

# US Hospital Encounter Form

Generated: AcroForm PDF

## Patient Information

Patient Name				
Date of Birth (MM/DD/YYYY)				
Medical Record Number (MRN)				
Gender (Radio)	Male	Female	Other	
Address				
City		State		ZIP
Phone		Email		

## Insurance Information

Insurance Provider		Policy #	
Group #			

## Encounter Details

Encounter Date (MM/DD/YYYY)		Attending Physician	
Reason for Visit			
Encounter Type (Radio)	Inpatient	Outpatient	Emergency Dept

## Triage / Vitals

Height (cm)		Weight (kg)		Temp (°C)	
BP Systolic		BP Diastolic		Heart Rate	

## Clinical

Allergies Present	On Current Medications	Smoker
Allergies (Details)		
Current Medications		
Past Medical History		
Surgical History		
Primary Diagnosis		

## Consent & Signatures

HIPAA Acknowledgement	Financial Consent	Treatment Consent
Patient/Guardian Signature		Date