DISTRICT 12-S LIONS HEARING AID PROGRAM

PCC James McBee
105 Ash Street
McMinnville, TN 37110-3101
(E)

Patient Information:

Name: ______________________ Age _______ Male/Female _____

Address: ______________________ City: ______________ Zip: _______

Social Security Number: ______________ Phone No. (____) __________

Date of Birth: ______________ Number in Family: __________

Total Family Gross Annual Income: $__________ Patient's Co-Pay Amount: ______

Employer Information:

Name: ______________________ Phone No. ______________

Address: ______________________ City: ______________ Zip: _______

Medical Insurance: ______________________________

Group No.: ____________ Individual Policy No. ______________________

Claims Address: ______________________________

Government Plans:

Medicare No. ______________ Welfare or Medicaid No, ______________

I hereby authorize the attending physician and/or clinic to release any and all information including evaluation, medical history, consultation, prescriptions or treatment including diagnosis or prognosis and copies of all medical records to the District 12-S Lions Hearing Aid Committee and sponsoring club.

Date: ______________ Signature: ______________________

All clubs are responsible for transportation of patient if necessary.

Sponsoring Club: ______________________________

Contact Person: ______________________ Phone No. (____) __________

Address: ______________________ City: ______________ Zip: _______

MAKE CHECKS PAYABLE TO: DISTRICT 12-S WHITE CANE.

Application must be filled out completely, signed and forwarded to PCC James McBee.