PhilHealth Konsulta Registration Form (PKRF)

BURAUEN NATURALLY C∞L

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 to Health

TO BE FILLED- OUT BY THE BENEFICIARY

☐ MEMBER   ☐ DEPENDENT

PIN: _____   DATE: _____

FULL NAME: _____

LAST NAME   FIRST NAME   MIDDLE NAME

ADDRESS: _____

BARANGAY/ TOWN   MUNICIPALITY/CITY   PROVINCE

DATE OF BIRTH (MM/DD/YYYY): _____   CONTACT NO: _____

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

FULL NAME : _____

LAST NAME   FIRST NAME   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".

_____
(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 Name of Authorized Personnel)

PHOTO CONSENT FORM

I, _____ with address _____ 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.

_____   _____   _____
Name of Konsulta Beneficiary   **Signature**   **Date**

HEALTH SCREENING FORM/ FIRST PATIENT ENCOUNTER | INDIVIDUAL HEALTH PROFILE

*Health Screening Date (mm/dd/yyyy) _____

Barangay: _____

I. Client Details:

PHILHEALTH IDENTIFICATION NUMBER:

MEMBER PIN: _____

DEPENDENT PIN _____

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?

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 Tuberculosis	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: _____