



Gender Affirming Surgical Interest Form

Denver Health asks these questions so we can provide the best care to every patient. Gathering this information is a critical step to eliminate health disparities and inequities among the patients we serve

Name:	Legal Name:	
Pronouns:	Date of Birth:	
Address:	City, State, Zip:	
Phone:	Email:	
SSN:		
Gender Identity:	Sex Assigned at Birth:	
Sexual Orientation:	Legal Sex:	
Birth Country/Nationality:	Race/Ethnicity:	
Preferred language:	Do you require an interpreter?	
Marital Status:	Are you a veteran?	
Current Employment Status:	Do you have a disability?	
Are you currently experiencing homelessness?	Weight:	Height:

Have you used any nicotine products in the last 5 years?: Yes No

Are you currently on Gender Affirming Hormone Therapy?: Yes No

If yes, what was your start date (MM/DD/YYYY):

EMERGENCY CONTACT:

Name:
Phone:
Relationship:

ALL ACTIVE INSURANCE PLANS: *(Please include a picture of your insurance card(s) and photo ID)*

Name of insurance company/provider:
Name of subscriber/policy holder (as appears on card):
Subscriber/policy holder date of birth:
Subscriber ID# (as appears on card):
Group # (if applicable):

SURGERIES OFFERED: *(Please select all surgeries you're interested in AND mark which surgery you would like to work towards first)*

Double Mastectomy (Top Surgery)

Hysterectomy

Orchiectomy

Tracheal Shave

Vaginoplasty (full-depth)

Vaginoplasty (minimal-depth)

Breast Augmentation

How did you hear about Denver Health LGBTQ Health Services?

Please send completed form and picture of your insurance card(s) and photo ID to:
hope.anderson@dhha.org