Aladdin Shriners

Hospital Association

for Children

PROGRAM APPLICATION

CHILD'S INFORMATION

Name: _____
(Last) (First) (Middle)

Mailing Address: _____
(Street)

_____
(City) (State) (Zip) (County)

Phone: _____ Sex: Male Female

Birthday: _____ Social Security: _____

Who does the child live with primarily? (Circle One) Both Parents Mother Father Other

MOTHER'S INFORMATION

☐ Check if same address as child.

Name: _____
(Last) (First) (Middle)

Mailing Address: _____
(Street) (City) (State) (Zip) (County)

Home Phone: _____ Work Phone: _____

Marital Status: Single____ Married_____ Separated_____ Divorced_____ Widowed_____

FATHER'S INFORMATION

☐ Check if same address as child.

Name: _____
(Last) (First) (Middle)

Mailing Address: _____
(Street) (City) (State) (Zip) (County)

Home Phone: _____ Work Phone: _____

Marital Status: Single____ Married_____ Separated_____ Divorced_____ Widowed_____

LEGAL GUARDIAN

☐ Check if same address as child.

Name (if different from above): _____
(Last) (First) (Middle)

Relationship to Child: _____

Mailing Address: _____
(Street) (City) (State) (Zip) (County)

Home Phone: _____ Work Phone: _____

SPONSORING SHRINER INFORMATION

Shriner's Name: _____
(Last) (First) (Middle)

Shriner's Address: _____
(Street) (City) (State) (Zip) (County)

Home Phone: _____ Work Phone: _____

Sponsoring Shriner's Signature: _____

3850 Stelzer Road ◆ Columbus, Ohio 43219

614-475-2609 ◆ www.aladdinshrine.org

MEDICAL INFORMATION

Problem or Diagnosis (if known): _____

_____

Date First Noticed: _____

Describe Chief Complaint (symptom): _____

_____

How long has child had the problem? From Birth_____ Developed Recently_____

Injury_____ Date_____

What other symptoms does your child have? _____

_____

Previous Treatment:

Physician: _____ Hospital: _____

Name: _____

Address: _____

Phone Number: _____

Treatment Provided:

Surgery/Dates: _____

Other Treatment/Dates: _____

X-Rays: Yes____ No____ Date of most recent x-ray: _____ (bring to first appointment)

When was the child last seen by a doctor? _____

Has the child been treated by another Shriners Hospital? Yes____ No____

If yes, Date: _____ Location/City: _____

FINANCIAL INFORMATION

Total Combined Family income for the 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

INSURANCE INFORMATION

Type: Private___ HMO___ Medicaid___ Medicare___ State Agency___ Other___ None___

Name of Company or Health Plan: _____ ID Number: _____

Name of HMO Physician: _____

(If this application is approved, further insurance information may be requested.)

---------- **OFFICE USE ONLY** ----------

MEDICAL DIRECTOR'S RECOMMENDATION

ACCEPT _____ REJECT _____ SCREEN _____

Reason for Rejection: _____

_____

Signature of Physician Date

BOARD OF TRUSTEES ACTION

APPROVED _____ DENIED _____

Reason for Denial: Medical Financial Overage
Non-Compliance Foreign Patient Policy

_____

Signature Date

OFFICE USE ONLY

Return To: _____

Address: _____

Application Number: _____ Medical Record Number: _____

Date/Call/Received: _____ Date of Screening Visit: _____

Name of Person Initiating Form: _____