WELCOME TO DR. MICHAEL J. NIEDERKORN & ASSOCIATES

Family Vision Care

PATIENT REGISTRATION

Patient Last Name ______________________ Patient First Name ______________________ Gender M / F

Date of Birth ____/____/____ Age ______ Name of Parent or Spouse ______________________

Address ______________________ City ______________ Zip Code __________

Phone ______________________ Home / Cell ______________________ Work

SS# (If using Insurance) ____/____/____ Email ______________________

Occupation ______________________ Employer/School ______________________

Have we seen other members of your family? Y / N If so, who ______________________

Last Eye Doctor ______________________ Date of Last eye Examination ____/____/____

Please describe the reason for your visit today.

UPDATED ☐ 2018 ☐ 2019 ☐ 2020 ☐ 2021 ☐ 2022 ☐ 2023 ☐ 2024

MEDICAL AND VISUAL HISTORY

Check any Medical Conditions that apply to You

☐ Diabetes ☐ Allergies ☐ Asthma ☐ Heart Disease ☐ High Blood Pressure
☐ Cancer ☐ Headaches ☐ Arthritis ☐ Seizures ☐ Lung Disease
☐ Other

Do You Smoke? ☐ Yes ☐ No

Please list any Medications you are currently taking

Are you allergic to any medications? If so, which?

Check any Eye Conditions that apply to YOU

☐ Glaucoma ☐ Cataracts ☐ Light Flashes ☐ Eye Surgery ☐ Macular Degeneration
☐ Dry Eyes ☐ Turned Eye ☐ Vision Therapy ☐ Lazy Eye ☐ Eye Disease
☐ Floaters ☐ Other

Check any Conditions present in FAMILY

☐ Glaucoma ☐ Cataracts ☐ Lazy Eye ☐ Macular Degeneration
☐ Blindness ☐ Diabetes ☐ Thyroid Disease ☐ High Blood Pressure
☐ Other

CONTACT LENS HISTORY

☐ I would like to know my contact lens options ☐ Not interested in contact lenses ☐ Never worn contact lenses

☐ When was the last time you wore contact lenses? ____________ ☐ Problems with contact lenses ______________________

Please list the type of contact lenses you currently wear

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