



AdlerEyeAssociates.com

919-929-7111

Center for Visual Excellence

861 Willow Drive, Chapel Hill, NC 27514 ~ Fax: 919-967-6122

Patient's Full Name: _____

Date of Birth: _____ Phone #: _____

Current Address: _____

Previous Address: _____

To: _____

Name of Doctor

Dear Doctor:

The patient named above has contacted our office web site to order contact lenses. Please supply the indicated information listed below.

Date of prescription: _____ Expiration Date: _____

Contact Lens Rx:

	Brand/Material	Sphere	Cylinder	Axis	Base Curve	Diameter
OD:						
OS:						

Comments: _____

Signed: _____ Date: _____

Doctor

I hereby agree that the above named doctor may disclose any and all information concerning this patient's eye and visual status, while acting in a professional capacity, waiving all provisions of law to the contrary, including photographs.

Signed: _____ Date: _____

Patient