NORTHWEST INDIANA EYE LASER CENTER

☐ New Patient ☐ Updated Information ☐ Updated Insurance

Today's Date:			
PATIENT INFORMATION			
Last Name	First Name & Initial		
Address 1			
Address 2	Email Address;		
City	State	Zip Code	
Home Phone	Cell Phone:		Age
Marital Status M/S/W/D	Sex: F / M	**Birthdate:**	
Patient's Social Security #			
Patient's Employer			
Employer Address			
City	State	Zip Code	
Employer's Phone	Ext		
Who Referred You Here Today?			
GUARANTOR/SPOUSE INFORMATION			
Responsible Party Last Name			
Responsible Party First Name & Initial		Relationship to Patient	
Address			
City	State	Zip Code	
Home Phone	Cell Phone		
Birthdate	**Responsible Party Social Security #**		
Employer	Employer Phone	Ext	
Employer Address	City	State	Zip Code
INSURANCE #1:			INS#1 CODE
Medicare/Medicaid/Insurance #1		Phone No.	
Address			
Policy Holders Last Name	First Name & Initial		Relationship
Certificate/ID #	Group#	Member #	
Effective Date of the Policy	**BIRTHDATE:**	**SOCIAL SECURITY:**	
INSURANCE #2:			INS#2 CODE
Medicare/Medicaid/Insurance #2		Phone No.	
Address			
Policy Holder Last Name	First Name & Initial		Relationship
Certificate#	Group#	Member#	
Effective Date of the Policy	**BIRTHDATE:**	**SOCIAL SECURITY:**	
Is your condition a result of an injury at work?	Yes No	Date of Injury:	Claim#
Is your condition a result of an auto accident?	Yes No	Date of Accient:	Claim#
Emergency Contact Person:		**Phone #:**	
INCOMPLETE OR INACCURATE COMPLETION WILL RESULT IN PAYMENT DUE FROM YOU			

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM