

BURAUE		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.		
		PhilHealth	
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: _____			
LAST NAME		FIRST NAME	MIDDLE NAME
ADDRESS: _____			
BARANGAY/ TOWN		MUNICIPALITY/CITY	PROVINCE
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: _____			
LAST NAME		FIRST NAME	MIDDLE NAME
1ST CHOICE KPP: MUNICIPAL HEALTH OFFICE BURAUE LEYTE			
ADDRESS: LGU COMPOUND, DISTRICT 7, BURAUE LEYTE			
BARANGAY/ TOWN		MUNICIPALITY/CITY	PROVINCE
2ND CHOICE KPP: _____			
ADDRESS: _____			
BARANGAY/ TOWN		MUNICIPALITY/CITY	PROVINCE
<input type="checkbox"/> TRANSFER			
PREVIOUS KPP: _____			
1ST CHOICE KPP: MUNICIPAL HEALTH OFFICE BURAUE LEYTE			
ADDRESS: LGU COMPOUND, DISTRICT 7, BURAUE 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 BURAUE LEYTE			
ADDRESS: LGU COMPOUND, DISTRICT 7, BURAUE LEYTE			
(Signature over Printed Name of Authorized Personnel)			

PHOTO CONSENT FORM		
I, _____ with address _____ grant permission and give my consent to <b>MUNICIPAL HEALTH OFFICE BURAUE LEYTE</b> 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	IV. PAST MEDICAL HISTORY
1. Chief complaint ( please describe) _____	<input type="checkbox"/> Cancer <input type="checkbox"/> Heart Disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Allergies <input type="checkbox"/> Others _____
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: _____	<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> COPD/emphysema /bronchitis <input type="checkbox"/> please Specify _____
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: _____	<input type="checkbox"/> Stroke <input type="checkbox"/> Brochial asthma <input type="checkbox"/> None _____
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: _____	V. PERTINENT PHYSICAL EXAMINATION FINDINGS
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: _____	Blood Pressure _____ / _____ mmHg Height: _____ (cm) _____ (h)
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: _____	Heart Rate: _____ / min Weight: _____ (kg) _____ (lb.)
7. For FEMALE ONLY, a. Number of Pregnancy: _____ b. Last menstrual period (mm/dd/yyyy) _____ c. First menstrual period (mm/dd/yyyy) _____	Respiratory Rate: _____ / min BMI: _____
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: _____	Visual Rate; (R) _____ / (L) _____ Temperature: _____
Pediatric Client aged 0-24 months	
Length: _____ (cm) Head Circumference: _____ (cm)	
Body Circumference Waist _____ (cm) Hip _____ (cm) Li mbs _____ (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 Sernsorium	
~~~~~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? <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: _____	