RUTHERFORD VISION CARE, LLC Date ____/_____/_____

Patient First Name_____ MI___ Last_____ Birthdate____/____/____ Age ____Sex M / F

Address_____ City_____ ST_____ Zip_____

PH: Home _____ PH: Cell _____ PH: Work _____

Occupation (or grade if school)_____ Employer_____

Email

(Please PRINT)

PATIENT HISTORY

What is the primary reason for today's visit?	Last eye exam?
List any eye conditions, injuries or EYE surgeries	List any allergies and/or allergies to medicine
List medications	
List any MEDICAL conditions, injuries or surgeries	
Do you have frequent headaches? No / Yes; If yes, what is the: • Frequency: _____ (times per day / week / month) (circle one) • Location _____ (front of head, back of head, eyes, etc…) • Severity _____ (0/10= least pain;10/10 = most pain)	
Do you or any blood relatives have: • Cataracts? (___Neither) (___Self) (___Family) (list member(s):_____) • Macular Degeneration? (___Neither) (___Self) (___Family) (list member(s):_____) • Glaucoma? (___Neither) (___Self) (___Family) (list member(s):_____) • Diabetes? (___Neither) (___Self) (___Family) (list member(s):_____)	
(Females only): Are you pregnant, breastfeeding or is there likelihood you may be pregnant? No / Yes	

CONTACT LENS INFORMATION

Are you interested in wearing contact lenses? No / Yes

Are you a new wearer to contact lenses? No / Yes

Current brand of Contacts? _____Daily Disposable / Bi-Weekly / Monthly?

Current Rx of lenses? (RIGHT)_____(LEFT)_____

INSURANCE INFORMATION

Name of the **PRIMARY MEMBER** for your insurance policy: _____& Date of Birth: _____

NOTE: (IF your insurer is *VSP*, *CIGNA* OR *EYEMED)* also include the last 4 of their social SSN: _____.

IF PATIENT IS UNDER 18 YEARS OF AGE:

Mother's Name:		Birthdate: / /	Phone:
Father's Name:		Birthdate: / /	Phone:
-Or- Guardian's Name:		Birthdate: / /	Phone:

PATIENT AUTHORIZATION FORM

(Required in order to send billing codes to your insurer)

Jason Rutherford, OD
Rutherford Vision Care, LLC

• I authorize the above named physician group and facility to release any and all records, medical history, services rendered or treatment given to the patient for purposes of review, investigation or evaluation of any claim submitted to my insurer(s).

• I authorize the transferring of any and all necessary personal, medical or demographic information by the pharmacy in order to fill or refill medical prescriptions. I understand that this information may be transferred electronically, verbally or in writing.

• I hereby assign, transfer and set over to the above named physician group and facility sufficient monies and or benefits to which I may be entitled from government agencies, insurance carriers and/or others who are financially liable for the cost of care and treatment rendered to the patient.

_____ _____
Date Signature of Patient/ Guarantor

_____
Printed name of Signee

Patient Name (if different from Guarantor):_____