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Glasses

LAST NAME | FIRST NAME | TODAY'S DATE

HOME ADDRESS | CITY | STATE | ZIP

PHONE NUMBERS
HOME: ( ) WORK: ( ) CELL: ( )
SOCIAL SECURTIY | DRIVERS LICENSE

MALE M / F FEMALE

YOUR BIRTHDAY DATE: MONTH | DAY | YEAR

RX1	SPHERE	CYLINDER	AXIS	PRISM	ADD	RX2	SPHERE	CYLINDER	AXIS	PRISM	ADD
1 OD						2 OD					
1 OS						2 OS					

1 FRAME NAME: ______ 2 FRAME NAME: ______

1 FRAME COLOR SIZE 2 FRAME COLOR SIZE

1 PLASTIC ○ GLASS ○ HIGH INDEX ○ POLYCARBONATE ○ ______
SV ○ BIF ○ TRI ○ TYPE ______
PROGRESSIVE ○ TYPE ______

SEG. HT | PD | SEG. HT

2 PLASTIC ○ GLASS ○ HIGH INDEX ○ POLYCARBONATE ○ ______
SV ○ BIF ○ TRI ○ TYPE ______
PROGRESSIVE ○ TYPE ______

1 CLEAR ○ TRANSITIONS ○ SOLID ○ GRADIENT ○
COLOR TYPE ______

2 CLEAR ○ TRANSITIONS ○ SOLID ○ GRADIENT ○
COLOR TYPE ______

1 RLX ○ UV400 ○ ROLL / POLISH ○ ANTI-REFLECT ○
POLAROID ○ RIMLESS GROOVING / DRILLING ○

2 RLX ○ UV400 ○ ROLL / POLISH ○ ANTI-REFLECT ○
POLAROID ○ RIMLESS GROOVING / DRILLING ○

INSURANCE AUTHORIAZTION # ______
INSURANCE NAME: ______
INSURANCE PLAN: ______

PATIENT NAME

	$ CHARGE
EXAM/REFRACTION	$
INSURANCE CO-PAY FOR EXAM/ MATERIALS	$
UV400 / RLX	$
TINT / TRANSTITION / POLAROID	$
COMPLETE GLASSES	$
FRAME ONLY / INSURANCE FRAME OVERAGE	$
LENSES ○ PLASTIC ○ GLASS ○ POLYCARBONATE	$
HIGH INDEX ○ 1.56 ○ 1.60 ○ 1.66 ○ 1.67 ○ 1.70	$
HIGH POWER (PRISM / CYLINDER / ADD) SURFACING	$
ROLL / POLISH	$
ANTI - REFLECTIVE	$
PROGRESSIVE TYPE	$
RIMLESS / DRILLING / GROOVING	$

DATE
TOTAL FEE $
COUPON OR DISCOUNT $
AMOUNT PAID $
PATIENT BALANCE $
INSURANCE BALANCE $

METHOD OF PAYMENT

○ CASH
○ CHECK
○ CREDIT CARD TYPE ______
○ INSURANCE NAME ______

DISPENSED DATE

1st Pair	2nd Pair	3rd Pair
DATE:	DATE:	DATE:

LAB WHERE EYE GLASSES SENT: ______

PATIENT SIGNATURE ① / ② / ③ ______

DISPENSER'S NAME ① / ② / ③ ______

DIAGNOSIS: PATHOLOGY:

	B.C.	O.C.	VA'S WITH OLD RX
PRIOR	OD		20/
RX	OS		20/
	ADD		20/
AGE:	OD		20/
	OS		20/
TYPE:	ADD		20/

UNAIDED VA'S — VA — OD 20/ — OS 20/ — OU 20/ — NEAR 20/

KERATOMETRY — OD — X — AXIS — MIRES

OS — X — AXIS — MIRES

RETINOSCOPY — OD

OS — P.D. /

SUBJECTIVE — OD — 20/

DISTANCE — OS — 20/

PHOREAS_______ DISTANCE_______ DUCTIONS _______

HORIZ — VERT.

NEAR — ADD — AT — DIST — 20/

COMPUTER — ADD — AT — DIST — 20/

NEAR — PHORIAS____________ DUCTIONS____________

CHIEF VISUAL COMPLAINT:

COVER TEST:

VERSIONS:

N.P.C.:

EXAMENING DR.'S SIGNATURE ______________________________

DILATION — YES — NO — MEDS — USED:

PT. REFERRED TO:

1ST RECHECK EXAM

REASON: — DATE:

FINDINGS:

2ND RECHECK EXAM

REASON: — DATE:

FINDINGS:

MEDICAL HISTORY

ANY HEALTH PROBLEMS? ______________________

ANY MEDICATIONS? ______________________

ANY HISTORY OF EYE DISEASE? ______________________

FAMILY HISTORY OF GLAUCOMA? ______________________

OR DIABETES? ______________________

OR MACULAR DEGENERATION?

EXTERNAL

LIDS CONJ. SCLERA

PUPIL REFLEXES

CORNEA

LENS

MEDIA

______________ EXAMENING DR.'S SIGNATURE

DISC RATIO

VESSELS — AV — RATIO

BACKGROUND

FOVEAL RELFEX

I.O.P. — OD — OS — TIME : A.M. OR P.M.

MM/ HG. — OD — OS — TIME : A.M. OR P.M.

CONFRONTATION TEST

SLIT; LAMP FINDINGS

COLOR VISION:

STEREO TEST

P.T.'S VOCATIONAL NEEDS

DIAGNOSIS:

PLAN