



PATIENT NAME \_\_\_\_\_

Head of Household (if different from patient): \_\_\_\_\_

DOB \_\_\_\_\_

**Would you like to participate in our federal grant that may help to lower the cost of your healthcare?**  Yes  No

Circle your household size	1	2	3	4	5
Circle your household income range	0-\$12,140 \$11,141-\$18,210 \$18,211-\$24,280 >\$24,281	0-\$16,460 \$16,461-\$24,690 \$24,691-\$32,920 >\$32,921	0-\$20,780 \$20,781-\$31,170 \$31,170-\$41,560 >\$41,561	0-\$25,100 \$25,101-\$37,650 \$37,651-\$50,200 >\$50,200	0-\$29,420 \$29,421-\$44,130 \$44,130-\$58,840 >\$58,840

**If household number is MORE THAN 5 fill in here**

Household \_\_\_\_\_ Estimated Annual Income \_\_\_\_\_

**Do you have Medicaid/TennCare?**  Yes  No

**Are you a Veteran?**  Yes  No  Choose Not to Answer

**Check your race:**  White  Black  Asian  American-Indian  Multi-Racial  Decline

**Are you Hispanic?**  Yes  No  Choose Not to Answer

**Do you think of yourself as:**

Straight/Heterosexual  Homosexual  Bisexual  Something Else  Don't Know/Decline

**What is your current gender identity? (Check all that apply)**

Male  Female  Transgender  Decline to Answer  Other

**What sex were you assigned on your birth certificate?**

Male  Female  Decline to Answer

Initials (Patient) \_\_\_\_\_ Initials (LS Employee) \_\_\_\_\_ Date \_\_\_\_\_