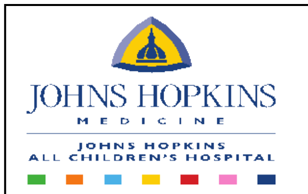

JOHNS HOPKINS ALL CHILDREN'S HOSPITAL
APPOINTMENT REQUEST FORM

Patient Information

Patient's First Name	Patient's Middle Name (if applicable)	Patient's Last Name		
Date of Birth mm / dd / yyyy	Place of Birth	Age	Gender M ___ F ___	Patient Weight

Permanent Address		
City (or State)	Country	Zip Code (if applicable)

Home Telephone Number (country code)+(area code)+(phone number)	Alternate Telephone (country code)+(area code)+(phone number)

Has this patient been to Johns Hopkins All Children's Hospital before? Yes ____ No ____

If so, when? Month__________________ Year ___________________

Has this patient been seen at any other facility in the USA for this same condition? Yes ____ No ____

If Yes, please send copies of the patient's medical records/notes relating to this condition at those facilities.

Does the patient/escort speak English? Yes ______ No______ If No, what language(s) are spoken?

Contact Information

Mother's Full Name	Date of Birth	Language(s) Spoken
Father's Full Name	Date of Birth	Language(s) Spoken

Home Telephone Number (country code)+(area code)+(phone number)	Office Telephone Number (country code)+(area code)+(phone number)
Mobile Telephone Number (country code)+(area code)+(phone number)	Fax Number (country code)+(area code)+(phone number)
E-mail Address	

Main contact for patient:

Name		**Relationship**
Email	**Phone**	**Fax**

Medical Diagnosis/Information – Please specify the Diagnosis and Medical Issue(s) to be addressed.

Physician(s) Information

Referring Physician Name	Phone Number (country code)+(area code)+(phone number)	
Specialty	E-mail Address	
Address	City	Country
Primary Care Physician Name	Phone Number (country code)+(area code)+(phone number)	
Specialty	E-mail Address	
Address	City	Country

May we contact the Physician(s)? Yes ____ No ____

Medical Appointment Information

Please indicate the requested date(s) for the appointment.

How did you hear about Johns Hopkins All Children's Hospital?

__ Friend / Family member	__ Healthcare Professional / Physician	__ Embassy / Insurance Company
__ Website	__ Television or other Media	__ Other:____________________________________

Travel Information

Does the patient/escort have a visa to come to Florida and receive medical treatment? Yes ____ No ____

Does the patient/escort require lodging accommodations? Yes ____ No ____ If Yes, Number of people needing accommodations: Number of nights requested:	What type of accommodations is preferred? Ronald McDonald House* ____ Hotel ____ (RMH) *Please note that if RMH is preferred, the following confirmations will be needed: • Current up-to-date immunizations for patient and accompanying family members • Current TB screening/test	Exact Date of Arrival: Exact Time of Arrival: (For Office Use): RMH location: Hotel Name and Location:

Temporary US address, phone number or fax number where Johns Hopkins All Children's Hospital can communicate with patient during their stay:

Insurance / Payment Information

Is the patient Self-Pay? Yes ____ No ____	Does the patient have International Insurance? Yes ____ No ____ **If Yes, please provide a copy of the front and back of the policyholder's insurance card.**	Primary Insurance Plan/Company Name
Insurance company contact person and phone number	Group Name	
Group Number	Policyholder's Member Number	Policy Holder's Name
Policy Holder's home phone number	Policy Holder's Cell/Office phone numbers	Date of Birth of Policy Holder

Note: If patient does not have International Insurance, Johns Hopkins All Children's Hospital will provide a cost estimate and agreement letter that will both need to be signed. The amount indicated will need to be paid in full prior to the patient's initial office visit.

Full Name of Person Responsible for the Bill	Date

Emergency Contact Information

Name of person to notify in case of emergency:	Relationship to Patient:
Phone number (country code)+(area code)+(phone number):	Address in Country:

I, ____, relationship to Patient ___________________________________ state that any and all of the information provided is true and correct. Further, I understand that this form and my child's medical information may be shared between Johns Hopkins All Children's Hospital and Physician practices.

Signature ____ Date: ____________________________