Patient Information and Treatment Authorization

Document Date: 01/09/2023

PATIENT INFORMATION # WESTSTAR MITCHELL LOMELO

Name:	MITCHELL LOMELO	**SSN:**	999-99-9999
Address:		**Sex:**	M
City,St Zip:	,,	**DOB:**	08/07/1977
Home Ph	(949)993-6928	**Age:**	45
Work Ph:		**Email:**	
Cell Ph:			

INJURY INFORMATION

Date:	11/07/2022	**Post Sx:**	
Type:	PI	**Sx Date:**	

REFERRING DOCTOR INFORMATION

Name:	MOHEIMANI, MICHAEL	**Body Pts:**	
Address:	902 N GRAND AVE STE 100		
City,St Zip::	SANTA ANA,CA,92701		
Phone:	(714)285-0014	**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

MITCHELL LOMELO, Patient

01/09/2023

Date Signed