



# KAYDOKTE HEALTH ORGANIZATION

## PATIENT INFORMATION

Name

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Month          Day          Year

Social Security Number:          -          -

Race  American Indian or native Alaskan  Asian  Black or African American  
 Haitian

Native Hawaiian or Pacific Islander  white  Other race Ethnicity:

Gender  Male  Female Gender ID:                                  or  not Hispanic or  
Latino

Sexual orientation  Lesbian, gay or homosexual  Straight or heterosexual   
Bisexual  Don't Know

Choose not to disclose

Pronouns  He/Him  She/Her  They/Them

Marital Status:  Married  Widow/Widower  Divorced  Separated

Home phone: (    )          -                                  Cell: (    )          -

Address:

City:

State:

Apt  
Zip

Code:

E-mail:

## INSURANCE INFORMATION

Primary Insurance

Policy #

Group #

## EMERGENCY CONTACT INFORMATION

Name:

Phone:

Relationship:

HOW DID YOU HEAR ABOUT US?: