

Name: _____ Date: ___/___/___ Expiration: ___/___/___

Primary Rx (Recommended)

<p>Wear Type</p> <input type="checkbox"/> Full Time <input type="checkbox"/> Distance Only <input type="checkbox"/> Intermediate Only <input type="checkbox"/> Safety <input type="checkbox"/> Reading Only <input type="checkbox"/> As Needed	<p>Lens Design</p> <input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Progressive	<p>Materials/Coats</p> <input type="checkbox"/> Plastic <input type="checkbox"/> Transitions <input type="checkbox"/> Poly <input type="checkbox"/> Mid Index <input type="checkbox"/> High Index <input type="checkbox"/> 1.60 <input type="checkbox"/> 1.67 <input type="checkbox"/> 1.70 <input type="checkbox"/> 1.74 <input type="checkbox"/> Trivex <input type="checkbox"/> Glass	<input type="checkbox"/> UV Cote <input type="checkbox"/> Tint <input type="checkbox"/> Scratch Coat <input type="checkbox"/> AR Coat <input type="checkbox"/> Other _____
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Sphere Cylinder Axis Prism Add

Match Old: BC OC PD PD/MM

Sun Rx/Computer/Occupational (Recommended)

<p>Wear Type</p> <input type="checkbox"/> Distance Only <input type="checkbox"/> Intermediate Only <input type="checkbox"/> Safety <input type="checkbox"/> Sun Rx <input type="checkbox"/> Reading Only <input type="checkbox"/> Computer	<p>Lens Design</p> <input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Progressive	<p>Materials/Coats</p> <input type="checkbox"/> Plastic <input type="checkbox"/> Transitions <input type="checkbox"/> Poly <input type="checkbox"/> Mid Index <input type="checkbox"/> High Index <input type="checkbox"/> 1.60 <input type="checkbox"/> 1.67 <input type="checkbox"/> 1.70 <input type="checkbox"/> 1.74 <input type="checkbox"/> Trivex <input type="checkbox"/> Glass	<input type="checkbox"/> UV Cote <input type="checkbox"/> Tint <input type="checkbox"/> Scratch Coat <input type="checkbox"/> AR Coat <input type="checkbox"/> Polarized <input type="checkbox"/> Other _____
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Sphere Cylinder Axis Prism Add

Match Old: BC OC PD PD/MM

Remarks

Contact Lens Rx

CL Expiration Date: ___/___/___

Sph	Cyl	Axis	B.C.	Dia.	Color	Lens Type

- Number of Boxes _____
- Suggest Non-Prescription Sunglasses with Contact Lens

_____ O.D.

YOUR NEXT APPOINTMENT IS AT _____ ON _____

Life Style Questions for Prescription Form

1. How many pairs of glasses do you currently use? _____
2. Do you have prescription sunglasses to protect your eyes from the damaging light of the sun? Yes No
3. Are you bothered by bright light or reflections? Yes or No
4. What feature do you like the most about your present glasses?

5. What do you like the least?

6. Is safety protection a concern? Yes or No
7. How do you use your eyes? Occupation? Computer use? Hobbies, Avid Reader?

8. Do you have an emergency back-up pair? Yes No
9. Do you have a specific eyeglass insurance plan? Yes No