# Patient Information and Treatment Authorization

Document Date: 02/12/2020

WESTSTAR MONTCLAIR

## PATIENT INFORMATION #

| | | | |
|---|---|---|---|
| Name: | BEATRIZ ALVAREZ | SSN: | 999-99-9999 |
| Address: | 1640 S TOWNE AVE | Sex: | F |
| City,St Zip: | POMONA 91766 | DOB: | 12/03/1957 |
| Home Ph: | (909)202-3430 | Age: | 62 |
| Work Ph: | | E-mail: | |
| Cell Ph: | | | |

## INJURY INFORMATION

| | | | |
|---|---|---|---|
| Date: | 10/17/2019 | Post Sx: | |
| Type: | PI | Sx Date: | |

## REFERRING DOCTOR INFORMATION

| | | | |
|---|---|---|---|
| Name: | GHODADRA, NEIL | Body Pts: | |
| Address: | 903 CRENSHAW BLVD STE 200 | | |
| City, Zip: | LOS ANGELES 90019 | | |
| Phone: | (213)984-2889 | Dx: | |

## ATTORNEY INFORMATION

| | |
|---|---|
| Name: | |
| Address: | |
| City, Zip: | |
| Phone: | |

## EMPLOYMENT INFORMATION

| | |
|---|---|
| Name: | |
| Address: | |
| City, 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 upo

BEATRIZ ALVAREZ, Patient

02/12/2020

Date Signed