Advanced Eye Care for Your Family
Chad H. Clark, OD
1205 S. Five Mile Rd., Boise, ID 83709
Ph: (208) 322-8381 | Fax: (208) 322-8389
www.visionsource-boise.com

Please help us meet your vision and eye health needs by providing the following information.

Today's Date___/___/_____

Name_____ _____ DOB_____/_____/_____ Age_____
First M.I. Last Preferred Name

Address_____ Soc. Sec. #_____
Street City State Zip

Cell Ph_____ Home Ph_____ Email Address_____

Employer/School_____ Occupation_____

Spouse's Name, if married_____ Parent's Name, if pt is a minor_____

Name of Medical Doctor_____ Last Medical Exam___/___/____ Last Eye Exam___/___/___

Medical Insurance_____ Vision Insurance_____

How will you settle your account today? ❑ Check ❑Cash ❑Credit Card ❑Payment Program

How did you find our office? ❑Location ❑Google/Internet Search ❑Other_____

If you were referred to our office, whom may we thank for the referral? _____

Fees are due in full when services are rendered. Deposit is required to order glasses. Phone verification of insurance coverage does not guarantee benefits or payment. Your signature on this form will serve as your signature on file for processing insurance claims. I have read and understand the above and I agree to pay for services and materials which I order that my insurance does not cover.

Please Sign Here _____

Please turn over and complete back page, if applicable. →

VISION SOURCE

CHAD H. CLARK, OPTOMETRIST

PROTECTED HEALTH INFORMATION RELEASE

Only for patients over the age of 18.

Please check all applicable boxes and fill in any blank spaces where information is requested.

☐ Only release information to me personally.

☐ You have my permission to speak with my spouse or significant other about my medical care and test results.

Spouse/Significant Other's Name _____ Phone _____

☐ You have my permission to talk with my children, family members, or others involved with my medical care as listed below.

Name	Relationship	Phone

☐ Other, please describe: _____

Emergency Contact Information

Name (first and last): _____ Phone# _____

City/State/Zip: _____ Relationship to pt: _____

Patient Contact Information

Cell # _____ Home # _____ Work# _____

Email Address _____

May we contact you at the above email address? Yes No

May we leave messages regarding your medical care and test results on your answering machine? Yes No

_____ _____ _____

Print Your Name Here *Signature* *Date*

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VISION SOURCE

Patient Name _____ Preferred Name _____ Date_____

VISION & EYEWEAR INFORMATION

Please list any complaints about your current glasses or contacts._____
Do you have more than one pair of glasses? Yes No
If you wear glasses, would you benefit from thinner, lighter lenses? Yes No
Do you spend significant time working on a computer? Yes No
Do you spend a lot of time outdoors? Yes No
Hobbies_____
If you wear contact lenses, what type do you wear?(please circle) Gas Permeable Disposable Soft Soft (yearly)
Laser vision correction is an option for many people. Do you desire information or a free consultation? Yes No

FAMILY HISTORY

Do your parents, grandparents, siblings, or children have any of the following conditions?

Condition			Relationship to You
Blindness	Yes	No	_____
Cataracts	Yes	No	_____
Glaucoma	Yes	No	_____
Macular Degeneration	Yes	No	_____
Retinal Disease	Yes	No	_____
Cancer	Yes	No	_____
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
Thyroid Disease	Yes	No	_____
Other	_____		

SOCIAL HISTORY

All information about our patients is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. Please initial here _____ if this is your preference.

Do you use tobacco products? Yes No If yes, type/amount/how long? _____
Do you drink alcohol? Yes No If yes, type/amount/how often? _____
Do you use illegal drugs? Yes No If yes, type/amount/how long? _____
Do you drive? Yes No If yes, do you have difficulty with your vision when driving?
Please explain/describe. _____
_____

Please turn over and complete back page.→

VISION SOURCE

MEDICAL HISTORY & REVIEW OF SYSTEMS

Please list ALL medications taken, including homeopathic remedies, birth control, and over-the-counter medications. If we haven't provided enough space, please attach a list of your medications.

_____

_____

_____

Please list any medications you are allergic to.

_____

_____

_____

Please list all major injuries and surgeries you have undergone. _____

_____

_____

Please check any of the following that you have had:

- ❑ lazy eye
- ❑ drooping eyelid
- ❑ retinal disease
- ❑ chronic eye infections
- ❑ crossed eyes
- ❑ glaucoma
- ❑ cataracts
- ❑ eye injury

Are you pregnant and/or nursing? Yes | No

Please check any of the following that have caused significant or chronic problems for you in the column under the current year:

EYES	2022			
Loss of vision	❑	❑	❑	❑
Blurred or distorted vision	❑	❑	❑	❑
Double vision	❑	❑	❑	❑
Dryness	❑	❑	❑	❑
Itching or burning	❑	❑	❑	❑
Chronic redness	❑	❑	❑	❑
Eye pain or soreness	❑	❑	❑	❑
Flashes or floaters	❑	❑	❑	❑
Glare or light sensitivity	❑	❑	❑	❑
Watering or tearing	❑	❑	❑	❑
EARS/NOSE/MOUTH/THROAT				
Allergy/hay fever	❑	❑	❑	❑
Chronic sinus infection	❑	❑	❑	❑
Dry mouth	❑	❑	❑	❑
NEUROLOGICAL				
Headaches or migraines	❑	❑	❑	❑
BONES/JOINTS/MUSCLES	❑	❑	❑	❑
CONSTITUTIONAL				
Fever, weight loss/gain	❑	❑	❑	❑
INTEGUMENTARY(SKIN)	❑	❑	❑	❑

HEMATOLOGIC	2022			
Bleeding problems	❑	❑	❑	❑
ALLERGIC/IMMUNOLOGIC	❑	❑	❑	❑
PSYCHIATRIC	❑	❑	❑	❑
GENITOURINARY				
Kidney, bladder, genitals	❑	❑	❑	❑
ENDOCRINE				
Thyroid or other glands	❑	❑	❑	❑
Diabetes Type I/Type II (circle)	❑	❑	❑	❑
RESPIRATORY				
Asthma	❑	❑	❑	❑
Emphysema	❑	❑	❑	❑
CARDIOVASCULAR				
High blood pressure	❑	❑	❑	❑
Heart attack	❑	❑	❑	❑
High cholesterol	❑	❑	❑	❑
Stroke	❑	❑	❑	❑
Vascular disease	❑	❑	❑	❑
GASTROINTESTINAL				
Chronic diarrhea or constipation	❑	❑	❑	❑

If you checked any of the above conditions or have a condition not listed, please explain.

_____

_____