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:

- The new patient information enclosed. If you have any questions, we will be glad to help you on the day of your appointment.
- Your insurance cards and a photo ID. As courtesy to our patients we file your insurance claims for you. You will be expected to pay any deductibles, coinsurance and co pays at the time of service.
- Some insurance carriers require an authorization or referral from your primary care physician. You will be responsible for obtaining an authorization for each visit to our office. If we have not received a valid authorization, you will be required to pay in full at the time of your appointment.
- A list of all medications that you are currently taking.

The doctor will be dilating your eyes and you will need a driver, as your eyes will be sensitive to sunlight. Cataract patients must discontinue soft contact lens wear for 1 week or 4 weeks for hard contact lens, prior to your appointment. Please allow 2 hours for your initial eye exam.

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

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: (____) _____ Cell: (____) _____

SS#_____ E-mail:_____

How did you hear about us? (Circle) Family/Friend Optometrist TV Ad Social Media Billboard

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

Employer:_____Reason for your visit: _____

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

Secondary Insurance:_____I.D.#_____Group#_____

Responsible Party Information (if different from patient information)

Name:_____ Relationship to patient:_____ SS#_____

Address:_____City_____State_____Zip_____

Date of Birth:_____ Phone#_____E-Mail:_____

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

X _____

Patient Signature Date

Patient Name: _____

DOB: _____

Circle "YES" or "NO" to indicate 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: _____

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: _____

Lupus Yes No Family History- Yes No Relationship: _____

Thyroid 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 _____

Lung Disease Yes No Family History- Yes No Relationship _____

Have you ever had a staph infection? Yes No _____

Do you work in healthcare field? Yes No _____

Have you ever taken Flomax? Yes No

Social History:

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

Are you pregnant? Yes No _____

Smoker Status: Never smoked Current smoker Former smoker _____

Drinker Status Current Former Never _____

Chemical Dependency/Drug use: Yes No _____

Do you drive? Yes No _____

Do you have difficulty driving 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
Loss of 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:	Yes	No	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
Cardiovascular (heart/arteries/veins)	Yes	No
Respiratory (lungs/larynx)	Yes	No
Gastrointestinal (digestive/stomach)	Yes	No
Genitourinary (kidney/bladder/genital)	Yes	No
Musculoskeletal (bones/joints)	Yes	No
Integumentary (skin)	Yes	No
Neurological (seizures/dizziness)	Yes	No
Psychiatric (stress/depression/anxiety)	Yes	No
Endocrine (sweating/frequent urination/thirst)	Yes	No
Allergic/Immunologic (HIV, Aids, Hepatitis)	Yes	No

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 _____

▪ Assignment of Medicare Benefits

PATIENT NAME: _____

I request that payment of authorized Medicare benefits be made on my behalf to the office of Grant Corning, M.D. for any service furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and **I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, and for any non-covered services.**

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare Benefits have been relinquished.

Patient Signature_____**Date** _____

MEDIGAP OR OTHER SECONDARY INSURANCE

I request that the payment of authorized Medigap or other Insurance benefits be made either by me or on my behalf to the office of Grant Corning, M.D. for services provided to me. I authorize any holder of medical information about me to release it to my Medigap insurer, _____ _____, or any information needed to determine these benefits payable for related services.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

I am responsible for any co-pays, co-insurance, deductible or non-covered services.

Patient Signature_____**Date** _____