ADULT 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:

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) ☐

Please add any additional requests or information related to scheduling here: