Application for **SIGHT** Service

The interviewing Lion should assist potential patients in completing this form.

Fill out COMPLETELY and return to:
Mid-South Lions
930 Madison Ave, Suite 101
Memphis, TN 38103

Attn Lion: Submitting an incomplete application will cause an unnecessary delay in providing service to your patient.

Please PRINT legibly.

Sponsoring Lions Club _____ **LCI#**_____ **Date**_____

Interviewing Lion_____ **Phone**_____

Address_____ **City**_____ **St**_____ **Zip**_____

Email Address_____ **Lions District**_____

Areas in **Red Bold** are REQUIRED information. Your clinic preference will be considered, but is not guaranteed:

[ ] HAMILTON EYE INSTITUTE
930 Madison Ave, Memphis, TN

[ ] HOLT EYE CLINIC
211 McAuley Court
Hot Springs, AR

[ ] EYE LASER & SURGERY CENTER
634 Leigh Dr., Columbus, MS

[ ] THOMAS OCULAR ***PROSTHETICS***)
Memphis, TN / Little Rock, AR

[ ] SNEED EYE CLINIC
140 Hwy 201 N
Mountain Home, AR

[ ] GULF COAST EYE CENTER
Ocean Springs, MS / Pascagoula, MS

[ ] NW ARKANSAS CLINICS
VOLD VISION CENTER
HENRY EYE CLINIC
THE EYE CENTER
(MID-SOUTH WILL DETERMINE WHICH NWA CLINIC BASED ON CONDITION)

(Please Mark One) Is this application for a NEW PATIENT _____ or Renewal for a CURRENT PATIENT _____

Patient's Name_____ **Date of Birth**_____ **Male**_____**Female**_____

Address_____ **City**_____ **St**_____ **Zip**_____

Phone (Home)_____(Work)_____(Cell)_____

Email Address_____ Is Patient a Minor? Yes_____ No_____

Social Security Number_____ **Number in the Household**_____

Do you have health insurance?_____ If so, your group and number_____

Other monthly medical bills (including prescription medication)_____

Household Income (please fill in ONE): Weekly_____ Monthly_____Yearly_____

SNAP (Food Stamps per month) _____Where do you work?_____

PRELIMINARY DIAGNOSIS (IF AVAILABLE)_____

In order to help secure funds for current and future patients, Mid-South Lions requests your cooperation by signing below (Patient or Parent/Guardian). Mid-South Lions sometimes uses photographs, film, videotape, news releases, internet publications and articles to keep the public informed of our services and activities. Occasionally, outside photographers from newspapers and/or television stations are also used to help illustrate our activities. We appreciate your permission to photograph you and/or use your name and story about your visits to our facilities and to use them as mentioned above. By signing below, you indefinitely waive the right to inspect or approve these photographs and/or materials before publication or airing. Also Mid-South Lions Sight and Hearing Service and it's affiliated corporations, officers, agents, employees, Lions Clubs and medical consultants are indefinitely released from all debts, claims and/or liability of any kind arising out of or in connection with the use of your name, story, and/or statements and the use of any caption or description of material therewith.

_____

Patient (or parent/guardian) signature

PATIENT INFORMATION (COMPLETE IF THE PATIENT IS UNDER 19)

Parent or Legal Guardian_____ Phone_____

Address (if different than patient)_____ City_____ St_____ Zip_____

Revised January 2019

Application for **HEARING** Service

The interviewing Lion should assist potential patients in completing this form.

Fill out COMPLETELY and return to:
Mid-South Lions
930 Madison Ave, Suite 101
Memphis, TN 38103

Attn Lion: Submitting an incomplete application will cause an unnecessary delay in providing service to your patient.

Please PRINT legibly.

To be considered for hearing service, applications MUST include a non-refundable contribution for $250. If the patient needs two hearing aids, the sponsoring club must decide whether or not they will also contribute for the second hearing aid. If so, a contribution of $500 should be included. These funds will be deposited in the Mid-South Lions unrestricted operating fund.

Sponsoring Lions Club_____**LCI#**_____**Date**_____

Interviewing Lion_____**Phone**_____

Address_____**City**_____**St**_____**Zip**_____

Email Address_____**Lions District**_____

Areas in **Red Bold** are REQUIRED information.

Hearing patients will receive a letter from Mid-South Lions assigning them to be seen at:
Memphis Speech and Hearing Clinic, 807 Jefferson Ave

(Please Mark One) Is this application for a NEW PATIENT _____ or Renewal for a CURRENT PATIENT _____

Patient's Name_____ **Date of Birth**_____ **Male**_____**Female**_____

Address_____**City**_____**St**_____ **Zip**_____

Phone (Home)_____(Work)_____(Cell)_____

Email Address_____ Is Patient a Minor? Yes_____ No_____

Social Security Number_____ **Number in the Household**_____

Do you have health insurance?_____ If so, your group and number_____

Other monthly medical bills (including prescription medication)_____

Household Income (please fill in ONE): Weekly_____ Monthly_____Yearly_____

SNAP (Food Stamps per month) _____

In order to help secure funds for current and future patients, Mid-South Lions requests your cooperation by signing below (Patient or Parent/Guardian). Mid-South Lions sometimes uses photographs, film, videotape, news releases, internet publications and articles to keep the public informed of our services and activities. Occasionally, outside photographers from newspapers and/or television stations are also used to help illustrate our activities. We appreciate your permission to photograph you and/or use your name and story about your visits to our facilities and to use them as mentioned above. By signing below, you indefinitely waive the right to inspect or approve these photographs and/or materials before publication or airing. Also Mid-South Lions Sight and Hearing Service and it's affiliated corporations, officers, agents, employees, Lions Clubs and medical consultants are indefinitely released from all debts, claims and/or liability of any kind arising out of or in connection with the use of your name, story, and/or statements and the use of any caption or description of material therewith.

_____

Patient (or parent/guardian) signature

PATIENT INFORMATION (COMPLETE IF THE PATIENT IS UNDER 19)

Parent or Legal Guardian_____ Phone_____

Address (if different than patient)_____ City_____ St_____ Zip _____

Revised January 2019