APPLICATION FOR TREATMENT
SHRINERS HOSPITALS FOR CHILDREN

***Required Information**

To Be Completed By Parent or Guardian

***Name of Child**			
*Last	*First	Middle	Suffix
*Application Date (Today's Date)	Child's SSN	*Gender ☐ Male ☐ Female ☐ Other ☐ Unknown	
*DOB	Who does child live with? ☐ Both Parents ☐ Mother ☐ Father ☐ Other (relationship)		
Primary Language	Interpreter Required ☐ Yes ☐ No		
***Home Address**			
*Country	*Street Address		
*Zip Code	*City	*State	County
Phone Primary/Home Number	Phone Alternate Number		
***Mailing Address (if different from home address)**			
*Country	*Street Address		
*Zip Code	*City	*State	County

Mother				
Last	First	Middle	Suffix	Maiden Name
Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed				
Home Address (if different from patient's)				
*Country	*Street Address			
*Zip Code	*City	*State	County	
Phone Primary/Home Number	Phone Alternate Number			

Father			
Last	First	Middle	Suffix
Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed			
Home Address (if different from patient's)			
*Country	*Street Address		
*Zip Code	*City	*State	County
Phone Primary/Home Number	Phone Alternate Number		

Additional Relations			
Relationship to Patient			
Last	First	Middle	Suffix
Home Address (if different from patient's)			
*Country	*Street Address		
*Zip Code	*City	*State	County
Phone Primary/Home Number	Phone Alternate Number		

APPLICATION FOR TREATMENT
SHRINERS HOSPITALS FOR CHILDREN

***Required Information**

Name of Child _____ **To Be Completed By Parent or Guardian**

Legal Guardian (if different from parent)			
Last	First	Middle	Suffix
Home Address (if different from patient's)			
*Country	*Street Address		
*Zip Code	*City	*State	County
Phone Primary/Home Number	Phone Alternate Number		

Sponsoring Temple and Shriner	Temple			
Sponsoring Shriner Name	Last	First		
Street Address	City	State	Zip Code	Country
Sponsoring Shriner's Signature			Date	
Needs Transportation ☐ Yes ☐ No	Ambulatory Status			

Medical Problem or Diagnosis				
*What is your child's problem?				
Onset ☐ Before Birth ☐ Developed Recently ☐ Injury-Date Known Injury date _____ ☐ Injury-Date Unknown ☐ Onset of walking ☐ Since Birth Other				
Chief Complaint (Why do you want to be seen by the Shrine Hospital? What services are you looking for?)				
Referring Physician (complete name)			Phone Number	
Street Address	City	State	Zip Code	Country
Previous treatments provided				
Treatments and Surgeries				
X-rays available? ☐ Yes ☐ No	Date of Most Recent X-ray	Date Last Seen by Physician		

Insurance/Primary				
Subscriber Name				
Health Plan				
Name	Subscriber Member Number	Patient Member Number		
Primary Care Provider (complete name)			Phone Number	
Street Address	City	State	Zip Code	Country

Supplemental Information

Referral Source (Select One)

☐ Billboard ☐ Bumper Sticker ☐ Family Member/Self ☐ Newspaper ☐ Unknown ☐ Other
☐ Poster/Flyer ☐ Physician ☐ Other Health Care Professional ☐ School Teacher ☐ School ☐ Radio
☐ Shriner ☐ Television ☐ Friend (non-Shriner) ☐ Watts Line ☐ Website

Family Income for last 12 months

☐ $0 - $10,000 ☐ $10,001 - $20,000 ☐ $20,001 - $30,000 ☐ $30,001 - $40,000 ☐ $40,001 - $50,000
☐ Over $50,000 ☐ Not provided