# Work Kare Patient Identification Information

**Please Print:**

Date: _____ Social Security Number: _____--_____--_____

Male: _____ Female: _____ Age: _____

Name: _____ Date of Birth: _____

Address: _____ Marital Status: ___ Single ___Married

___ Divorced ___ Widowed

City: _____ State: _____ Zip: _____

Preferred language for medical communication: _____

Driver's License Number: _____ State: _____

Race: ___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ Native Hawaiian or Other Pacific Islander
___ Other Race
___ Unknown
___ White

Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino

Employer: _____ Department: _____

Home Phone: _____ Work Phone: _____

Reason for Visit: (Please check one)

____ Pre-Placement ____ TB Skin Test ____ Hepatitis ____ Drug Screen

**If work injury, please complete below:**

Date of Injury/Illness: _____

Description of Incident:

_____

_____

_____

Chief Complaint: _____

WILLIS-KNIGHTON WORK KARE
OCCUPATIONAL PROVIDER NETWORK