



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
[ ] THOMAS OCULAR PROSTHETICS Memphis, TN / Little Rock, AR
[ ] NW ARKANSAS CLINICS (MID-SOUTH WILL DETERMINE WHICH NWA CLINIC BASED ON PATIENT'S CONDITION)
[ ] SNEED EYE CLINIC 140 Hwy 201 N Mountain Home, AR
[ ] EYE LASER & SURGERY CENTER 634 Leigh Dr., Columbus, MS

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

Patient's Name Date of Birth Gender

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

INCLUDING PROOF OF INCOME IS REQUIRED FOR AN APPLICATION TO BE APPROVED

SNAP (Food Stamps per month) Where do you work?

PATIENTS MUST BE EXAMINED BY A PRIMARY VISION CARE PROFESSIONAL BEFORE REFERRAL (INCLUDE DIAGNOSIS)

DIAGNOSIS (FROM PRIMARY VISION CARE PHYSICIAN)

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 its 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 INFORMATION (COMPLETE IF THE PATIENT IS UNDER 19)

Patient (or parent/guardian) signature.

Parent or Legal Guardian Relationship Phone

Address (if different than patient) City St Zip



# 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

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**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 either:**

Memphis Speech and Hearing Clinic, 4055 N. Park Loop, Memphis, TN 38152

OR UTMP Head and Neck Surgery/Hearing 1325 Eastmoreland St. Suite 260 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** \_\_\_\_\_ **Gender** \_\_\_\_\_

**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?** \_\_\_\_\_

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**PATIENT INFORMATION (COMPLETE IF THE PATIENT IS UNDER 19)**

**Patient (or parent/guardian) signature.**

**Parent or Legal Guardian** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Address (if different than patient)** \_\_\_\_\_ **City** \_\_\_\_\_ **St** \_\_\_\_\_ **Zip** \_\_\_\_\_