ART Optical contact lens, inc. CUSTOM LENS ORDER SPECIFICATION FORM

Account Name _____

Account # _____ **Phone** _____

Contact Person _____ **Order Date** _____

Patient Name _____ **Patient Date of Birth** _____
Last First

_____ **Ship completed lens order to:**
Patient Street Address Apt or Suite# ❑ Office ❑ Patient

_____
City State Zip Patient Phone #

Shipping Method ❑ 1st Class Mail ❑ 2-day *(minimum for Soft CL's & mail-to-patient orders)* ❑ Overnight

ORDER TYPE

❑ New GP Lens ❑ W ❑ NW **— OR —** ❑ GP Lens Exchange - Invoice #_____

❑ New Soft Lens ❑ W ❑ NW **— OR —** ❑ Soft Lens Exchange - Invoice #_____

❑ Soft Lens NW Replacement - # of lenses OD_____OS_____ Invoice #_____

GP Material_____ **Design**_____ **Tint**_____ **❑ w/Plasma Treatment ❑ w/THP**

Soft Lens Material: *(6 mo. replacement)* ❑ Hioxifilcon B 49% ❑ Acofilcon B 49% ❑ Blue Visi-tint ❑ Clear

(quarterly replacement) ❑ Definitive Silicone Hydrogel 74% ❑ Blue Visi-tint ❑ Clear

	Keratometer Readings	Spectacle Rx	Add Power	HVID	Pupil	Dominant
OD						
OS						

	Base Curve	Diameter	Power	Add Power	CT	OZ	Dominant
OD							
OS							

ADDITIONAL SPECIFICATIONS - GP LENS ORDERS ONLY

		Peripheral Curves	Prism	Seg Height	Truncation
OD	❑ ID Dot ❑ Drill Dot				
OS					

ADDITIONAL SPECIFICATIONS - CUSTOM SOFT LENS ORDERS ONLY

	Over Refraction	Rotation
OD		
OS		

NOTES _____

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NEW INVOICE NUMBER_____

CONSULTATION ASSISTANCE: 800.566.8001 **ORDER BY PHONE: 800.253.9364** **ORDER BY FAX: 800.648.2272**

5/21 CS102.f rev 8

For Art Optical Use Only - Taken/Entered by:_____ /_____