



Patient Information and Treatment Authorization

Document Date: 01/02/2023

PATIENT INFORMATION #193445

WESTSTAR JUAN ALVAREZ

Name:	JUAN ALVAREZ	SSN:	999-99-9999
Address:	15453 MALLORY DRIVE	Sex:	M
City,St Zip:	FONTANA,CA,92335	DOB:	01/04/1965
Home Ph	(702)488-3229	Age:	57
Work Ph:		Email:	
Cell Ph:			

INJURY INFORMATION

Date:	07/25/2017	Post Sx:	
Type:	WC	Sx Date:	

REFERRING DOCTOR INFORMATION

Name:	HARONIAN, EDWIN	Body Pts:	
Address:	724 CORPORATE CENTER DRIVE		
City,St Zip::	POMONA,CA,91768		
Phone:	(909)622-6222	Dx:	

ATTORNEY INFORMATION

Name:	
Address:	
City,St Zip:	
Phone:	

EMPLOYMENT INFORMATION

Name:	HARDWOOD CREATIONS
Address:	

City,St Zip::

Phone:

PRIMARY INSURANCE INFORMATION

Name: SEDGWICK CMS

Address:

Adj/Ph#:

Type: JENNIFER JONES

Ins Name:

Pol#/Cln#:

30178377814-0001

SECONDARY INSURANCE INFORMATION

Name:

Address:

Adj/Ph#:

Type:

Ins Name:

Pol#/Cln#:

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 ALVAREZ, Patient

01/02/2023

Date Signed