

**JOHNS HOPKINS MEDICINE – DEPARTMENT OF PSYCHIATRY - PATIENT INFORMATION FORM**

**CLINIC \_\_\_\_\_**

DEMOGRAPHICS			
Existing Hopkins Patient MRN:		<input type="checkbox"/> New Patient	
Assigned Name:		Chosen/Affirmed Name:	Pronoun: she/he
Date of Birth:	SSN:	Religion:	Country or Birth
Sex: Male ___ Female ___ Nonbinary ___ Other _____			
Ethnicity: Hispanic or Latino: ___ Not Hispanic ___ Unknown ___		<b>RACE:</b>	
Address (city, state, zip):		<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
Contact Phone:	Email:	<input type="checkbox"/> Asian	<input type="checkbox"/> White or Caucasian
Preferred Language: <i>(if not English, request interpreter)</i>		<input type="checkbox"/> Black or African American	<input type="checkbox"/> Other
Preferred Pharmacy: (Name, address, phone)			
Are you employed?	Employer Name:	Employment Status:	
Are you a student?	College/School Name:	Student Status:	
EMERGENCY CONTACT			
Name:		Relationship:	
Address: (city, state, zip)			
Phone:		Email:	
MEDICAL INFORMATION			
Clinical Diagnosis			
Treating Psychiatrist (name, address, phone):			
Treating Therapist/Counselor (name, address, phone):			
Primary Care Physician (name, address, phone):			
Psychiatrically Hospitalized: Y/N	If yes, when and where:		
Is this appointment accident related? Y/N			
INSURANCE			
Primary Insurance:	Subscriber Name/DOB:	Subscriber Member ID:	
Secondary Insurance:	Subscriber Name/DOB:	Subscriber Member ID:	
Additional Information:			