



Goffstown Fire Department

Patient Information Sheet



Patient's Legal Name : _____

Goes by _____

Date of Birth ____/____/____ Age ____ Sex ____

Primary Emergency Contact

Name _____ # _____ - _____ - _____ Relation _____

Secondary Emergency Contact

Name _____ # _____ - _____ - _____ Relation _____

Primary Care Doctor

Name _____ # _____ - _____ - _____

Medical History

Allergies

Things EMS should know about me

Location of advance directives or DNR if not attached

Transport Location

Emergent Hospital Preference (circle one) CMC Elliot

Specialty Hospital (that can accept emergency ambulances)

Insurance

