

Date: _____
Time: _____
Invoice Number: _____

Patient ID: _____
Patient Name: _____
Address: _____
Telephone: _____

Patient Copy

Item Description	Quantity	Unit Price	Discount	Total

Delivery Date: _____

Created By: _____

Conforme

Date

Subtotal

Amount Paid

Total Amount Due

Date: _____ Patient ID: _____
Time: _____ Patient Name: _____
Invoice Number: _____ Address: _____
Job Order: _____ Telephone: _____

Clinic Copy

	Sph	Cyl	Axis	Add	PD	Mono Spd	SH	BC	Dia	Tint
R										
L										

Item Description	Quantity	Unit Price	Discount	Total
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Release Date: _____

Release By: _____

Conforme

Date

Subtotal

Amount Paid

Total Amount Due

Item received in good condition by _____

Received date

Lab pick up date

Laboratory: Platilense

Date: _____ Patient ID: _____
Time: _____ Patient Name: _____
Invoice Number: _____ Address: _____
Job Order: _____ Telephone: _____

Laboratory Copy

	Sph	Cyl	Axis	Add	PD	Mono Spd	SH	BC	Dia	Tint
R										
L										

Frame:

Lense:

Delivery Date

Note:

Lab Pick Up Date and Time