

US Hospital Encounter Form

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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