

DANIA
EYE TECH Optical
CENTER

REFRACTION

NAME _____ PHONE _____ D.O.B. _____

DATE INS

	SPHERE	CYLINDER	AXIS	PRISM	ADD	BASE CURVE
R						
L						

BEST VISUAL ACUITY

R

L

FRAME & COLOR			FRAME & COLOR		
SIZE		PROG.	SIZE		PROG.
DV ONLY		NV ONLY	BIFOCAL TYPE		BIFOCAL TYPE
TRIFOCAL TYPE		SPECIAL	TRIFOCAL TYPE		SPECIAL
SEG HEIGHT	BASE CURVE	POLISH EDGE	SEG HEIGHT	BASE CURVE	POLISH EDGE
PD	TRAN	POLY	PD	TRAN	POLY
	TINT COLOR	GLASS/PLASTIC		TINT COLOR	GLASS/PLASTIC
	SIGN.	Rx GIVEN		SIGN.	Rx GIVEN

LENSES		
	SINGLE VISION	PRICE
REGULAR	90	
OVERSIZED	110	
HIGH POWER	130	
BIFOCALS		
FLATTOP 28	120	
FLATTOP 28 OVERSIZED	130	
FLATTOP 35	140	
FLATTOP 35 OVERSIZED	150	
ROUND	120	
BLENDED	120	
EXECUTIVE	150	
TRIFOCALS PROGRESS		
7 x 28	140	
8 x 35	150	
DOUBLE SEG	190	
PROGRESSIVES	180	
HIGH INDEX PROG. 667	250	
HIGH INDEX PROG. 174	300	

HIGH INDEX/POLY		PRICE	CHARGES		FEE
	SINGLE VISION	130		EXAM FEE	95
	FLATTOP 28	165		CONTACT LENS EXAM NEW	89
	FLATTOP 35	190			
TRANSITIONS					
	SINGLE VISION	145			
	FLATTOP 28	190			
	FLATTOP 35	230			
	PROGRESSIVE	300		MISC	
	7 x 28	255		DRILL MOUNT	40
	HIGH INDEX SINGLE VISION	220		TINT/UV/S.R./SPECIAL	40
	HIGH INDEX FLATTOP 28	255		POLISH EDGES	20
	HIGH INDEX PROGRESSIVE	350		A.R. COATING	130
PHOTOCHROMATIC				POLARIZED	120
				FRAME	
				FRAME	
DATE CHARGES			PAID BALANCE		

DANIA EYE CENTER
EYEGLASSES AND CONTACT LENSES FORM CONSENT FORM

PATIENT NAME: _____

DATE: _____

GLASS ORDER

FRAME INFORMATION
MODEL
COLOR

Signature: _____

Lens type

<input type="checkbox"/> SINGLE VISION
<input type="checkbox"/> BI FOCAL
<input type="checkbox"/> TRI FOCAL
<input type="checkbox"/> PROGRESSIVE
<input type="checkbox"/> OTHER

Signature: _____

Material

<input type="checkbox"/> Plastic
<input type="checkbox"/> Polycarbonate
<input type="checkbox"/> High index
<input type="checkbox"/> Glass

Signature: _____

COATING

<input type="checkbox"/> AR
<input type="checkbox"/> UV
<input type="checkbox"/> POLARIZED-COLOR
<input type="checkbox"/> TRANSITION COLOR
<input type="checkbox"/> TINT COLOR _____

Signature: _____

If patient is using their own or insurance frame, we take no responsibility if frame breaks. If going through insurance company it may take up to three weeks for delivery. 50% deposit on all materials final balance must be paid when receiving glasses. Any problems with product or RX must be returned within 7 days for recheck after date received. _____

I have inspected the Frame & Lenses.

Date: _____

Signature: _____