

For Current patients of International Eye Center use only.



4506 Wishart Blvd. • Tampa, Florida, 33603 • 875-6588 • Fax: 873-8435

1

Please print and fill in this request form to order your contact lens by fax.

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: day _____ month _____ year _____

2

Check your brand of contact lenses and circle number of boxes ordered.



\$25.00



\$25.00



\$31.00



\$41.50

Acuvue (6 Lens box)

Boxes
Right: 1 2 3 4 5 6 7 8
Left: 1 2 3 4 5 6 7 8

Acuvue2 (6 Lens box)

Boxes
Right: 1 2 3 4 5 6 7 8
Left: 1 2 3 4 5 6 7 8

Acuvue Advance (6 Lens box)

Boxes
Right: 1 2 3 4 5 6 7 8
Left: 1 2 3 4 5 6 7 8

Acuvue Colors (6 Lens box)

Boxes
Right: 1 2 3 4 5 6 7 8 Color: _____
Left: 1 2 3 4 5 6 7 8 _____



\$80.00



\$49.95



\$30.00

Acuvue Toric (6 Lens box)

Boxes
Right: 1 2 3 4 5 6 7 8
Left: 1 2 3 4 5 6 7 8

Acuvue Bifocal (6 Lens box)

Boxes
Right: 1 2 3 4 5 6 7 8
Left: 1 2 3 4 5 6 7 8

Hydrogenics (6 Lens box)

Boxes
Right: 1 2 3 4 5 6 7 8
Left: 1 2 3 4 5 6 7 8

Order 4 or more boxes and we pay the shipping.

3

Please choose method of payment.



American Express

MasterCard

Visa

Expiration Date _____ Code _____

4

Shipping Address.

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

5

Fax this request form to International Eye Center:

873-3688

You will receive comformation within 24 hours.

FOR OFFICAL USE ONLY

Received by: _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Eye</th> <th style="width: 15%;">Power</th> <th style="width: 15%;">Base Curve</th> <th style="width: 15%;">Diameter</th> <th style="width: 15%;">Qty</th> </tr> </thead> <tbody> <tr> <td>Right (OD)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Left (OS)</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Eye	Power	Base Curve	Diameter	Qty	Right (OD)					Left (OS)					Date order received: _____
Eye	Power	Base Curve	Diameter	Qty													
Right (OD)																	
Left (OS)																	
Date patient notified of shipment _____																	