# Paula M. Muto, M.D.

General and Vascular Surgery

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**Personal Information**

**Name:** _____

**Street Address:** _____

**City:** _____ **State:** _____ **Zip:** _____ **Home Phone:** _____

**Age:** _____ **Date of Birth:** _____

**Social Security Number:** _____

**Employer Name & Address:** _____

_____

**Work Phone:** _____

**Notify in Case of Emergency:** _____ **Phone:** _____

**Referring Physician:** _____

**Insurance Information:**

**Primary Carrier:** _____ **Number:** _____

**Secondary Carrier:** _____ **Number:** _____

Assignment of Benefits

I hereby authorize payment of medical benefits to Paula M. Muto, M.D. for all medical services rendered. I further understand that if payment is not received for services that I will be responsible for payment.

Date: _____ Signature: _____