# *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:* _____