DESERT SUN GASTROENTEROLOGY
DSG Patient Registration

Craig G. Gross, MD / Gary P. Gottlieb, MD / John K. Tsai, MD / Cristiana Bortuzzo, MD

7140 E Rosewood St.
Tucson, AZ 85710
Phone: 520.547.4900
Fax: 520.547.2435
www.dsgastro.com

Patient Information:

Legal Name: ____
Last First Middle Preferred Name (Nick Name)

Sex ☐Male ☐ Female ☐Trans Gender Date of Birth: ____/____/____ SS#: ______-____-_______

Home Address: ____
Street City/Town State Zip Code

Home Phone: (___) ___________________ Cell Phone: (___)_______________ Business Phone: (___)________________

Email Address: ____

Emergency Contact: ___________________________ Emergency Phone: __________________ Relationship: _____________

Please Circle:

Marital Status: Married / Single / Divorced / Widow

Ethnicity: Hispanic / Non Hispanic / Refused To Report

Race: White / Black or African American / American Indian/ Alaska Native / Asian / Native Hawaiian or Other Pacific Islander / Other Race / Refused To Report

Language: English / Indian (includes Hindi & Tamil) / Spanish / Russian

---

Appointment Notification Preference: Home Phone ☐ Cell Phone ☐ Text Message ☐ Work ☐
Select one:

How did you hear about us? ____

Employment Status:

Are You (please circle): Full-time / Part-time / Self Employed / Disabled / Currently Unemployed / Student / Retired

Employer: __________________________ Phone:_______________________ Occupation: ________________________________

Address: ____
Street City/Town State Zip Code

Continued on next page:

DESERT SUN GASTROENTEROLOGY

DSG Patient Registration

Craig G. Gross, MD / Gary P. Gottlieb, MD / John K. Tsai, MD / Cristiana Bortuzzo, MD

7140 E Rosewood St.
Tucson, AZ 85710
Phone: 520.547.4900
Fax: 520.547.2435
www.dsgastro.com

Pharmacy Information:

Primary Care Physician: ________________ Referring Physician: ____________________ Phone: ______________________

Pharmacy Name : ____________________ Location: ____________________________ Pharmacy Phone: _______________

Insurance Information:

1.) Primary Insurance Name: ____

Policy Holder's Name: __________________________ Date of Birth: _____________________________________

Relationship: Self Spouse Dependant Employers Name: ____

2.) Secondary Insurance Name: ____

Policy Holder's Name: ____ Date of Birth: _____________________

Relationship: Self Spouse Dependant Employers Name: ____

Are you currently on AHCCCS? Yes / No Have you recently applied for AHCCCS? Yes / No

If **YES** When & Where (Date: ___ / ___ / ___) (Where: __________)

1. I understand, by signing, the information above is complete and accurate and I DO NOT have any other insurance coverage and I am required by law to notify this office of any other Primary Insurance coverage.
2. I understand I am responsible for charges not covered by the above agents. I agree, in the event of non-payment, to assume the cost of interest collection and legal action (if required).
3. I authorize my insurance carrier to release information regarding my coverage to Desert Sun Gastroenterology.
4. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to Desert Sun Gastroenterology.

Signature: ____ **Date:** ___________________________