

Vontéle, LLC Eyewear Prescription Form

Request Eye Doctor's Office to Complete Form

Date: _____

Patient Name: _____

Patient Address: _____ State/Zip: _____

Patient Phone: _____ Email: _____

I. Type of Prescription - Check One

Single Vision Multi Vision Progressives *Progressive Lenses - Please complete full prescription section below*

For Readers - Check Box and Add Reader Strength

Readers Reader Strength

II. PRESCRIPTION *Complete full prescription section below*

	EYE	SPHERE	CYLINDER	AXIS	ADD	SEGMENT HEIGHT
						<small>ADD & Height for Bifocals/ Multi Vision/Progressives</small>
Right OD	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Left OD	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

PD - Pupil Distance:

Right

Left

III. Signature/Stamp of Prescriber or Eye Doctor's Office