

Contact Lenses Fax Order Form

Customer Information

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Date of birth: __ __ / __ __ / __ __ __ __ Phone number: () _____

Prescription Information

Doctor name: _____ or Location: _____

Phone number: () _____ Fax number: () _____

Please fill in the appropriate information, or attach your prescription here:

	Brand	Power/ Sphere (+ or -)	Base Curve (BC)	Diameter (DIA)	Cylinder (toric lenses only)	Axis (toric lenses only)	Tint/Color (colored lenses only)	Quantity (number of boxes)
O.D. (right eye)								
O.S. (left eye)								

Delivery and Payment Options

If shipping address is different from above, please provide it here:

Name: _____

Ship to: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ (Visa, MC, Discover, Am. Express)

Exp. Date: __ __ / __ __ Signature: _____