

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	
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