Patient Information and Treatment Authorization

Document Date: 12/28/2022

PATIENT INFORMATION # WESTSTAR DAVID ARNOLD

Name:	DAVID ARNOLD	**SSN:**	999-99-9999
Address:	707 EAST OCEAN BLVD	**Sex:**	M
City,St Zip:	LONG BEACH,CA,90802	**DOB:**	10/22/1989
Home Ph	(229)585-2106	**Age:**	33
Work Ph:		**Email:**	
Cell Ph:			

INJURY INFORMATION

Date:	09/22/2022	**Post Sx:**	
Type:	PI	**Sx Date:**	

REFERRING DOCTOR INFORMATION

Name:	DWORKIN, IAN	**Body Pts:**	
Address:	3300 WEST COAST HWY STE A		
City,St Zip::	NEWPORT BEACH,CA,92663		
Phone:	(949)491-9991	**Dx:**	

ATTORNEY INFORMATION

Name:	
Address:	
City,St Zip:	,,
Phone:	

EMPLOYMENT INFORMATION

Name:	
Address:	

City,St Zip:: ,,
Phone:

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Name:	**Name:**
Address:	**Address:**
Adj/Ph#:	**Adj/Ph#:**
Type:	**Type:**
Ins Name:	**Ins Name:**
Pol#/Clm#:	**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

12/28/2022

DAVID ARNOLD, Patient

Date Signed