



Application for SIGHT Service
The interviewing Lion should assist potential patient in completing this form.

Fill out **COMPLETELY** and return to:
 Mid-South Lions
 930 Madison Ave, Suite 101
 Memphis, TN 38163

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. Please indicate your clinic preference:

- | | | |
|---|---|---|
| <input type="checkbox"/> HAMILTON EYE INSTITUTE
930 Madison Ave, Memphis, TN | <input type="checkbox"/> THOMAS OCULAR <u>PROSTHETICS</u>
Memphis, TN / Little Rock, AR | <input type="checkbox"/> OPHTHALMOLOGY ASSOCIATES
720 S. Bishop, Rolla, MO |
| <input type="checkbox"/> BOOZMAN-HOF REG. EYE
3737 West Walnut, Rogers, AR | <input type="checkbox"/> WALLACE EYE CLINIC
211 McAuley Court, Hot Springs, AR | <input type="checkbox"/> SNEED EYE CLINIC
140 Hwy 201 N, Mountain Home, AR |
| <input type="checkbox"/> EYE LASER & SURGERY CENTER
634 Leigh Dr., Columbus, MS | <input type="checkbox"/> ASHFORD EYE CLINIC
501 Marshall St, Ste 604, Jackson, MS | <input type="checkbox"/> GULF COAST EYE CENTER
Ocean Springs, MS / Pascagoula, MS |

(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** _____ **House Note/Rent Payment** _____

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 _____

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 IT THE PATIENT IS UNDER 19)

Parent or Legal Guardian _____ **Phone** _____

Address (if different than patient) _____ **City** _____ **St** _____ **Zip** _____



Application for HEARING Service

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

Fill out **COMPLETELY** and return to:
Mid-South Lions
930 Madison Ave, Suite 101
Memphis, TN 38163

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 check for \$225 to cover the cost of one hearing aid. If the patient needs two hearing aids, the sponsoring club must decide whether or not they will also pay for the second hearing aid. If so, a check for \$450 should be included to cover the cost of two hearing aids.

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

Interviewing Lion _____ **Phone** _____

Address _____ **City** _____ **St** _____ **Zip** _____

Email Address _____ **Lions District** _____

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

The hearing clinic is located at: Methodist University Hospital, 1265 Union Ave, Memphis, TN 38104

(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** _____ House Note/Rent Payment _____

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 _____

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 IT THE PATIENT IS UNDER 19)

Parent or Legal Guardian _____ Phone _____

Address (if different than patient) _____ City _____ St _____ Zip _____