Dar a Luz
Health Center

Gender Affirming Hormone Therapy Intake Form (Rev 08/2026)

What name should we call you? _____ Pronouns _____

If different, legal name (as documented on your ID) _____ Date of Birth_____

Phone Number _____ Legal sex (as documented on your ID) _____

How did you hear about us?_____

Insurance Company _____ Insurance subscriber ID _____

Primary Care Provider (if any)_____
Name Phone

Mental Health Provider (if any)_____
Name Phone

Please share briefly what you are looking for from care _____

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