Prescription Eyeglass Order Form

Company Name: _____

Telephone Number: _____

Company Purchase Order #: _____

Patient's Name: _____

Date: _____

Ship to Address: _____

City: _____ State: _____ Zip: _____

Glasses Model #: _____

Lead Equivalency:

☐ .50mm ☐ .75mm

Distant:

	Sph.	Cyl.	Axis	Dec.	Prism	Base
Right						
Left						

Add for Read:

	Segment Height	Segment Width	Segment Dec.	Total Dec.
Right				
Left				

IMPORTANT: FOR PROPER PRESCRIPTION CENTERING PD MUST BE INCLUDED.

In order to process prescription orders, we require the dispensing optician's signature.

Dispensing Optician's Signature: _____

Fill out this form and email, fax, or mail to Wolf X-Ray: 100 West Industry Court Deer Park, NY 11729

Telephone: 631.242.9729 Fax: 631.242.1001

Email: info@wolfxray.com