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

Best way to contact you (please circle): Home Phone Cell Phone Text Email Mail

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? (Please Mark)

□ Newspaper □ Yellow Pages □ Sign on Building/Drove By □ Radio/Television □ Internet/WebSite

□ Friend/Family Member Name: □ Doctor/Optometrist Name:

Signature of Patient Date