ENROLLMENT FORM
PATIENT ASSISTANCE PROGRAM-VENTURA COUNTY MEDICAL CENTER

**** MUST BE ACCOMPANIED BY MEDICATION REQUEST FORM ****

1. NAME: _____

2. BIRTHDATE: _____

3. SOCIAL SECURITY OR GREEN CARD NUMBER: _____

4. CHART NUMBER: _____

5. SEX (CIRCLE): MALE OR FEMALE

6. MARITAL STATUS (CIRCLE): SINGLE MARRIED SEPARATED DIVORCED WIDOWED

7. ADDRESS: _____CITY: _____ZIP CODE: _____

8. TELEPHONE NUMBER: HOME: _____WORK: _____CELL:_____

9. NUMBER OF PEOPLE IN HOUSEHOLD (INCLUDING YOURSELF): _____

10. ARE YOU EMPLOYED OR UNEMPLOYED (CIRCLE)

11. WEIGHT (POUNDS) _____

12. MONTHLY INCOME OF HOUSEHOLD:

SALARY/WAGES	$_____
DISABILITY	$_____
SOCIAL SECURITY	$_____
PENSION	$_____
UNEMPLOYMENT	$_____
CHILD SUPPORT	$_____
OTHER (SPECIFY)	$_____
TOTAL	$_____

13. NAME OF PHYSICIAN: _____

14. NAME OF CLINIC: _____

15. MEDICATION ALLERGIES: _____

WE WILL APPLY FOR YOUR MEDICATIONS THROUGH THE PHARMACEUTICAL COMPANY'S PATIENT ASSISTANCE PROGRAM. IF APPROVED, THE APPLICATION PROCESS USUALLY REQUIRES 4 TO 6 WEEKS BEFORE YOU RECEIVE THE MEDICATION(S). YOU MAY BE CONTACTED IF FUTHER INFORMATION IS NEEDED. NOT ALL MEDICATIONS ARE PROVIDED THROUGH THESE PROGRAMS.

THE INFORMATION PROVIDED ABOVE IS TRUE, AND YOU ARE AUTHORIZING THE RELEASE OF THIS INFORMATION WHEN REQUESTED BY THE PHARMACEUTICAL COMPANY PROGRAM(S) AND AS NEEDED.

SIGNATURE: _____ DATE: _____