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				
Home Address (if different from patients)				
*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			
Home Address (if different from patients)			
*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 patients)			
*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 patients)			
*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			Sponsor signature date
Street Address	City	State	Zip Code	Country	
Sponsoring Shriners Signature					
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				
Referring Physician				
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		

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					