US Healthcare Encounter Form

Patient Name

Date of Birth (MM/DD/YYYY)

Address

City

State

ZIP

Phone

Email

MRN

Encounter Date (MM/DD/YYYY)

Provider Name

Facility Name

Reason for Visit

Blood Pressure

Heart Rate

Temperature (°F)

Insurance Provider

Policy Number

Copay Amount ($)

Diagnosis

Procedures

Medications

Follow-Up Date (MM/DD/YYYY)

Allergies: NKDA Penicillin Latex Nuts

Smoking Status: Never Former Current

Notes

Patient Signature