Patient Information and Treatment Authorization

Document Date: 01/05/2023

PATIENT INFORMATION # WESTSTAR ABEL GONZALEZ

Name:	ABEL GONZALEZ	**SSN:**	999-99-9999
Address:	10631 LINDLEY AVE APT 216	**Sex:**	M
City,St Zip:	PORTER RANCH,CA,	**DOB:**	06/12/1984
Home Ph	(559)712-1000	**Age:**	38
Work Ph:		**Email:**	
Cell Ph:			

INJURY INFORMATION

Date:	12/25/2022	**Post Sx:**	
Type:	PI	**Sx Date:**	

REFERRING DOCTOR INFORMATION

Name:	NATANZI, NAVEED	**Body Pts:**	
Address:	14332 VENTURA BLVD		
City,St Zip::	SHERMAN OAKS,CA,91423		
Phone:	(818)581-2001	**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

01/05/2023

ABEL GONZALEZ, Patient

Date Signed