New Glasses Rx Form

Patient Name: _____ Date: _____
Registration #: _____ Expires: _____
Address: _____

	L/R	Sphere	Cyl	Axis	Add	Prism
OD	L					
	R					
OS	L					
	R					

Recommendations		
☐ Anti-Reflective Coating	☐ Bifocal	☐ Digital Measurements
☐ Hi-Index Plastic	☐ No-Line Progressive	☐ Photochromic
☐ Polarized	☐ Polycarbonate	☐ Progressive
☐ Single Vision	☐ Trifocal	☐ Tint
☐ Other:		

O.D. Signature: _____ www.FreePrintableMedicalForms.com

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