NEW DOCTOR REQUEST FORM

Please fill out the requested information below and send to customerservice@classicoptical.com or fax it to us at 888-522-2022.

Date:	
Name of Doctor:	
Name of Practice:	
Is your practice associated with another entity?	**If your practice is associated with another entity (such as a partnership or private equity group), please provide the name of the entity:**
Address:	
Phone Number:	
Fax Number:	
Email Address:	
Doctor's individual NPI and Taxonomy Number	
Medicaid ID Number (if applicable):	
Tax Exempt? *(If YES, please provide exempt form)*	**[ ] YES [ ] NO**
Expected number of frame-only orders/month	
Accounts Payable Contact Person (name/phone #/email):	
Preferred Method of Payment	**[ ] Check [ ] ACH** **[ ] Credit Card [ ] AutoPay**
Name of a Contact Person:	
Doctor's or Office Manager's Signature:	

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