

**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	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown
*DOB	Who does child live with? <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other (relationship) _____		
Primary Language		Interpreter Required <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> 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 <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> 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	