

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.