Williams Eye Institute & Surgery Center
6850 Hohman Avenue – Hammond, IN 46324
9797 Massachusetts Street – Crown Point, IN 46307

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 Date of Birth	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