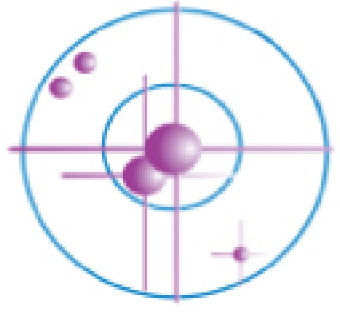

Date:

VISIONARY CONTACT LENS ORDER FORM

Customer Name: ____________________
Patient's Name: ____________________
Location: ____________________

Right Lens (OD) Left Lens (OS)

Material:		Color:		Material:		Color:	

	Base Curve	
	Power	
	Diameter	
	Optic Zone	
	Thickness	
	Secondary Curve	
	Width	
	Intermediate Curve	
	Width	
	Intermediate Curve 2	
	Width	
	Peripheral Curve	
	Width	

Comments: ____________________

Design: ____________________

DOT OD DOT OS

Email to: info@visionarylens.com
or
Fax to: 800-300-3299

Visionary Lens

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