

Name of Child: _____

MEDICAL INFORMATION

Problem or Diagnosis (If Known): _____ Date First Noticed: _____

Chief complaint (symptom) describe: _____

How long has child had the problem: From birth Developed recently Injury Date _____

What other symptoms does your child have (describe): _____

Currently Under Care Of	Physician:	Hospital:
Name:		
Address:		
Phone #:		

Treatment Provided:
Surgery/Dates: _____
Other treatment/Dates: _____
X-rays: Yes No Date of most recent x-ray _____ (should bring to 1st visit)
When was child last seen by doctor? _____
Has child been treated at another Shriners Hospital? Yes No Date of Treatment _____
Location/City: _____

FINANCIAL INFORMATION

TOTAL COMBINED FAMILY INCOME FOR LAST 12 MONTHS: \$0 - \$10,000 \$10,000 - \$20,000 \$20,000 - \$30,000
 \$30,000 - \$40,000 \$40,000 - \$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 by the Hospital in order to assist with services performed at Shriners Hospitals.)

Name of Person Completing Form _____ Relationship _____ Date _____

FOR HOSPITAL USE ONLY:

CHIEF OF STAFF RECOMMENDATIONS

Accept Reject Screen

Reason For Rejection: _____

Signature - Chief of Staff _____ Date _____

ACTION BOARD OF GOVERNORS

Approved Denied

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

Overage Other