JOHNS HOPKINS MEDICINE

# YOUNG ADULT CONSULTATION CLINIC PATIENT INFORMATION FORM

Psychiatry and Behavioral Sciences

## DEMOGRAPHICS

***In this section, please provide the patient's information ONLY.***
***If you are the direct contact for the patient, your information should be provided in the emergency contact section****

| | | |
|---|---|---|
| Patient's Name: | Preferred Name: | |
| Patient's Date of Birth: | Check Biological Sex at Birth: Male ☐ | Female ☐ |
| Race: | Patient's Social Security Number: | |
| Preferred Language: | Check if you need a Translator or Interpreter: | |
| Patient's Address: | | |
| City: | State: | Zip code: |
| Patient Contact Number: | Patient Email: | |
| Country place of birth: | | |
| Check the box that applies: **Unemployed** ☐ **Retired** ☐ **Student** ☐ **Part time** ☐ **Full time** ☐ | | |
| Employer's/Company's Name: | Office Number: | |
| Who should we contact to schedule? | Name: | Number: |
| Who will be participating in the consultation? **Please provide name(s) and email(s)** | | |

## EMERGENCY CONTACT INFORMATION

| | | |
|---|---|---|
| Emergency Contact's Name: | Relationship: | |
| Emergency Contact's Address: | | |
| City: | State: | Zip code: |
| Emergency Contact's Phone: | Emergency Contact's Email: | |

## MEDICAL INFORMATION

| | | |
|---|---|---|
| Psychiatric Diagnosis: | | |
| Treating Psychiatrist **(REQUIRED)** Full Name: | | |
| Years established with this provider: | Office Number: | Office Fax number: |
| Primary Care Physician Name and Office Number: | | |
| Check if you were hospitalized for mental health ☐ | Most recent date: | Facility name: |

## INSURNACE INFORMATION

***If your Insurance is not in network, the fee will be due at the time of service****

| | | |
|---|---|---|
| Primary Insurance: | | |
| Subscriber's Name: | | Subscriber's Date of Birth: |
| Subscriber's ID: | Check if you Primary Insurance is in network: | |
| Secondary Insurance | | |
| Subscriber's Name | | Subscriber's Date of Birth: |
| Subscriber's ID: | Check if you Primary Insurance is in network: | |

## OTHER INFORMATION

How did you hear about us?

Please add any additional requests and share what you are hoping to gain from this consultation:

Check if you are a new patient to Johns Hopkins ☐

Check if you've had a prior Hopkins visit ☐
if so, provide your Hopkins medical record number