Patient Information and Treatment Authorization

Document Date: 01/06/2023

PATIENT INFORMATION # WESTSTAR DIANA DEAN HERNADNEZ

Name:	DIANA DEAN HERNADNEZ	**SSN:**	999-99-9999
Address:	4520 RODEO LANE APT 3	**Sex:**	F
City,St Zip:	LOS ANGELES,CA,90016	**DOB:**	11/24/1987
Home Ph	(323)534-7995	**Age:**	35
Work Ph:		**Email:**	
Cell Ph:			

INJURY INFORMATION

Date:	09/23/2022	**Post Sx:**	
Type:	PI	**Sx Date:**	

REFERRING DOCTOR INFORMATION

Name:	MILLER, LAWRENCE ROSS	**Body Pts:**	
Address:	8641 WILSHIRE BLVD STE 200		
City,St Zip::	BEVERLY HILLS,CA,90211		
Phone:	(310)657-7246	**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

01/06/2023

DIANA DEAN HERNADNEZ, Patient

Date Signed