US Hospital Encounter Form

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Patient Information

Patient Name: Jane Q. Sample

Date of Birth (MM/DD/YYYY): 02/14/1985

Medical Record Number (MRN): A1234567

Gender (Radio): ( ) Male (•) Female ( ) Other

Address: 123 Maple Street

City: Springfield State: IL ZIP: 62701

Phone: \(217\ Email: jane.sample@example.com

Insurance Information

Insurance Provider: Acme Health Policy #: POL-998877

Group #: GRP-445566

Encounter Details

Encounter Date (MM/DD/YYYY): 08/18/2025 Attending Physician: Dr. Samuel Carter, MD

Reason for Visit: Headache and dizziness

Encounter Type (Radio): ( ) Inpatient (•) Outpatient ( ) Emergency Dept

Triage / Vitals

Height (cm): 168 Weight (kg): 65 Temp (°C): 37.2

BP Systolic: 118 BP Diastolic: 76 Heart Rate: 78

Clinical

[✔] Allergies Present [✔] On Current Medications [✔] Smoker

Allergies (Details): Penicillin \(rash\

Current Medications: Loratadine 10mg daily

Past Medical History: Seasonal allergies

Surgical History: Appendectomy \(2010\

Primary Diagnosis: Tension headache

Consent & Signatures

[ ] HIPAA Acknowledgement [✔] Financial Consent [✔] Treatment Consent

Patient/Guardian Signature: Yes Date: 08/18/2025

This PDF contains interactive AcroForm fields (text, checkboxes, and radio buttons).