

John A. Pfeiffer, M.D.
Family Practice - Celebration
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Enrollment Form

Last Name _____ First Name _____ MI _____

Nickname _____ Date of Birth ____/____/____ SSN _____

Street Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Fax _____

E-mail Address _____

Emergency contact name _____ Phone _____

Primary Insurance

Insurance Name _____

Insurance Street Address _____

City _____ State _____ Zip Code _____

Policy Number _____ Group Number _____

Policy Holders Name _____

Relationship _____ Date of Birth ____/____/____ SSN _____

Policy Holders Day Phone _____

Secondary Insurance

Insurance Name _____

Insurance Street Address _____

City _____ State _____ Zip Code _____

Policy Number _____ Group Number _____

Policy Holders Name _____

OVER

Relationship _____ Date of Birth ____/____/____ SSN _____

Policy Holders Day Phone _____

I hereby authorize payment directly to John A. Pfeiffer, M.D. For all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ **Date** ____/____/____