



Application for **SIGHT** Service

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

Mid-South CANNOT provide initial eye exams or eyeglasses.

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

Submitting an incomplete application or without a referral letter from an eyecare professional 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)

[] 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? _____

EVERY SIGHT APPLICATION MUST BE ACCOMPANIED BY A REFERRAL LETTER FROM AN EYECARE PROFESSIONAL

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

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 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?** _____

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** _____