

**Williams Eye Institute & Surgery Center**

6850 Hohman Avenue – Hammond, IN 46324

8510 Broadway – Merrillville, IN 46410

**PATIENT INFORMATION**

Patient Name (Last, First, Middle Initial)		M/F	Birthdate	SSN
Address		Primary Language	Race*	Ethnicity**
City, State, Zip Code		*Race: White/Black /Hispanic/Asian/Hawaiian/Greek/Multi **Ethnicity: Hispanic/Latino or Not Hispanic/Latino		
Home Phone	Cell Phone	Email		
Emergency Contact		Contact Phone	Contact relationship	

Primary Employer	Employer Address
Employer City State Zip	Employer Phone

**RESPONSIBLE PARTY INFORMATION (If different than above)**

Name (Last, First, Middle Initial)		M/F	Birthdate	SSN
Address		Primary Language		
City, State, Zip Code		Relationship to Patient		
Home Phone	Cell Phone	Email		

**PRIMARY INSURANCE**

Name of Insurance Company	Policy Number
Name of Insured	Group Number
Insurance Address	Insurance Company Phone
Insurance City, State, Zip Code	Relationship to Patient

**SECONDARY INSURANCE (If Applicable)**

Name of Insurance Company	Policy #
Name of Insured	Group #
Insurance Address	Insurance Company Phone
Insurance City, State, Zip Code	Relationship to Patient

**HOW DID YOU HEAR ABOUT WILLIAMS EYE INSTITUTE?**
 Newspaper     Yellow Pages     Sign on Building/Drove By     Radio/Television     Internet/WebSite
 Friend/Family Member Name: Doctor/Optometrst Name:\_\_\_\_\_  
Signature of Patient\_\_\_\_\_  
Date