



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:	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired	<input type="checkbox"/> Student
	<input type="checkbox"/> Part time	<input type="checkbox"/> 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:	

INSURANCE 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