



Fax Toll Free to 1-800-401-1495

P. O. Box 366 Louisiana, MO 63353 Phone: 1-800-536-7266 Fax: 1-800-401-1495

Instructions: If you would like to order by fax or mail you can print this form and fill it out. Please make sure that all of your entries are complete and clearly legible to ensure quick processing. Orders within the US can be faxed to 1-800-401-1495 (International 001-573-754-3600) or mailed to Lens.com, P. O. Box 366, Louisiana, MO 63353.

Prescription Information			
	Left Eye (OS)		Right Eye (OD)
LENS NAME:	<input type="text"/>	LENS NAME:	<input type="text"/>
BASE CURVE (BC):	<input type="text"/>	BASE CURVE (BC):	<input type="text"/>
DIAMETER (DIA):	<input type="text"/>	DIAMETER (DIA):	<input type="text"/>
POWER (Sphere):	<input type="text"/>	POWER (Sphere):	<input type="text"/>
CYLINDER (for Toric):	<input type="text"/>	CYLINDER (for Toric):	<input type="text"/>
AXIS (for Toric):	<input type="text"/>	AXIS (for Toric):	<input type="text"/>
ADD (for Bifocal):	<input type="text"/>	ADD (for Bifocal):	<input type="text"/>
COLOR (Optional):	<input type="text"/>	COLOR (Optional):	<input type="text"/>
QUANTITY:	<input type="text"/>	QUANTITY:	<input type="text"/>

Eye Care Practitioner			
Doctor / Store Name:	<input type="text"/>	Doctor / Store Phone:	<input type="text"/>
Patient Name:	<input type="text"/>	Patient Birthdate:	<input type="text"/>

Shipping Information			
Name:	<input type="text"/>		
Address:	<input type="text"/>		
City:	<input type="text"/>	State:	<input type="text"/>
		Zip / Postal Code:	<input type="text"/>
Country:	<input type="text"/>		
Day Phone:	<input type="text"/>	Evening Phone:	<input type="text"/>
Email:	<input type="text"/>		
Shipping Method:	<input type="radio"/> Expedited <input type="radio"/> 2nd Day <input type="radio"/> Next Day <input type="radio"/> International (SELECT ONE)		

Billing Information			
Credit Card Type:	<input type="radio"/> Visa <input type="radio"/> Master Card <input type="radio"/> Discover <input type="radio"/> American Express (SELECT ONE)		
Credit Card Number:	<input type="text"/>	Expiration Date:	<input type="text"/>
Cardholder Name:	<input type="text"/>		
Address:	<input type="text"/>		
City:	<input type="text"/>	State:	<input type="text"/>
		Zip / Postal Code:	<input type="text"/>
Country:	<input type="text"/>		