

Note: This section must be completed by a qualified and registered physician. Costs, if any, shall be shouldered by the Claimant.

1. PATIENT'S INFORMATION

- a. Name : _____
Last Name First Name Middle Name
- b. Address : _____
- c. Date of Birth : _____ Place of Birth : _____ Age: _____ Status: _____

2. CONSULTATION FOR CURRENT ILLNESS OR INJURY/IES

- a. Date of first consultation _____
Patient's complaint(s) _____
- b. Symptoms experienced _____ Date symptoms first experienced _____
- c. Name and Address of Hospital

- d. Date of Diagnosis _____ Date patient was informed of the diagnosis _____
- e. Please provide brief history of patient's illness

- f. If Surgical Procedure was performed, please narrate in detail the procedure and provide a copy of the Operation Room Record and Pathology Report .

- g. If the condition was a result of an accident, please provide the following information:
Date of accident _____
Please describe the injuries sustained by the patient. _____
- h. Final Diagnosis/ses _____
- i. Prognosis _____

3. PATIENT'S CONDITION

- a. Please describe fully the nature and severity of the patient's current condition.

b. Please describe the past and current treatment/s provided, including any operations performed and whether these are likely to improve patient's condition.

c. Is the patient compliant with the recommended treatment program? _____

If No, please elaborate _____

d. What, if any, are other or further treatments recommended to be performed in the future?

e. How often must the patient be on follow-up consultation/treatments for his/her condition? _____

4. MEDICAL HISTORY

a. Did the patient previously suffer from any related illness(es) that caused the present condition? _____ If Yes, please provide details:

b. Does the patient have family history for this condition? _____ If Yes, please provide information, such as relationship to insured, nature of illness, date of diagnosis/ses and source of information

c. Did the patient consult other doctors for this illness or its symptoms before he/she consulted you? If Yes, please provide the following information:

Date of Attendance	Name of Physician	Medical Institution and Address	Diagnosis/Treatment/ Procedure

d. Is the patient suffering or has suffered from any other significant illnesses? _____ If Yes, please provide details.

e. Please give any other information, which you feel would be helpful in the assessment of the patient's claim.

NOTE: Please enclose copies of specialist or hospital reports together with any test results or similar evidence to support the validity of the patient's claim.

I hereby certify that the above statements are true, correct and complete to the best of my knowledge and according to records in my possession, if any.

Executed at _____ this _____ day of _____ 20_____.

Signature Over Printed Name
of Physician

Specialty

Address

Contact Number (s)

PRC Number

PTR Number