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LAST NAME		FIRST NAME	DOB
PHONE ()		EMAIL ADDRESS	
STREET ADDRESS		CITY / STATE	ZIP CODE
<div style="border: 1px solid black; display: inline-block; padding: 2px;">Apt.#</div>			

MEDICARE ID#	SUPPLEMENTAL INSURANCE NAME
SUBSCRIBER ID#	GROUP#

I GIVE 2U VISION PERMISSION TO SHARE MY HEALTH INFO AND RECORD WITH DR. YAAKOV ZACKS AND FOR DR. ZACKS TO SHARE MY INFORMATION WITH 2U VISION.

SIGNATURE	DATE
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I HAVE BEEN OFFERED A COPY OF THE PRIVACY AGREEMENT FOR 2U VISION, LLC. I UNDERSTAND MY RIGHTS TO PRIVACY AND THAT 2U VISION WILL NOT SHARE MY INFORMATION WITHOUT MY PERMISSION

SIGNATURE	DATE
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I GIVE 2U VISION THE RIGHT TO PHOTOGRAPH ME. I UNDERSTAND THE PHOTO MAY BE USED SOLELY BY 2U VISION AND MAY BE POSTED ON SOCIAL MEDIA SUCH AS FACEBOOK AND INSTAGRAM

SIGNATURE	DATE
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This side is for internal use only. Please leave blank.

LOCATION

PRESCRIPTION INFORMATION

Expiration Date on RX _____ Dr Name _____

Lens SKU# _____ Frame SKU# _____

	SPHERE	CYLINDER	AXIS	ADD	PD	PRISM
OD						
OS						

FRAME INFORMATION

SKU	BRAND	NAME	COLOR	SEG / OC
A	B	ED	DBL	TEMPLE

LENS INFORMATION

SV	EXECUTIVE	POLY 1.59	TRANSITIONS BROWN	SOLID TINT	GRADIENT TINT
PROGRESSIVE	CR39 1.49	HI INDEX 1.67	TRANSITIONS GREY	10% 15%	15% 30%
FT28	MID INDEX 1.50	HI INDEX 1.74	POLARIZED BROWN SUN	25% 40%	40% 50%
ROUND 35	TRIVEX 1.53	TRANSITIONS POLARIZED	POLARIZED GREY SUN	50% 80%	70% 80%