

Avant Chiropractic, P.C.
Michael MacKinnon, D.C

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NEW PATIENT INTAKE FORM

Name _____ Date _____

Address _____

City/State/Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Social Security # _____ Birth Date _____

Employer's Name _____ Position _____

Employer's Address _____

Referred by _____

COMPLAINTS

Main Compliant(s) _____

How & when it started _____

Activities that aggravate your condition _____

Activities that lessen your condition _____

Review of Systems

**Please check current problems and past problems
with a C (current) or P (past) respectively**

<input type="checkbox"/> Headaches	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Numbness (where) _____	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Constipation
<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Pins & needles _____	<input type="checkbox"/> Hernia
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Mood swings	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Gas
<input type="checkbox"/> Irritability	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Stomach problems	<input type="checkbox"/> Indigestion
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Heart attacks	<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anemia	<input type="checkbox"/> Sweats	<input type="checkbox"/> High/Low blood pressure	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Allergies _____	_____		
<input type="checkbox"/> Cancer _____	_____		

Please list any medications that you are currently taking:

Please list any health conditions or concerns you have in relation to your:

Father _____

Mother _____

Significant other _____

Children _____

Brother(s) _____

Sister(s) _____

The statements made on this form are true and accurate to the best of my knowledge. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I understand that pain syndromes can be caused by conditions (such as tumor, etc.) which may be visualized by x-rays. Should doctor deem x-rays are not necessary for my condition, I agree, not to hold anyone associated with this clinic responsible for such pathology. I authorize the release of any medical information necessary to process this claim. I also request payment of my health and/or government benefits be directed to Avant Chiropractic, P.C. who accepts assignment when insurance pays directly. I agree all claims submitted by this office are my responsibility to settle regardless of my insurance company. I understand when the insurance company verifies my benefits, it is not a guarantee or authorization to pay on claims submitted. I agree to pay my portion (which is only an estimate) at the time of service. I agree to pay/settle any denied and unpaid claims. I understand payment is due, in full, upon notification from this office. I may have to pursue reimbursement directly from the insurance company or the third party payor.

_____ Date: _____

Patient/ Guardian- print name

Patient/ Guarantor- signature