Patient Information and Treatment Authorization

Document Date: 01/05/2023

PATIENT INFORMATION # WESTSTAR JUAN ALEGRIA

Name:	JUAN ALEGRIA	**SSN:**	571-31-2487
Address:	10550 PALOMINO CIRCLE	**Sex:**	M
City,St Zip:	MONTCLAIR,CA,92763	**DOB:**	01/27/1957
Home Ph	(909)621-0314	**Age:**	65
Work Ph:		**Email:**	
Cell Ph:	(909)261-5364		

INJURY INFORMATION

Date:	12/18/2012	**Post Sx:**	
Type:	WC	**Sx Date:**	

REFERRING DOCTOR INFORMATION

Name:	JOHNSON, DAVID	**Body Pts:**	
Address:	10837 LAUREL STREET STE 102		
City,St Zip::	RANCHO CUCAMONGA,CA,91730		
Phone:	(909)204-6611	**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

JUAN ALEGRIA, Patient

01/05/2023

Date Signed