

PhilHealth Konsulta Registration Form (PKRF)	
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.
TO BE FILLED- OUT BY THE BENEFICIARY	
<input type="checkbox"/> MEMBER <input type="checkbox"/> DEPENDENT	
PIN: _____ DATE: _____	
FULL NAME: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> LAST NAME FIRST NAME MIDDLE NAME </div>	
ADDRESS: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> BARANGAY/ TOWN MUNICIPALITY/CITY PROVINCE </div>	
DATE OF BIRTH (MM/DD/YYYY): _____ CONTACT NO: _____	
<input type="checkbox"/> REGISTER TO A KONSULTA PACKAGE PROVIDER (KPP) (please use additional form if necessary) <input type="checkbox"/> REGISTER ALL MY DECLARED MINOR DEPENDENTS	
FULL NAME: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> LAST NAME FIRST NAME MIDDLE NAME </div>	
1ST CHOICE KPP: <u>MUNICIPAL HEALTH OFFICE BURAUEEN LEYTE</u>	
ADDRESS: <u>LGU COMPOUND, DISTRICT 7, BURAUEEN LEYTE</u> <div style="display: flex; justify-content: space-between; font-size: small;"> BARANGAY/ TOWN MUNICIPALITY/CITY PROVINCE </div>	
2ND CHOICE KPP: _____ ADDRESS: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> BARANGAY/ TOWN MUNICIPALITY/CITY PROVINCE </div>	
<input type="checkbox"/> TRANSFER	
PREVIOUS KPP: _____ 1ST CHOICE KPP: <u>MUNICIPAL HEALTH OFFICE BURAUEEN LEYTE</u> ADDRESS: <u>LGU COMPOUND, DISTRICT 7, BURAUEEN LEYTE</u> <div style="display: flex; justify-content: space-between; font-size: small;"> BARANGAY/ TOWN MUNICIPALITY/CITY PROVINCE </div>	
2ND CHOICE KPP: _____ ADDRESS: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> BARANGAY/ TOWN MUNICIPALITY/CITY PROVINCE </div>	
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". _____ (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: <u>MUNICIPAL HEALTH OFFICE BURAUEEN LEYTE</u> ADDRESS: <u>LGU COMPOUND, DISTRICT 7, BURAUEEN LEYTE</u> _____ (Signature over Printed Name of Authorized Personnel)	

<h2 style="margin: 0;">PHOTO CONSENT FORM</h2>		
I, _____ with address _____ grant permission and give my consent to MUNICIPAL HEALTH OFFICE BURAUEEN LEYTE for the use of my photo or picture as one of the requirements in the avilment of <u>Konsulta Benefit</u> /Yakap. By Signing below, I hereby authorize my Konsulta Facility to save my photo for post-audit monitoring purposes of PhilHealth.		
_____ Name of Konsulta Beneficiary	_____ Signature	_____ Date

HEALTH SCREENING FORM/ FIRST PATIENT ENCOUNTER	INDIVIDUAL HEALTH PROFILE														
*Health Screening Date (mm/dd/yyyy) _____ Barangay: _____	PHILHEALTH IDENTIFICATION NUMBER: MEMBER PIN: _____ DEPENDENT PIN: _____														
I. Client Details: Last Name: _____ First Name: _____ Middle Name: _____ Extension Name: _____ Age: _____ Date of Birth (mm/dd/yyyy) _____ Sex/ Gender: _____ Client Type: _____															
II. REVIEW OF SYSTEMS 1. Chief complaint (please describe) _____ 2. Do you experience any of the following: fever, cough, colds, or headache? <input type="checkbox"/> Yes or <input type="checkbox"/> 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 <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, please explain: _____ 4. Do you experience any of the following: chest pain or difficulty in breathing? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, please explain: _____ 5. Do you experience any of the following frequent urination, frequent eating, and frequent intake of fluids? <input type="checkbox"/> Yes or <input type="checkbox"/> 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? <input type="checkbox"/> Yes or <input type="checkbox"/> 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? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, please explain: _____	IV. PAST MEDICAL HISTORY <table border="1" style="width: 100%; border-collapse: collapse; font-size: small;"> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Heart Disease</td> <td><input type="checkbox"/> Tuberculosis</td> <td><input type="checkbox"/> Allergies</td> <td><input type="checkbox"/> Others</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Hypertension</td> <td colspan="2"><input type="checkbox"/> COPD/emphysema /bronchitis</td> <td rowspan="2">please Specify _____</td> </tr> <tr> <td><input type="checkbox"/> Stroke</td> <td><input type="checkbox"/> Brochial asthma</td> <td><input type="checkbox"/> None</td> <td></td> </tr> </table> V. PERTINENT PHYSICAL EXAMINATION FINDINGS Blood Pressure _____ / _____ mmHg Height: _____ (cm) _____ (h) Heart Rate: _____ / min Weight: _____ (kg) _____ (lb.) Respiratory Rate: _____ / min BMI: _____ Visual Rate; (R) _____ / (L) _____ Temperature: _____ <div style="text-align: center; background-color: #e0ffe0; padding: 5px; font-weight: bold;">Pediatric Client aged 0-24 months</div> 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) <input type="checkbox"/> A+ <input type="checkbox"/> AB+ <input type="checkbox"/> O+ <input type="checkbox"/> A- <input type="checkbox"/> B- <input type="checkbox"/> O- General Survey <input type="checkbox"/> Awake and alert <input type="checkbox"/> Altered Sensorium	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Allergies	<input type="checkbox"/> Others	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> COPD/emphysema /bronchitis		please Specify _____	<input type="checkbox"/> Stroke	<input type="checkbox"/> Brochial asthma	<input type="checkbox"/> None	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Allergies	<input type="checkbox"/> Others											
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> COPD/emphysema /bronchitis		please Specify _____											
<input type="checkbox"/> Stroke	<input type="checkbox"/> Brochial asthma	<input type="checkbox"/> None													
~~~~~If the answer is YES to Question 1-8, the beneficiary needs to consult a doctor.~~~~~															
<b>III. PERSONAL/ SOCIAL HISTORY</b> 1. Do you smoke cigar, cigarette, e-cigarette, vape, or other similar products? <input type="checkbox"/> Yes <input type="checkbox"/> No    Number of years: _____ 2. Do you drink alcohol or alcohol-containing beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No    Number of years: _____															