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Section	Description
Patient Demographics Section	This records the patient whose health information is described by the clinical document.
Encounters Section	This section lists and describes any healthcare encounters pertinent to the patient's current health status or historical health history. It may include visits, appointments, as well as non face-to-face interactions. This section may contain all encounters for the time period being summarized, but should include notable encounters.
Problem Section	This section lists and describes all relevant clinical problems at the timeat tho8oblemt T01.3Td[(t)4(o the patient hist)42
Payer Section	The Payers section contains data on the patient's payers, whether a 'third party' insurance, self-pay, other payer or guarantor, or some combination of payers, and is used to define which entity is the responsible fiduciary for the financial aspects of a patient's care. Each unique instance of a payer & all the pertinent data needed to contact, bill to, and collect from that payer should be included. Authorization information can be used to define pertinent referral, authorization tracking number, procedure, therapy, intervention, device, or similar authorizations for the patient or provider, or both should be included. At a minimum, the patient's pertinent current payment sources should be listed. The sources of payment are represented as a Coverage Activity, which identifies all of the insurance policies or government or other programs that cover some or all of the patient's healthcare expenses. The policies or programs are sequenced by preference.

Reg ent

Section	Description
Social History Observation Section	This section contains data defining the patient's occupational, personal (e.g. lifestyle), social, and environmental history and health risk factors, as well as administrative data such as marital status, race, ethnicity and religious a liation. Social history can have significant influence on a patient's physical, psychological and emotional health and wellbeing so should be considered in the development of a complete record.
Allergies Section	This section lists and describes any medication allergies, adverse reactions, idiosyncratic reactions, anaphylaxis/anaphylactoid reactions to food items, and metabolic variations or adverse reactions/allergies to other substances (such as latex, iodine, tape adhesives) used to assure the safety of health care delivery. At a minimum, it should list currently active and any relevant historical allergies and adverse reactions.
Advance Directive Section	This section contains data defining the patient's advance directives and any reference to supporting