Encounter Form

Patient Information:

Name: _____ Date of Birth: _____

Date of Visit: _____ Patient ID: _____

Contact Number: _____

Medical Departments:

- ☐ **General Medicine**
- ☐ Initial Consultation
- ☐ Follow-Up: _____
- ☐ Emergency Visit
- ☐ Regular Checkup
- ☐ Immunization
- ☐ Surgery Consultation
- ☐ **Dental**
- ☐ Oral Exam/Cleaning
- ☐ Dental X-Ray
- ☐ Cavity Filling
- ☐ Orthodontia
- ☐ Surgery: _____
- ☐ **Behavioral Health**
- ☐ Initial Psychological Evaluation
- ☐ Therapy Session
- ☐ Medication Consultation
- ☐ Crisis Intervention
- ☐ **Vision**
- ☐ Initial Eye Exam
- ☐ Glasses Prescription
- ☐ Contact Lens Fitting
- ☐ Follow-Up: _____

☐ **Hearing**

☐ Hearing Test

☐ Hearing Aid Fitting

☐ Follow-Up: _____

Diagnosis/Conditions (Include medical, mental health, developmental, learning, etc.):

Procedures Conducted & Results:

Immunizations Administered:

Known Allergies:

Prescription(s) Issued:

Follow-up or Referral Required:

☐ Yes (Provide details below)

☐ No

Additional Notes (Medical or Social):

Provider Details:

Signature: _____

Printed Name: _____

Facility: _____

Contact Number: _____

ADMINISTRATIVE USE ONLY:

Date Processed: _____

Processed By: _____

Note: Retain a copy of this Encounter Form in the Medical Section of the patient's record.