JOHNS HOPKINS MEDICINE – DEPARTMENT OF PSYCHIATRY - PATIENT INFORMATION FORM

CLINIC_____

DEMOGRAPHICS			
Existing Hopkins Patient MRN:		☐ 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 ____		RACE:	
Address (city, state, zip):		☐ American Indian or Alaska Native	☐ Native Hawaiian or Other Pacific Islander
Contact Phone:	Email:	☐ Asian	☐ White or Caucasian
Preferred Language: (*if not English, request interpreter)*		☐ Black or African American	☐ 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:		