



Demetricia C. Patterson Foundation

Non-Profit Assistance Drug Program for Senior Citizens

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Questionnaire/Application

Applicant Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Social Security: _____ Date of Birth: _____ Age: _____

Telephone #: _____ Cell: _____

U.S. Citizen: (Circle one) Yes No

INSURER INFORMATION:

Insurance Provider: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Group Number: _____ Telephone #: _____

PHYSICIAN INFORMATION:

Attending Physician: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____

GOVERNMENT ASSISTANCE/TYPE OF ASSISTANCE:

EMPLOYMENT (IF ANY):

Employer: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____