

Artful Art of Massage, LLC

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PATIENT INFORMATION

Today's Date _____

Name _____ Birth date _____

Address _____

City _____ State _____ Zip _____

Home phone# _____ Work phone# _____

Cell # _____ E-mail _____

Occupation / Type of work _____

INSURANCE INFORMATION

Primary Insurance Co. _____

Claims Address _____

City _____ State _____ Zip _____

Insurance phone# _____ Subscriber Name _____

Relationship to Patient () Self () Spouse () Other _____

Subscriber ID# _____ SSN# _____

Subscriber Employed by: _____ Phone#: _____

Address _____ City _____ State _____ Zip _____

Do you have other coverage you will be using today? yes _____ no _____