AKLILU & COBIAN INFECTIOUS DISEASES, LLC
PATIENT DEMOGRAPHICS

GENERAL INFORMATION:

Patient Name: _____ *Date:* _____

Date of Birth: _____ *Age:* _____

Social Security #: _____ *Sex:* □ Male □ Female

Address: _____

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

Preferred Method of Contact: □ Home □ Cell □ Work

Email Address: (Needed for patient portal access) _____ □ None

Patient Portal Access: www.AkliluandCobian.com

Race: □ White □ Black □ Hispanic or Latin □ Asian
□ American Indian □ Pacific Islander □ Alaskan Native

Pharmacy Name: _____ *Primary Physician:* _____

Pharmacy Phone: _____ *Physician's Phone:* _____

Pharmacy Fax: _____ *Referring Physician:* _____

EMERGENCY CONTACT:

*Name:*_____ *Phone:* _____

Relationship: _____

INSURANCE GUARANTOR:

Name: _____ *Phone:* _____

Date of Birth: _____ *Relationship:* _____