PhilHealth Konsulta Registration Form (PKRF)

BURAUEN NATURALLY COOL

Instructions
1. All information should be written in UPPER CASE/ CAPITAL LETTER.
3. If the beneficiary is dependent use the dependent PIN.
4. If the beneficiary is below 21 years old ,the signatory should be parent/guardian.

PhilHealth Your Partner in Health

TO BE FILLED- OUT BY THE BENEFICIARY

☐ MEMBER ☑ DEPENDENT

PIN: 130000745988 DATE: 01/28/2026

FULL NAME: TANGPUZ (LAST NAME) RHEANNA (FIRST NAME) PADOC (MIDDLE NAME)

ADDRESS: MAABAB (BARANGAY/ TOWN) Burauen (MUNICIPALITY/CITY) LEYTE (PROVINCE)

DATE OF BIRTH (MM/DD/YYYY): 08-15-2011 CONTACT NO:

☐ REGISTER TO A KONSULTA PACKAGE PROVIDER (KPP)
☐ REGISTER ALL MY DECLARED MINOR DEPENDENTS
(please use additional form if necessary)

FULL NAME : TANGPUZ (LAST NAME) RHEANNA (FIRST NAME) PADOC (MIDDLE NAME)

1ST CHOICE KPP: MUNICIPAL HEALTH OFFICE BURAUEN LEYTE

ADDRESS: LGU COMPOUND, DISTRICT 7, BURAUEN LEYTE (BARANGAY/ TOWN) (MUNICIPALITY/CITY) (PROVINCE)

2ND CHOICE KPP: _____

ADDRESS: _____ (BARANGAY/ TOWN) (MUNICIPALITY/CITY) (PROVINCE)

☐ TRANSFER

PREVIOUS KPP: _____

1ST CHOICE KPP: MUNICIPAL HEALTH OFFICE BURAUEN LEYTE

ADDRESS: LGU COMPOUND, DISTRICT 7, BURAUEN LEYTE (BARANGAY/ TOWN) (MUNICIPALITY/CITY) (PROVINCE)

2ND CHOICE KPP: _____

ADDRESS: _____ (BARANGAY/ TOWN) (MUNICIPALITY/CITY) (PROVINCE)

I hereby certify that I did not avail of FPE in other KPP.Moreover ,I grant free and voluntary consent to the collection,Transmission and processing of my personal data and health records to Philhealth for the purpose of paying and Monitoring the provider for the Konsulta benefit in accordance with the Republic Act No. 10173, otherwise Known as the "Data Privacy Act of 2012".

RHEANNA P TANGPUZ
(Signature over Printed Name)

TO BE FILLED- OUT BY PHILHEALTH KONSULTA PERSONNEL

PHILHEALTH KONSULTA REGISTRATION CONFIRMATION SLIP

REGISTRATION NO: _____ DATE REGISTERED: _____

FULL NAME (LAST NAME, FIRST NAME, MIDDLE NAME): _____

PIN: _____ DATE OF BIRTH: _____

KPP: MUNICIPAL HEALTH OFFICE BURAUEN LEYTE

ADDRESS: LGU COMPOUND, DISTRICT 7, BURAUEN LEYTE

_____
(Signature over Printed Nameof Authorized Personnel)

PHOTO CONSENT FORM

BURAUEN, LEYTE OFFICIAL SEAL

I, RHEANNA P TANGPUZ with address MAABAB, Burauen, LEYTE grant permission and give my consent to **MUNICIPAL HEALTH OFFICE BURAUEN LEYTE** for the use of my photo or picture as one of the requirements in the availment of Konsulta Benefit/Yakap.

By Signing below, I hereby authorize my Konsulta Facility to save my photo for post-audit monitoring purposes of PhilHealth.

RHEANNA P TANGPUZ		01/28/2026
Name of Konsulta Beneficiary	**Signature**	**Date**

HEALTH SCREENING FORM/ FIRST PATIENT ENCOUNTER

INDIVIDUAL HEALTH PROFILE

*Health Screening Date (mm/dd/yyyy) 01/28/2026

Barangay: MAABAB

PHILHEALTH IDENTIFICATION NUMBER:

MEMBER PIN: 130000745988

DEPENDENT PIN 132503925749

I. Client Details:

Last Name: TANGPUZ First Name RHEANNA Middle Name PADOC

Extension Name: _____ Age: 14 Date of Birth (mm/dd/yyyy) 08-15-2011

Sex/ Gender: Female Client Type _____

II. REVIEW OF SYSTEMS

1. Chief complaint (please describe) _____

2. Do you experience any of the following: fever, cough, colds, or headache?
o Yes or o No If yes, please explain: _____

3. Do you experience any of the following: unexplained change in weight, loss of appetite, Change in bowel movement, or abdominal
o Yes or o No If yes, please explain: _____

4. Do you experience any of the following: chest pain or difficulty in breathing?
o Yes or o No If yes, please explain: _____

5. Do you experience any of the following frequent urination, frequent eating, and frequent intake of fluids?
o Yes or o No If yes, please explain: _____

6. For male and female, do you experience any of the following: pain or discomfort on urine or frequency in urination?
o Yes or o No If yes, please explain: _____

7. For FEMALE ONLY, a. Number of Pregnancy: _____
b. Last menstrual period (mm/dd/yyyy) _____
c. First menstrual period (mm/dd/yyyy) _____

8. Do you experience any of the following, muscle spasm, tremors, weakness; muscle/joint pain, stiffness, limitation of movement?
o Yes or o No If yes, please explain: _____

IV. PAST MEDICAL HISTORY

o Cancer	o Heart Disease	o Tubercolosis	o Allergies	o Others
o Diabetes	o Hypertension	o COPD/emphysema /bronchitis		please Specify_____
o Stroke	o Brochial asthma	o None		

V.PERTINENT PHYSICAL EXAMINATION FINDINGS

Blood Pressure _____ / _____mHg Height: _____ (cm) _____ (h)

Heart Rate: _____/ min Weight: _____ (kg) _____ (lb.)

Respiratory Rate: _____/ min BMI: _____

Visual Rate; (R) _____/ (L) _____ Temperature: _____

Pediatric Client aged 0-24 months

Length: _____ (cm) Head Circumference: _____ (cm)

Body Circumference Waist _____ (cm) Hip _____ (cm) Limbs _____(cm)

Middle and Upper Arm_____ (cm) Skinfold Thickness _____ (cm)

Blood Type (as available)

o A+ o AB+ o O+ o-A o B- o O-

General Survey o Awake and alert o Altered Sensorium

~~~~~~If the answer is **YES to Question 1-8**, the **beneficiary needs to consult a doctor.**~~~~~~~

III. PERSONAL/ SOCIAL HISTORY

1. Do you smoke cigar, cigarette, e-cigarette, vape, or other similar products? o Yes o No Number of years: _____

2. Do you drink alcohol or alcohol-containing beverages? o Yes o No Number of years: _____
~~~~~~