



To be completed by parent or guardian (please print).

Application Date (Today's date): _____

1. Child's Information (Required) * required fields							
Child's Last Name*		Child's First Name*		Child's Middle Name		Child's Suffix	
Child's Date of Birth* (mm/dd/yyyy)		Gender* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Primary Language		Interpreter Needed? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Child's Home Address*			City*		State / Province*		
Zip / Postal Code*		Country		County		Is home address the mailing address?* <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child's Permanent Mailing Address (if different than home address)*			City*		State / Province*		
Zip / Postal Code*		Country		Who does child live with?*		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/> Other, relationship:	
Primary Phone Number* <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> no phone <input type="checkbox"/> other:		Alternate Phone Number 1 <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> pager <input type="checkbox"/> other:		Alternate Phone Number 2 <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> pager <input type="checkbox"/> other:			

2. Medical Information (Required) * required fields	
What is your child's medical problem or diagnosis?* Please feel free to attach any photographs that may better depict your child's condition	
Onset of problem* <input type="checkbox"/> Before Birth (congenital) <input type="checkbox"/> Since Birth <input type="checkbox"/> Onset of walking <input type="checkbox"/> Developed recently <input type="checkbox"/> Injury, Date: <input type="checkbox"/> Injury, date unknown <input type="checkbox"/> Other, describe:	
What medical care or services are you looking for from the Shriners Hospitals for Children®?*	
What previous treatments have been provided?* (Treatments and surgeries, dates etc.)	
Are X-Rays Available? <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of most recent X-ray _____ Date last seen by physician? _____ > Please attach any other medical information you have regarding this problem such as a physician referral letter, or past medical records

3. Referring Physician's Information * required fields			
<input type="checkbox"/> No referring physician			
Referring Physician's Last Name*	Referring Physician's First Name*	Referring Physician's Specialty	
Referring Physician's Office Address		City*	State / Province*
Zip / Postal Code	Country	Phone Number with Area Code	

4. Primary Care Physician (PCP) Information * required fields			
<input type="checkbox"/> Same as referring physician <input type="checkbox"/> No PCP			
PCP Physician's Last Name*	PCP Physician's First Name*	PCP Physician's Specialty	
PCP Physician's Office Address		City*	State / Province*
Zip / Postal Code	Country	Phone Number with Area Code	

5. Mother's Information				Not applicable		* required fields	
Mother's Last Name*		Mother's First Name*		Mother's Middle Name		Mother's Maiden Name	
Mother's Home Address			City*		State / Province*		
Zip / Postal Code*	Country		County		Marital Status*	<input type="checkbox"/> married	<input type="checkbox"/> divorced
					<input type="checkbox"/> single	<input type="checkbox"/> widowed	<input type="checkbox"/> separated
Primary Phone Number*	<input type="checkbox"/> home	<input type="checkbox"/> cell	Alternate Phone Number 1	<input type="checkbox"/> home	<input type="checkbox"/> cell	Date of Birth* (mm/dd/yyyy)	
	<input type="checkbox"/> work	<input type="checkbox"/> no phone		<input type="checkbox"/> work	<input type="checkbox"/> pager		
	<input type="checkbox"/> other			<input type="checkbox"/> other			

6. Father's Information				Not applicable		* required fields	
Father's Last Name*		Father's First Name*		Father's Middle Name		Father's Suffix	
Father's Home Address*			City*		State / Province*		
Zip / Postal Code*	Country		County		Marital Status*	<input type="checkbox"/> married	<input type="checkbox"/> divorced
					<input type="checkbox"/> single	<input type="checkbox"/> widowed	<input type="checkbox"/> separated
Primary Phone Number*	<input type="checkbox"/> home	<input type="checkbox"/> cell	Alternate Phone Number 1	<input type="checkbox"/> home	<input type="checkbox"/> cell	Date of Birth* (mm/dd/yyyy)	
	<input type="checkbox"/> work	<input type="checkbox"/> no phone		<input type="checkbox"/> work	<input type="checkbox"/> pager		
	<input type="checkbox"/> other:			<input type="checkbox"/> other:			

7. Legal Guardian's Information (if different from parent)				Not applicable		* required fields	
Legal Guardian's Last Name*		Legal Guardian's First Name*		Legal Guardian's Middle Name		Suffix / Maiden Name	
Legal Guardian's Home Address*			City*		State / Province*		
Zip / Postal Code*	Country		County		Relationship to Child*		
Primary Phone Number*	<input type="checkbox"/> home	<input type="checkbox"/> cell	Alternate Phone Number 1	<input type="checkbox"/> home	<input type="checkbox"/> cell	Date of Birth* (mm/dd/yyyy)	
	<input type="checkbox"/> work	<input type="checkbox"/> no phone		<input type="checkbox"/> work	<input type="checkbox"/> pager		
	<input type="checkbox"/> other:			<input type="checkbox"/> other:			

8. Other Relative with Custody				Not applicable		* required fields	
Other Relative's Last Name*		Other Relative's First Name*		Other Relative's Middle Name		Suffix / Maiden Name	
Other Relative's Home Address			City*		State / Province*		
Zip / Postal Code*	Country		County		Relationship to Child		
Primary Phone Number*	<input type="checkbox"/> home	<input type="checkbox"/> cell	Alternate Phone Number 1	<input type="checkbox"/> home	<input type="checkbox"/> cell	Date of Birth* (mm/dd/yyyy)	
	<input type="checkbox"/> work	<input type="checkbox"/> no phone		<input type="checkbox"/> work	<input type="checkbox"/> pager		
	<input type="checkbox"/> other:			<input type="checkbox"/> other:			

9. Shriner Information		
Temple Name	Sponsoring Shriner Last Name	Sponsoring Shriner First Name
Sponsoring Shriner Address		City
		State / Province
Zip / Postal Code	Country	Child's ambulatory status?

10. How did you hear about Shriners Hospitals for Children?			
<input type="checkbox"/> Billboard	<input type="checkbox"/> Newspaper	<input type="checkbox"/> School / Teacher	<input type="checkbox"/> Website / Internet
<input type="checkbox"/> Bumper sticker	<input type="checkbox"/> Physician	<input type="checkbox"/> Shriner	<input type="checkbox"/> Unknown
<input type="checkbox"/> Family Member / Self	<input type="checkbox"/> Other healthcare provider	<input type="checkbox"/> Television	<input type="checkbox"/> Other, describe:
<input type="checkbox"/> Friend (non-Shriner)	<input type="checkbox"/> Poster / Flyer	<input type="checkbox"/> Watts line	