



Patient Information and Treatment Authorization

Document Date: 01/03/2023

PATIENT INFORMATION

WESTSTAR ASHLEY GALLEGOS

Name:	ASHLEY GALLEGOS	SSN:	999-99-9999
Address:	4950 BECK AVE	Sex:	F
City,St Zip:	BELL,CA,90201	DOB:	04/11/1998
Home Ph	(323)453-8921	Age:	24
Work Ph:		Email:	
Cell Ph:			

INJURY INFORMATION

Date:	09/06/2022	Post Sx:	
Type:	PI	Sx Date:	

REFERRING DOCTOR INFORMATION

Name:	EGAN, ETHAN	Body Pts:	
Address:	1200 ROSECRANS BLVD STE 110		
City,St Zip::	MANHATTAN BEACH,CA,90266		
Phone:	(424)220-4400	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#/Cln#:

SECONDARY INSURANCE INFORMATION

Name:

Address:

Adj/Ph#:

Type:

Ins Name:

Pol#/Cln#:

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

ASHLEY GALLEGOS, Patient

01/03/2023

Date Signed