Patient Information and Treatment Authorization

Document Date: 12/28/2022

PATIENT INFORMATION # WESTSTAR NICOLE FOSTER

Name:	NICOLE FOSTER	**SSN:**	591-56-4182
Address:	3203 YEARLING STREET	**Sex:**	F
City,St Zip:	LAKEWOOD,CA,90712	**DOB:**	02/28/1987
Home Ph	(818)650-7653	**Age:**	35
Work Ph:		**Email:**	
Cell Ph:			

INJURY INFORMATION

Date:	07/05/2022	**Post Sx:**	
Type:	WC	**Sx Date:**	

REFERRING DOCTOR INFORMATION

Name:	PAZMINO, PABLO	**Body Pts:**	
Address:	4014 LONG BEACH BLVD STE 210		
City,St Zip::	LONG BEACH,CA,90807		
Phone:	(562)977-7100	**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

NICOLE FOSTER, Patient

12/28/2022

Date Signed