

the GREAT eyedeal™

CUSTOM RX ORDER FORM

UPON COMPLETION, PLEASE FAX TO (800) 422-2903.

PLEASE COMPLETE THE FOLLOWING INFORMATION: (PLEASE PRINT CLEARLY) SUBMIT ONE FORM PER DOCTOR.

Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

City: _____ State: _____ Zip: _____

License No.: _____ Email: _____

SELECT A FORM

PF921940 CORP

PEARLE VISION Cecilia T. Cook, O.D. • Therapeutic Optometrist
5767 Fairmont Pkwy., Pasadena, TX 77505
Telephone: 281-991-1166 • Fax: 281-999-9991
Lic. # TX 6833T

PATIENT NAME _____
DATE _____ EXPIRATION _____ NEXT APPT. _____
at _____ a.m. p.m.

Match Prior: BC OC PD PD/MM

PRIMARY RX				
SPHERE	CYLINDER	AXIS	PRISM	ADD
OD				
OS				

SUN RX				
SPHERE	CYLINDER	AXIS	PRISM	ADD
OD				
OS				

COMPUTER/OCCUPATIONAL/SAFETY	
SPHERE	CYLINDER
OD	
OS	

CONTACT LENS RL	
SPHERE	DIA
OD	
OS	

ADDITIONAL RECOMMENDATIONS/REMARKS:	

PF921940 White copy - Patient Yellow copy - Dispenser Pink copy - Doctor

PF921940

Aileen LaMela, O.D.
4980 E. Silver Springs Blvd.
Ocala, FL 34470
Telephone: 352-861-4544 • Fax: 352-236-2378
Lic. # FL OPC 002296

Name _____ Date _____ Expiration _____

PRIMARY RX (Recommended)		SUN RX/COMPUTER/OCCUPATIONAL (Recommended)	
WEAR TYPE	LENS DESIGN	WEAR TYPE	LENS DESIGN
<input type="checkbox"/> FULL-TIME	<input type="checkbox"/> SINGLE VISION	<input type="checkbox"/> DISTANCE ONLY	<input type="checkbox"/> SINGLE VISION
<input type="checkbox"/> DISTANCE ONLY	<input type="checkbox"/> BIFOCAL	<input type="checkbox"/> INTERMEDIATE ONLY	<input type="checkbox"/> BIFOCAL
<input type="checkbox"/> INTERMEDIATE ONLY	<input type="checkbox"/> TRIFOCAL	<input type="checkbox"/> SCRATCH COAT	<input type="checkbox"/> TRIFOCAL
<input type="checkbox"/> SAFETY	<input type="checkbox"/> PROGRESSIVE	<input type="checkbox"/> AR COAT	<input type="checkbox"/> AR COAT
<input type="checkbox"/> READING ONLY		<input type="checkbox"/> POLYCARB	<input type="checkbox"/> POLYCARB
<input type="checkbox"/> AS NEEDED		<input type="checkbox"/> OTHER	<input type="checkbox"/> OTHER

SPHERE					SPHERE				
CYLINDER	AXIS	PRISM	ADD	CYLINDER	AXIS	PRISM	ADD	SPHERE	AXIS
OD									
OS									

Match Old: BC OC PD PD / MM

REMARKS _____

CONTACT LENS RL		CL Expiration Date:	SPH	CYL	AXIS	B.C.	DIA	COLOR	LENS TYPE
OD									
OS									

NUMBER OF BOXES _____
 SUGGEST NON-PRESCRIPTION SUNGLASSES WITH CONTACT LENSES _____

O.D. YOUR NEXT APPOINTMENT
IS AT _____
ON _____

PF921940 Rev.12/08 White copy - Patient Yellow copy - Dispenser Pink copy - Doctor

Dr. Elliott J. Brass
Optometrist
150 Pearl Nix Pkwy
Gainesville, GA 30501
Telephone: 770-536-0908 • Fax: 770-287-9108
Lic. # GA 714

Name _____ Date _____ Expiration _____

SPHERE					SPHERE				
CYLINDER	AXIS	PRISM	ADD	CYLINDER	AXIS	PRISM	ADD	SPHERE	AXIS
OD									
OS									

PRIMARY PAIR		SUN RX		COMPUTER / OCCUPATIONAL	
WEAR TYPE	LENS DESIGN	WEAR TYPE	LENS DESIGN	MATERIALS/COATS	MATERIALS/COATS
<input type="checkbox"/> FULL-TIME	<input type="checkbox"/> SINGLE VISION	<input type="checkbox"/> DISTANCE ONLY	<input type="checkbox"/> SINGLE VISION	<input type="checkbox"/> CR39 SCRATCH	<input type="checkbox"/> CR39 SCRATCH
<input type="checkbox"/> DISTANCE ONLY	<input type="checkbox"/> BIFOCAL	<input type="checkbox"/> INTERMEDIATE ONLY	<input type="checkbox"/> BIFOCAL	<input type="checkbox"/> RESISTANT	<input type="checkbox"/> RESISTANT
<input type="checkbox"/> INTERMEDIATE ONLY	<input type="checkbox"/> TRIFOCAL	<input type="checkbox"/> READING ONLY	<input type="checkbox"/> TRIFOCAL	<input type="checkbox"/> SAFETY	<input type="checkbox"/> SAFETY
<input type="checkbox"/> PROGRESSIVE ONLY	<input type="checkbox"/> PROGRESSIVE	<input type="checkbox"/> AS NEEDED	<input type="checkbox"/> PROGRESSIVE	<input type="checkbox"/> ANTIREFLECTIVE	<input type="checkbox"/> ANTIREFLECTIVE
<input type="checkbox"/> AS NEEDED				<input type="checkbox"/> POLYCARBONATE	<input type="checkbox"/> POLYCARBONATE
				<input type="checkbox"/> ASPHERIC POLY	<input type="checkbox"/> ASPHERIC POLY

Match Old: BC OC PD PD / MM

REMARKS _____

O.D. YOUR NEXT APPOINTMENT
IS AT _____
ON _____

PF921973 Rev.06/07 White copy - Patient Yellow copy - Dispenser Pink copy - Doctor

PF921973

CASE	PRICE	QUANTITY	TOTAL COST
1000	\$120.00		

TOTAL _____

S&H \$11.50

GRAND TOTAL _____

Please indicate method of payment:

I am a subleased or independent doctor and will pay via: MasterCard Visa American Express

Credit Card #: _____ Exp. Date: _____

Name on Card: _____ Signature: _____