

# Order Form

Please complete the following information as accurately as possible and either fax (212)765-4459, email [dr.cassel@verizon.net](mailto:dr.cassel@verizon.net) or mail 55 W. 49th St. NY, NY 10020.

Doctor's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

lens name or Design: \_\_\_\_\_

Iris Diameter: OD \_\_\_\_\_ mm OS \_\_\_\_\_ mm

Pupil Size: OD \_\_\_\_\_ mm OS \_\_\_\_\_ mm Pupil: Clear Black

Prescription: (if needed) OD \_\_\_\_\_ OS \_\_\_\_\_

Keratometry Reading: OD \_\_\_\_\_ OS \_\_\_\_\_

Photographs-(send if applicable for prosthetic or custom designs)

Quantity (circle) 1 2

Eye Using Prosthetic OD OS (circle for prosthetic only)

Send lenses to: (circle) direct to doctor direct to patient

Patients signature

Date

Enclose fee: (call , fax or email for exact pricing . We accept checks, money order, credit cards (MC,VISA, AMEX)