Glasses/Contact Lens Prescription Signed Acknowledgment Form

Sign below to acknowledge that you were provided with a copy of your

____ glasses prescription
____ contact lens prescription (if applicable)

Patient Name: _____

Patient Signature:_____

Date: _____

We, at Palatine Vision Center, want you to be safe, healthy, and comfortable with your contact lens wear. If you have any symptoms of an eye infection, please call our office immediately.

Symptoms of Eye Infection include:
• Irritated, red eyes
• Worsening pain in or around the eyes—even after contact lens removal
• Light sensitivity
• Sudden blurry vision
• Unusually watery eyes or discharge