Welcome to Our Office

MOORE FAMILY EYECARE, LLC.
A MEMBER OF VISION SOURCE

Full Name: _____ Date: _____/_____/_____
Last First MI

Preferred Name: _____ Mailing Address: _____

City: _____ State: _____ Zip Code: _____ SSN: _____-_____-_____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

DOB: _____/_____/_____ Sex: Male - Female Marital status: Married Divorced Single Widowed Other

Employment: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed ☐ Student ☐ Military

Employer: _____ What kind of work do you do? _____

*** Our office uses many forms of communication for things like appointment confirmation and patient education. We NEVER provide this information to outside entities. Please CIRCLE your preferred method(s) of communication.

ANY – Mail – Text – Cell Phone – Home Phone – **EMAIL**: _____

How did you hear about our office?

☐ Friend/Family (Name) _____ May we thank them for sending you in? ☐ Yes ☐ No

☐ Internet ☐ Newspaper ☐ Signage ☐ Physician (Name) _____ ☐ Other _____

INSURANCE (please provide BOTH Medical and Vision Insurance)

→ **Vision:** often covers routine eye exams, glasses and contact lenses
→ **Medical:** eye health issues like cataracts, eye infections, eye injuries, diabetes, dry eye, glaucoma, etc.

Do you want us to file insurance for you? If so, please list them here:

Primary insurance name:_____ Policy#: _____

Secondary insurance name: _____ Policy#: _____

Is your insurance under: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Responsible party's name (if not self): _____ DOB: _____/_____/_____

City: _____ State: _____ Zip Code: _____ SSN: _____-_____-_____

_____ _____/_____/_____
Signature of Patient or Responsible Party **Date Signed**

1902 W. 19th, Ste A • Mountain Grove, Mo 65711 • Phone: 417-926-3937 • Fax: 417-926-3952
www.moorefamilyeyecare.com, www.facebook.com/moorefamilyeyecare