Patient Information and Treatment Authorization

Document Date: 01/09/2023

PATIENT INFORMATION # WESTSTAR ANTONIO ALCALA

Name:	ANTONIO ALCALA	**SSN:**	999-99-9999
Address:	322 N BUSH STREET APT D	**Sex:**	M
City,St Zip:	ANAHEIM,CA,92805	**DOB:**	02/07/1961
Home Ph	(657)615-4016	**Age:**	61
Work Ph:		**Email:**	
Cell Ph:			

INJURY INFORMATION

Date:	09/14/2022	**Post Sx:**	
Type:	WC	**Sx Date:**	

REFERRING DOCTOR INFORMATION

Name:	ROSARIO, MANUEL	**Body Pts:**	
Address:	1950 E 17TH STREET STE 200		
City,St Zip::	SANTA ANA,CA,92705		
Phone:	(714)495-4050	**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

ANTONIO ALCALA, Patient

01/09/2023

Date Signed