

Please open an Art Optical account for my office

Today's Date: _____ Have you ever ordered from Art Optical before?: Yes No

Individual completing request form: _____

ACCOUNT INFORMATION:

Account Name: _____

Doctor's Name: _____ OD MD Other: _____

Doctor's License #: _____

Name of Person Legally Responsible for Account Balance (required): _____

Do you prefer to bill through a buying group? Yes No

If yes, please provide the name of your preferred buying group & your member #: _____

Billing Address: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

Shipping Information (if different)

Shipping Address: _____

Shipping Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

Preferred Shipping Method*: _____ E-mail Address: _____

* Default is First Class Mail if no preference.

For immediate processing, fax your completed request to:

1-800-648-2272

Thank you!

We look forward to serving your custom contact lens needs!



PO Box 1848 • Grand Rapids, MI 49501-1848

Toll-Free Ordering 1-800-253-9364 • Consultation Direct 1-800-566-8001

Online www.artoptical.com