ADULT CONSULTATION CLINIC
PATIENT INFORMATION FORM

DEMOGRAPHICS

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 #:**

Name:	Preferred Name:	
Date of birth:	SSN:	Race:
Permanent Address:		
City:	State:	ZIP Code:
Patient's Email:	Mobile phone number:	
Biological Sex at Birth: Male ☐ Female ☐		
Mother's Maiden Name:		

EMERGENCY

Emergency contact name:	Relationship:
Emergency contact address:	
Emergency contact email:	Emergency contact phone #:

MEDICAL INFORMATION

Psychiatric Diagnosis:	
Treating Psychiatrist (required):	
Primary Care Physician:	
Check if you were hospitalized for mental health ☐	If so, when was the last hospitalization?
Preferred Language:	Check if you need a translator/interpreter ☐
Please provide any further medical/psychiatric information relevant to scheduling:	

INSURANCE *(If your insurance is not in network, the fee will be due at time of service)*

Primary Insurance:	Subscriber's ID:
Subscriber's name and date of birth:	
Check if your primary insurance is in network ☐	
Secondary Insurance:	Subscriber/ID:
Check if your secondary insurance is in network ☐	

OTHER

How did you hear about us?
If living away from your permanent residence (at college, for example), in what state do you currently reside? (N/A if not applicable)
If available, please check if you are interested in a consultation via telemedicine (using video) ☐
Who should we contact to schedule? Name: Phone #:
Who will be participating in the consult with the patient? Please provide name and e-mail address:
Please add any additional requests and share what you are hoping to gain from this consultation: