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| MISSOURI DEPARTMENT OF SOCIAL SERVICES  FAMILY SUPPORT DIVISION  **OPHTHALMOLOGIST / OPTOMETRIST INFORMATION REQUEST** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INDIVIDUAL NAME (FIRST) | | | | (MIDDLE) | | | | | | (LAST) | | | | | | | | | INDIVIDUAL DCN | | | | | DATE OF BIRTH | | | |
|  | | | |  | | | | | |  | | | | | | | | |  | | | | |  | | | |
| **Instructions**: List all ophthalmologist(s) or optometrist(s) that have provided care or services to you within the last year (12 months). If needed use a separate sheet and attach to this form. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Do you have an ophthalmologist or optometrist?** | | | | | | | | | | | | | | | | **Yes** | | |  | | **No** |  | | |  |  |
|  |  | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
|  | **If yes, list their information below:** | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
|  | Facility & Doctor Name/s: | | | |  | | | | | | | | | | | | | | | | | | | | | |  |
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|  | Mailing Address: | | | |  | | | | | | | | | | | | | | | | | | | | | |  |
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|  | City: | | | |  | | | | | | | | | State: | | | |  | | | Zip Code: | | | |  | |  |
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|  | Telephone number: | |  | | | | | | | |  | | | | | | |  | | |  | | | |  | |  |
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|  | Date Last Seen: |  | | | | |  |  |  | | |  | | | | | | | | | | | | | | |  |
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|  | Any upcoming appointments? | | | | | | Yes |  | **No** | | |  | | |  | | | | | | | | | | | |  |
|  |  | | | | |  | | | | | | | | | |  | | | | | | | | | | |  |
|  | If yes, date of appointment: | | | | |  | | | | | | | | | |  | | | | | | | | | | |  |
|  |  | | | | |  | | |  | | | | | | |  | | | | | | | | | | |  |
|  | **Please list additional ophthalmologist or optometrist seen within the last 12 months:** | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | Facility & Doctor Name/s: | | | |  | | | | | | | | | | | | | | | | | | | | | |  |
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|  | Mailing Address: | | | |  | | | | | | | | | | | | | | | | | | | | | |  |
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|  | City: | | | |  | | | | | | | | | State: | | | |  | | | Zip Code: | | | |  | |  |
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|  | Telephone number: | |  | | | | | | | |  | | | | | | |  | | |  | | | |  | |  |
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|  | Date Last Seen: |  | | | | |  |  |  | | |  | | | | | | | | | | | | | | |  |
|  |  |  | | | | |  |  |  | | |  | | | | | | | | | | | | | | |  |
|  | Any upcoming appointments? | | | | | | Yes |  | **No** | | |  | | |  | | | | | | | | | | | |  |
|  |  | | | | |  | | | | | | | | | |  | | | | | | | | | | |  |
|  | If yes, date of appointment: | | | | |  | | | | | | | | | |  | | | | | | | | | | |  |
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|  | IM-61D OPTH | | | | | | | | 08/2014 | | | | | | | | | | | | | | | | | |  |