Corning Eye Center
Excellence in Eye Care

▪ *Welcome!*

Your appointment is with Dr. Corning on_____at_____.

We appreciate the opportunity to be your eye care provider. In order to expedite your first visit, we have enclosed a packet of information for you to fill out prior to your appointment. Please bring the forms with you to your appointment:

Lasik pre-op screening:

1) Are you, or have you taken Accutane (isotretinoin)
2) Are you, or have you taken Amiodarone (pacerone)
3) Are you a Diabetic?
   If so A1C=

4) Do you have Glaucoma?

5) Any Autoimmune diseases?

   (RA,Lupus,Sjogrens)

6) Are you pregnant or planning to become pregnant in the next 6 months?

7) Do you have a history of Herpes Simplex of the eyes?

*Please bring a list of your medications.

The doctor will be dilating your eyes and you may need a driver, as your eyes will be sensitive to sun light. Lasik patients must discontinue soft contact lens wear 1 week or 3 weeks for hard contact lens, prior to your appointment.

Please allow 2 hours for your consultation.

We are so glad that you and your optometrist chose Dr. Corning for your vision health care. Again, we look forward to seeing you. Please feel free to contact us at **(580) 332-1880** if you have further questions.

1425 Arlington, Ada, Oklahoma 74820
Ph: 580-332-1880 ▪ Fax: 580-332-2214

▪ Patient Data Sheet

Account # _____

First Name:_____ Middle Initial:_____ Last Name: _____

Address:_____ City:_____ State:_____ Zip:_____

Date of Birth:_____ Age:_____ Marital Status: M S D W Sex: M F

Home Phone: (_____)_____ Work Phone: ( )_____ Cell Phone: (_____)_____

SS#_____ E-mail:_____ Driver's License #: _____

Race:_____ Ethnicity:_____ Preferred Language: _____

Follow-up Preference: ☐ Phone ☐ E-mail ☐ Mail

How do you prefer appointment reminders: Text Message or Phone Call (Cell, Home or Work)

Optometrist:_____ Referring Physician:_____ Primary Care Physician: _____

How did you hear of our office? (*circle*) Family/Friend Insurance Plan Optometrist TV Ad Other _____

Employer:_____ Employer Address:_____ City/State/Zip: _____

Insurance Information

Primary Insurance:_____ I.D.#:_____ Group #: _____

Secondary Insurance:_____ I.D. #:_____ Group #: _____

Primary Insured/Responsible Party Information
(if different from patient information)

ss# _____

Name:_____ Relationship to patient: _____

Address:_____ City:_____ State:_____ Zip: _____

Date of Birth:_____ Age:_____ Marital Status: M S D W Sex: M F

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____) _____

E-mail: _____

Visit Information

Reason for your visit? _____

If this visit is due to an accident, please provide accident date: _____

What Pharmacy do you use?_____ **Pharmacy Address:** _____

Privacy Information

Relative/Friend whom we may contact in case of an emergency and/or about your visit if necessary (HIPPA compliance):

1) _____ Relationship_____ Phone#: _____

2) _____ Relationship_____ Phone#: _____

I certify that I have been provided the Patient Information Privacy Notice: Copy available at the office or on our website. www.corningeyecenter.com

_____ _____

Patient Signature Date

Patient Name:_____

DOB: _____

Circle "Yes" or "No" to indicate if you have had any of the following:

Eye History:

Blindness	Yes	No	Family History -	Yes	No	Relationship:
Cataracts	Yes	No	Family History -	Yes	No	Relationship:
Diabetic Retinopathy	Yes	No	Family History -	Yes	No	Relationship:
Glaucoma	Yes	No	Family History -	Yes	No	Relationship:
Macular Degeneration	Yes	No	Family History -	Yes	No	Relationship:
Retinal Detachment	Yes	No	Family History -	Yes	No	Relationship:

General History:

Arthritis	Yes	No	Family History -	Yes	No	Relationship:
Cancer	Yes	No	Family History -	Yes	No	Relationship:
Diabetes	Yes	No	Family History -	Yes	No	Relationship:
Heart Disease	Yes	No	Family History -	Yes	No	Relationship:
High Blood Pressure	Yes	No	Family History -	Yes	No	Relationship:
High Cholesterol	Yes	No	Family History -	Yes	No	Relationship:
Kidney Disease	Yes	No	Family History -	Yes	No	Relationship:
Lung Disease	Yes	No	Family History -	Yes	No	Relationship:
Lupus	Yes	No	Family History -	Yes	No	Relationship:
Stroke	Yes	No	Family History -	Yes	No	Relationship:
Thyroid	Yes	No	Family History -	Yes	No	Relationship:

Have you ever taken Flomax? Yes No If yes – how long:

Have you ever had a staph infection? Yes No

Do you work in a healthcare field? Yes No

Social History:

Current Occupation/Hobbies: Full time/Part time/Not Employed/Retired

Are you pregnant? Yes No

Smoker Status: Current smoker Former smoker Never smoked

Drinker status: Current Former Never

Chemical Dependency: Yes No Drug use:

Living Arrangements: Lives alone With family Lives in assisted living/Nursing Home/Skilled Nursing

Do you drive? Yes No If no - why:

Do you have visual difficulty when driving? Yes No

Do you have problems with night vision? Yes No

Do you have difficulty with computer use? Yes No

Do you have difficulty when reading? Yes No

Do you have difficulty watching television? Yes No

Do you wear contacts? Yes No Type: Hours per day: How many years:

Do you wear glasses? Yes No

Patient Name:_____

DOB: _____

Circle "Yes" or "No" to indicate if you currently have any of the following:

Eye:

Loss of Vision:	Yes	No	Blurred Vision:	Yes	No
Fluctuated Vision:	Yes	No	Distorted Vision:	Yes	No
Loss of Side Vision:	Yes	No	Double Vision:	Yes	No
Dryness:	Yes	No	Mucus:	Yes	No
Redness:	Yes	No	Sandy or Gritty Feeling:	Yes	No
Burning or Itchy:	Yes	No	Foreign Body Sensation:	Yes	No
Excess Tearing/Watering:	Yes	No	Glare and Light Sensitivity:	Yes	No
Eye Pain or Soreness:	Yes	No	Infection of Eyelid:	Yes	No
Tired Eyes:	Yes	No	Crossing Eyes:	Yes	No
Lazy Eye:	Yes	No	Drooping Eyelid:	Yes	No

Circle "Yes" or "No" to indicate if you have any signs or symptoms in these body systems:

Review of Systems:

Constitutional symptoms (fever, weight loss, fatigue, trouble sleeping)	Yes	No
Ears, nose, mouth, throat	Yes	No
Cardiovascular (heart/artery/vein)	Yes	No
Respiratory (lung/larynx)	Yes	No
Gastrointestinal (digestive/stomach)	Yes	No
Genitourinary (kidney/bladder/genital)	Yes	No
Musculoskeletal (bones/joints)	Yes	No
Integumentary (skin and/or breast)	Yes	No
Neurological (seizures/dizziness/etc.)	Yes	No
Psychiatric (stress/depression/nervousness)	Yes	No
Endocrine (sweating/frequent urination/thirst)	Yes	No
Hematologic/lymphatic (bruising/bleeding)	Yes	No
Allergic/immunologic (immune system, HIV, AIDS, Hepatitis)	Yes	No

Please List All Current Medications and Dosage:

Please List All Known Allergies:

Please List All Past Surgeries & Surgery Dates:

▪ CONSENT FOR DILATING EYE DROPS

A variety of eye drops may be administered during the course of your eye examination. Dilating drops enlarge the pupils of the eye to allow for the examination of the inside of your eye. These drops usually cause blurred vision. The length of time vision will be blurred and the degree of eyesight impairment varies from person to person. It is not possible for your doctor to predict how much or how long your vision will be affected. Driving even in low light conditions may be difficult or impossible after an examination with dilating drops, and, if possible you should not drive yourself afterwards.

Instead, we strongly suggest you make alternate arrangements for transportation after your examination. If you choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving. Although uncommon, the potential for adverse reactions from eye drops does exist, such as acute angle-closure glaucoma, which may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

You hereby authorize Dr. Corning and/or assistants to administer dilating eye drops or other eye drops during the course of your treatment. You understand that these eye drops are necessary to diagnose your condition. You further understand and acknowledge that you have been warned of the potential risks that dilating eye drops may have on your ability to drive and will take appropriate steps to reduce this risk by not driving immediately after your eyes have been dilated or by wearing sunglasses while driving.

_____ _____

Patient (or patient's authorized representative) Date

▪ Cash Payment Policy
General Insurance Payment Policy

Our goal is to provide out patients with exceptional care. For us to maintain this high standard of care, we respectfully request all co-pays, coinsurances, or deductibles which apply be paid at the time services are rendered.

Your appointment today may be for an initial consultation; however, the doctor may find it medically necessary to perform additional testing. If you have questions regarding cost, etc. for any additional tests, please ask any of our staff as you or your insurance company will be charged for services rendered. If your insurance company does not pay or denies your claim within 60 days, you are responsible for payment. We will be glad to assist you in determining any benefit information or acquiring any other information needed from your insurance company.

Payment is expected when services are rendered, unless other arrangements are made in advanced. If you have any questions, please feel free to ask for assistance.

Note:
We will be glad to file any insurance on your behalf; however, we do not participate with all insurance companies. If you have an insurance plan that has preferred providers, you should first check to see if the doctor you are seeing is a member in your preferred provider organization. If you are not sure, please consult with our staff and we will verify this for you. If your insurance company does not cover a service or portion of our fees, you are responsible for this amount. As the policy holder, it is ultimately your responsibility to know your plan benefits, requirements, exclusions, and limitations. Our staff is available to assist you.

Authorization:
I hereby authorize the office of Grant Corning, M.D. to release all medical information necessary for processing of insurance claims to all insurers or their agents. I also authorize the contact of my insurance company or health plan administrator and obtain all pertinent financial information concerning my health plan benefits and payments. I direct the insurance company or health plan administrator to release this information to the office of Grant Corning, M.D. and allow a Xerographic copy of my signature to be used. I understand that these provisions will remain in full effect until otherwise revoked by me.

State law requires that we advise you that the information authorized for release may include records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also know as Acquired Immune Deficiency Syndrome (AIDS).

I certify that I have read and understand the above and have had each item explained to my satisfaction.

Patient's Signature_____Date _____

If I am not the patient, but instead signing on behalf of the patient, I further certify that I am legally authorized to sign on the patient's behalf and to bind the patient to the above terms and conditions. I agree that the patient and I are jointly and severally responsible for complying with the above terms and conditions, including any and all payment obligations.

Representative's Signature_____Date _____

Relationship of Representative to Patient _____