



Patient Information and Treatment Authorization

Document Date: 01/03/2023

PATIENT INFORMATION

WESTSTAR DERRICK HORTON

Name:	DERRICK HORTON	SSN:	514-11-3274
Address:	1325 N WESTERN AVE	Sex:	M
City,St Zip:	LOS ANGELES,CA,90027	DOB:	02/26/1995
Home Ph	(323)455-6697	Age:	27
Work Ph:		Email:	
Cell Ph:			

INJURY INFORMATION

Date:	05/29/2022	Post Sx:	
Type:	WC	Sx Date:	

REFERRING DOCTOR INFORMATION

Name:	SHANAA, MANO	Body Pts:	
Address:	10845 MAGNOLIA BLVD STE 2		
City,St Zip::	NORTH HOLLYWOOD,CA,91601		
Phone:	(818)980-6500	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#/Cln#:

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

DERRICK HORTON, Patient

01/03/2023

Date Signed