Patient Information and Treatment Authorization

Document Date: 01/03/2023

PATIENT INFORMATION # WESTSTAR VERONICA ROSIO AVILA

Name:	VERONICA ROSIO AVILA	**SSN:**	999-99-9999
Address:	3409 N E ST UNIT N	**Sex:**	F
City,St Zip:	SAN BERNARDINO,CA,92405	**DOB:**	09/28/1967
Home Ph	(909)222-8818	**Age:**	55
Work Ph:		**Email:**	
Cell Ph:	(909)222-8818		

INJURY INFORMATION

Date:	09/17/2021	**Post Sx:**	
Type:	WC	**Sx Date:**	

REFERRING DOCTOR INFORMATION

Name:	TENENBAUM, MAX	**Body Pts:**	
Address:			
City,St Zip::	RIVERSIDE,CA,		
Phone:	(951)323-1021	**Dx:**	

ATTORNEY INFORMATION

Name:	
Address:	
City,St Zip:	,,
Phone:	

EMPLOYMENT INFORMATION

Name:	
Address:	

City,St Zip:: ,,
Phone:

PRIMARY INSURANCE INFORMATION

Name:
Address:
Adj/Ph#:
Type:
Ins Name:
Pol#/Clm#:

SECONDARY INSURANCE INFORMATION

Name:
Address:
Adj/Ph#:
Type:
Ins Name:
Pol#/Clm#:

RELEASE OF INFORMATION and ASSIGNMENT OF BENEFITS

I hereby authorize West-Star Physical Therapy to release information requested by my insurance carrier concerning this illness

VERONICA ROSIO AVILA, Patient

01/03/2023

Date Signed