUCTIBLE
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

Please choose one of these options for race, language and ethnicity :

Race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian, Caucasian/White, Multiracial, Refused.
Preferred Language: English, Spanish, Other, Refused.
Ethnicity: Hispanic or Latino, Not Hispanic or Latino, Refused.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____