

## Titan Healthcare – Patient Intake Form

In an effort to ensure that you are scheduled with the most appropriate provider, we ask that you complete this form prior to scheduling. Our goal is to provide high-quality, patient-centered care and support positive health outcomes.

As a small, private clinic operated by Nurse Practitioners, there are some limitations to our services. None of our providers have hospital privileges. If a situation arises requiring advanced or hospital-based care, we are unable to provide that level of support. Additionally, we do not offer some of the expanded services available at larger clinics (such as registered nursing support, social work services, diabetes education, or insulin management).

As Nurse Practitioners and Physician Assistants, there are also certain complex conditions that fall outside of our scope of practice and may require care through an internal medicine team or specialty provider.

Please complete the information below. You may return this form via:

**Email:** admin@titanhealthcare.org (unsecured)

**Fax:** 360-839-2852

**Mail or in person** at our office

Incomplete forms may be returned and could delay scheduling.

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### Patient Information

**Name:** \_\_\_\_\_

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

**Insurance:** \_\_\_\_\_

**ID #:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Family members seen at Titan (if any):** \_\_\_\_\_

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### Medications

Please list all prescribed or chronic medications you are currently taking:

(You may attach a medication list if preferred)

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**Chronic Medical Conditions**

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**Providers & Specialists**

Please list your primary care provider (if applicable) and any specialists you see, including the reason:

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**Reason for Visit**

- Establish primary care
- Menopause
- Gender-affirming care
- Gynecological care
- Establish care with Carole for nutrition therapy
- Other: \_\_\_\_\_

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**What Happens Next**

Once your completed form is received, **your request will be reviewed by our providers.**

- If your request is **approved**, and with your consent, we may request relevant prior medical records to support your care.
- You may be placed on our callback list for scheduling.
- If we are unable to meet your care needs, you may receive a letter explaining the decision.

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**Medical Records (Optional – With Consent)**

To support continuity of care, we may request prior medical records with your permission.

**Date of most recent labs:** \_\_\_\_\_

**Ordering Provider/Lab:** \_\_\_\_\_

**Date of most recent Pap:** \_\_\_\_\_

**Ordering Provider:** \_\_\_\_\_

**Date of colonoscopy:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Date of mammogram:** \_\_\_\_\_

**Location:** \_\_\_\_\_

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### **Consent to Request Medical Records**

I authorize Titan Healthcare to request and obtain my prior medical records as needed for my care.

I do NOT authorize Titan Healthcare to request my medical records.

**Patient Signature:** \_\_\_\_\_