



# REGISTRATION

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

Welcome to Gilbert Medical Center. Please Print your Name and Date of Birth. Check the Doctor you are to see. If you are here only for Lab, Injection, Mammogram or Therapy, please check accordingly.

Print Patient's Legal Name \_\_\_\_\_

New Patient?  
 Yes  No

Date Of Birth    /    /

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

Name Of Insurance \_\_\_\_\_

<input type="checkbox"/> Dr. Paul Rothwell	<input type="checkbox"/> Dr. Brown
<input type="checkbox"/> Dr. Wade McCoy	<input type="checkbox"/> Dr. Spence
<input type="checkbox"/> Dr. Patzkowsky	<input type="checkbox"/> Dr. David Rothwell
<input type="checkbox"/> Dr. Fisher	<input type="checkbox"/> _____

- Auto Accident
- Work Comp
- Lab Only
- Injection Only
- Mammogram Only
- Therapy Only
- Blood Pressure Only
- X-ray
- Bone Density

After completing this form, **Pleased Be Seated. Thank You.**