Patient Information and Treatment Authorization

Document Date: 01/03/2023

PATIENT INFORMATION # WESTSTAR ALEXANDER RAMIREZ

Name:	ALEXANDER RAMIREZ	**SSN:**	999-99-9999
Address:	9451 OLIVE STREET #2	**Sex:**	M
City,St Zip:	FONTANA,CA,92335	**DOB:**	12/30/1984
Home Ph	(909)491-0762	**Age:**	38
Work Ph:		**Email:**	
Cell Ph:			

INJURY INFORMATION

Date:	06/14/2022	**Post Sx:**	
Type:	WC	**Sx Date:**	

REFERRING DOCTOR INFORMATION

Name:	WILKER, MOSHE H	**Body Pts:**	
Address:	11980 SAN VICENTE BLVD STE 114		
City,St Zip::	LOS ANGELES,CA,90049		
Phone:	(310)337-7463	**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

ALEXANDER RAMIREZ, Patient

01/03/2023

Date Signed