Patient Information and Treatment Authorization

Document Date: 01/06/2023

PATIENT INFORMATION # WESTSTAR EMIL HAKIM

Name:	EMIL HAKIM	**SSN:**	999-99-9999
Address:	2134 SALTBUSH CIRCLE	**Sex:**	M
City,St Zip:	CORONA,CA,92882	**DOB:**	08/04/1966
Home Ph	(310)808-5015	**Age:**	56
Work Ph:		**Email:**	
Cell Ph:			

INJURY INFORMATION

Date:	12/12/2022	**Post Sx:**	
Type:	PI	**Sx Date:**	

REFERRING DOCTOR INFORMATION

Name:	MILLER, LAWRENCE ROSS	**Body Pts:**	
Address:			
City,St Zip::	SANTA ANA,CA,		
Phone:	(714)953-6000	**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

EMIL HAKIM, Patient

01/06/2023

Date Signed