



GOODELL PHYSICAL THERAPY & FITNESS TRAINING
"Goodell for Good Health"

Patient Information

Last Name: _____ First Name: _____ M.I.: ____ Goes By: _____

Date of Birth: _____ Age: _____ Sex: _____ SS#: _____

Home Address: _____
City State Zip Code

Mailing Address: _____
City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ (email addresses used only by Goodell PT)

I would like to receive Goodell Physical Therapy's quarterly newsletter and updates by email: YES NO

Marital Status: Single Married Widowed Other Spouse/Partner Name _____

Work Status: Employed FT Student PT Student N/A

Employer: _____ Title/Position: _____

Have you received Physical Therapy Before?: _____ If yes, where: _____

How did you hear about us? _____

I would like to receive appointment confirmations by _____ email _____ text? (cell #)

Emergency Contact

Last Name: _____ First Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Do we have permission to discuss medical information with your emergency contact? Yes No

Workers Comp (WC) and Motor Vehicle Accident (MVA) Information

Insurance Company: _____ Phone: _____

Claims Address: _____

Claim Number: _____ Date of Injury/Accident: _____
City State Zip Code MVA WC

Caseworker/Adjustor Name: _____ Phone: _____

Attorney's Name (if applicable): _____ Phone: _____

Address: _____
City State Zip Code

Primary Insurance: see card attached (if you are not the policyholder please complete below)

Policyholder's Name: _____ Date of Birth: _____

Relationship: _____ Employer: _____