Eye Associates of Washington, DC, P.C.

(PLEASE PRINT CLEARLY)

CONTACT LENS ORDER			
Date:	Time:	Account No.:	
Patient's last name:	First:	Middle:	
Home Phone No.: ( )	Work Phone No.: ( )	Cell Phone No.: ( )	
Patient to pick-up lenses at: ❑ DC Office ❑ VA Office			
Mail lenses to patient at address below: Street address:			
City:	State:	ZIP Code:	
Credit Card No.: (Visa, Mastercard, Discover, American Express)	Expiration No.:	Billing Street No.	Billing Zipcode:

LENSES TO ORDER:		
RIGHT EYE:		
No. of lenses:	OR	No. of boxes:
LEFT EYE:		
No. of lenses:	OR	No. of boxes:
Notes:		

Patient/Guardian signature *Date*