Patient Information and Treatment Authorization

Document Date: 01/09/2023

PATIENT INFORMATION # **WESTSTAR ANNA SALMAN**

Name:	ANNA SALMAN	**SSN:**	999-99-9999
Address:	16520 BRASS LANTERN DRIVE	**Sex:**	F
City,St Zip:	LA MIRADA,CA,90638	**DOB:**	04/02/1969
Home Ph	(562)712-5240	**Age:**	53
Work Ph:		**Email:**	
Cell Ph:			

INJURY INFORMATION

Date:	01/31/2019	**Post Sx:**	
Type:	PI	**Sx Date:**	

REFERRING DOCTOR INFORMATION

Name:	GHATAN, ALEX	**Body Pts:**	
Address:	120 S SPALDING DRIVE STE 305		
City,St Zip::	BEVERLY HILLS,CA,90212		
Phone:	(855)786-7846	**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

ANNA SALMAN, Patient

01/09/2023

Date Signed