Patient Information and Treatment Authorization

Document Date: 01/03/2023

PATIENT INFORMATION # WESTSTAR TAILIER BOONE

Name:	TAILIER BOONE	**SSN:**	999-99-9999
Address:	2449 W BALL RAOD	**Sex:**	
City,St Zip:	ANAHEIM,CA,92804	**DOB:**	08/14/1993
Home Ph	(714)733-3797	**Age:**	29
Work Ph:		**Email:**	
Cell Ph:			

INJURY INFORMATION

Date:	05/14/2022	**Post Sx:**	
Type:	PI	**Sx Date:**	

REFERRING DOCTOR INFORMATION

Name:	EGAN, ETHAN	**Body Pts:**	
Address:	11525 BROOKSHIRE AVE STE 405		
City,St Zip::	DOWNEY,CA,90241		
Phone:	(424)220-4426	**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

01/03/2023

TAILIER BOONE, Patient

Date Signed