WILKEN FAMILY EYE CARE
& Distinctive Eye Wear

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Coppell, Texas 75019
972-410-1313

Welcome to Our Office

Name _____ Mid. Init._____

Street_____

City_____ State_____ Zip_____

Home Phone_____

Work Phone_____

Cell Phone_____

Email_____

Employer (School)_____

Today's date _____ Date of last exam_____

Date of Birth_____ Age_____ Sex: M F

Insurance Provider_____

Primary Member Name_____

Member SS #_____ DOB_____

Member ID# (if using medical ins.)_____

Primary Member Employer_____

*We bill your insurance based on direct quotation of benefits.

This does NOT guarantee payment by your insurance company.

Medical History – F=Family, S=Self

Allergies	F	S	Arthritis	F	S
Asthma	F	S	Cancer	F	S
Skin Disorder	F	S	Diabetes	F	S
Eye Diseases	F	S	Heart Disease	F	S
Eye Injury	F	S	High Blood		
Eye Surgery	F	S	Pressure	F	S
Lazy Eye	F	S	Kidney Disease	F	S
Cataracts	F	S	Nerves	F	S
Glaucoma	F	S	Other_____		

Current Medications (Rx or Over the Counter)

(especially for any conditions listed above)

		Name of Medication
Antihistamines	Yes	No_____
Eye Drops	Yes	No_____
Blood Pressure Meds	Yes	No_____
Cholesterol Meds	Yes	No_____
Oral Contraceptives	Yes	No_____

Other_____

Drug Allergies_____

HIPPA Privacy Statement

I have had the full opportunity to read the Notice of Privacy Practices from WFEC that is attached to the clipboard (copies available):

Name _____ Date_____

What brings you in today?

_____

_____

Do you have any specific concerns?

_____

_____

Do you currently Wear Glasses? Yes No

What would you change about your glasses?

_____

_____

_____

Do you have more than 1 pair? Yes No

If yes, for what purpose_____

What kind of frames or lenses would you be interested in?

_____

_____

Do you currently wear contacts? Yes No

If ***Yes***:

What brand do you wear?_____

What solution do you use?_____

How often do you dispose of them?_____

Do you wear them overnight?_____

If ***No***:

Are you interested in contact lenses? Yes No

Are you interested in a "Test Drive" of the latest contact lens technology? Yes No

Are you interested in contacts to non-surgically correct your nearsightedness overnight? Yes No

Do you Experience any the following Symptoms?

Burning	Itchiness	Watery Eyes
Discomfort	Glare or Reflections	Dryness
Headaches	Sensitivity to Light	Poor Night Vision

How did you hear about our Office?

Friend or Relative Yellow Pages Insurance

Previous Patient (Who?_____)

Drive by Other_____

This is a notice to inform you that Wilken Family Eye Care takes your privacy very seriously. Our privacy practices are posted and any information contained on this page is for our use and will not be shared with anyone for any use other than healthcare operations.