Patient Information and Treatment Authorization

Document Date: 01/03/2023

PATIENT INFORMATION # WESTSTAR CORNELIA GREEN

Name:	CORNELIA GREEN	**SSN:**	999-99-9999
Address:	174 CEDAR TURN	**Sex:**	
City,St Zip:	LONG BEACH,CA,90805	**DOB:**	03/18/1970
Home Ph	(562)204-7553	**Age:**	52
Work Ph:		**Email:**	
Cell Ph:			

INJURY INFORMATION

Date:	09/01/2022	**Post Sx:**	
Type:	PI	**Sx Date:**	

REFERRING DOCTOR INFORMATION

Name:	SHAH, GOOJAN	**Body Pts:**	
Address:	50 N LA CIENEGA STE 201		
City,St Zip::	BEVERLY HILLS,CA,90211		
Phone:		**Dx:**	

ATTORNEY INFORMATION

Name:	
Address:	
City,St Zip:	,,
Phone:	

EMPLOYMENT INFORMATION

Name:	
Address:	

City,St Zip:: ,,
Phone:

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Name:	**Name:**
Address:	**Address:**
Adj/Ph#:	**Adj/Ph#:**
Type:	**Type:**
Ins Name:	**Ins Name:**
Pol#/Clm#:	**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

CORNELIA GREEN, Patient

Date Signed