Patient Information and Treatment Authorization

Document Date: 12/28/2022

PATIENT INFORMATION # WESTSTAR

Name:		**SSN:**	
Address:		**Sex:**	
City,St Zip:	,,	**DOB:**	
Home Ph		**Age:**	
Work Ph:		**Email:**	
Cell Ph:			

INJURY INFORMATION

Date:		**Post Sx:**	
Type:		**Sx Date:**	

REFERRING DOCTOR INFORMATION

Name:		**Body Pts:**	
Address:			
City,St Zip::	,,		
Phone:		**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

12/28/2022

, Patient

Date Signed