Encounter Form

Patient information		**Payment information**	
Patient name:	Age:	Primary ID #:	Primary group #:
Gender:	Phone number:	Secondary ID #:	Secondary group #:
Address:		Payment method:	
Provider information		**Insurance information**	
Name of provider:		Insurance carrier:	Insurance plan:
Address:		Policy number:	Group number:
Phone number:	Email:	Social security #:	Copay:
Visit information			
Type of visit: ◯ Initial ◯ Follow up ◯ Emergency ◯ Other:		Date of visit:	Time of visit:
History of present illness			
Location of problem:		Nature of problem:	
Severity: ◯ Mild ◯ Moderate ◯ Severe ◯ Other:		Duration:	Timing:
Modifying factors:		Associated symptoms:	

Past medical history	
Medical conditions:	Surgeries:
Allergies:	Medications:

List of services provided

Service	Description	Provider	Remark

Diagnoses	
ICD code	**Diagnosis/description**

Procedures						
CPT code	**Description**	**Modifier**	**Units**	**Fee**	**Amount paid**	**Amount due**

Total charges: _____ **Total paid:** _____ **Total due:** _____