



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:

\_\_\_\_\_  
Mailing Address:

\_\_\_\_\_  
City:

\_\_\_\_\_  
State:

\_\_\_\_\_  
Zip Code:

\_\_\_\_\_  
Telephone number:

\_\_\_\_\_  
Date Last Seen:

Any upcoming appointments? ☐ YES ☐ NO

If yes, date of appointment: \_\_\_\_\_

Please list additional ophthalmologist or optometrist seen within the last 12 months:

\_\_\_\_\_  
Facility & Doctor Name/s:

\_\_\_\_\_  
Mailing Address:

\_\_\_\_\_  
City:

\_\_\_\_\_  
State:

\_\_\_\_\_  
Zip Code:

\_\_\_\_\_  
Telephone number:

\_\_\_\_\_  
Date Last Seen:

Any upcoming appointments? ☐ YES ☐ NO

If yes, date of appointment: \_\_\_\_\_