



## Patient Information and Treatment Authorization

Document Date: 12/30/2022

### PATIENT INFORMATION #

WESTSTAR JIYOUNG CHANG

Name:	JIYOUNG CHANG	SSN:	999-99-9999
Address:	301 E HERMOSA DRIVE	Sex:	F
City,St Zip:	FULLERTON,CA,92835	DOB:	05/20/1979
Home Ph	(213)507-4648	Age:	43
Work Ph:		Email:	
Cell Ph:			

### INJURY INFORMATION

Date:	03/29/2022	Post Sx:	
Type:	PI	Sx Date:	

### REFERRING DOCTOR INFORMATION

Name:	YAGHOOBIAN, ARASH	Body Pts:	
Address:	2010 WILSHIRE BLVD STE 926		
City,St Zip::	LOS ANGELES,CA,90057		
Phone:	(213)989-6931	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

JIYOUNG CHANG, Patient

**12/30/2022**

Date Signed