Encounter Form

PATIENT INFORMATION

See below:

[ClientInfo]

PAYMENT INFORMATION

Primary ID number: _____ Primary group number: _____

Secondary ID number: _____ Secondary group number: _____

Payment method: _____

PROVIDER INFORMATION

Name of provider: _____ Address: _____

Phone number: _____ Email: _____

INSURANCE INFORMATION

Insurance carrier: _____ Insurance plan: _____

Policy number: _____ Group number: _____

Social security number: _____ Copay: _____

VISIT INFORMATION

Date of visit: _____ dd / mm / yyyy Time of visit: _____

Type of visit:

◯ Initial ◯ Follow up ◯ Emergency ◯ Other

HISTORY OF PRESENT ILLNESS

Location of problem: _____ Nature of problem: _____

Severity:

◯ Mild ◯ Moderate ◯ Severe

Duration: _____ Timing: _____

Modifying factors:

Associated symptoms:

PAST MEDICAL HISTORY

Medical conditions:

Surgeries:

Allergies:

Medications:

LIST OF SERVICES PROVIDED

1. Service:

Description:

Provider:

Remark:

2. Service:

Description:

Provider:

Remark:

3. Service:

Description:

Provider:

Remark:

4. Service:

Description:

Provider:

Remark:

5. Service:

Description:

Provider:

Remark:

DIAGNOSES

1. ICD code: _____ Diagnosis/description: _____

2. ICD code: _____ Diagnosis/description: _____

3. ICD code: _____ Diagnosis/description: _____

4. ICD code: _____ Diagnosis/description: _____

PROCEDURES

1. CPT code: _____

Description:

Modifier: _____ Units: _____

Fee: _____ Amount paid: _____

Amount due: _____ 2. CPT code: _____

Description:

Modifier: _____ Units: _____

Fee: _____ Amount paid: _____

Amount due: _____ 3. CPT code: _____

Description:

Modifier: _____ Units: _____

Fee: _____ Amount paid: _____

Amount due: _____ 4. CPT code: _____

Description:

Modifier: _____ Units: _____

Fee: _____ Amount paid: _____

Amount due: _____ Total charges: _____

Total paid: _____ Total due: _____