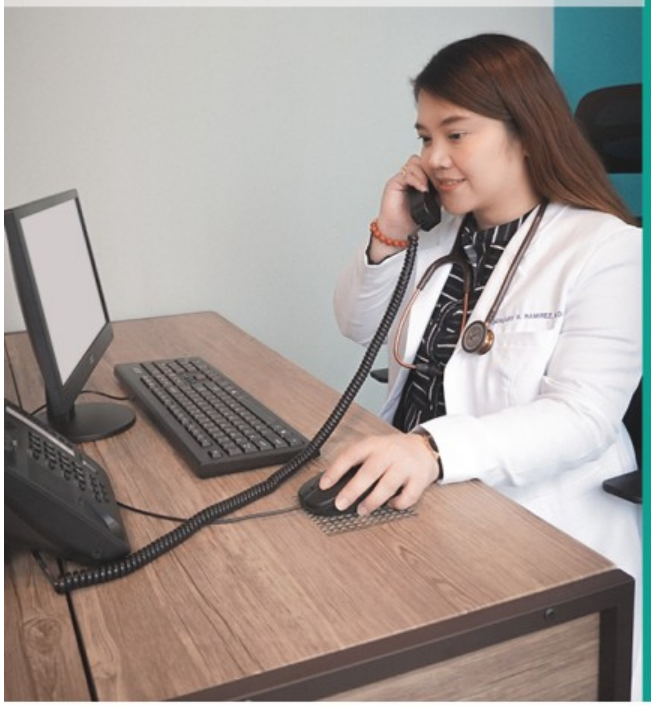
iDoc
Telehealth System

Holistic Inclusive Telehealth System



iDoc Telehealth System is a holistic 10/7 telehealth service that gives you access to health professionals where ever you are.

More than just answering your medical queries, iDoc is here to make sure that your health is on track through its personalized wellness programs.

MEMBERSHIP BENEFITS

I. Unlimited medical consultation with our licensed doctors via phone,SMS,email and instant messenging applications

II. Online Health Records

III. Personalized Care and Health Analytics

- Check your health status through Health Risk Assessment and Health Appraisal
- Get health and wellness advice and disease management plans
- Get the latest health news, trends and updates

IV. Electronic Medicine Prescription

V. Electronic Laboratory Referrals

VII. Access to our strategic partners:

GENERAL TERMS OF SERVICE:

I. COVERAGE: The iDoc telehealth system covers non-urgent and non-emergency cases only.

II. ELIGIBILITY: The membership shall cover individuals with age 18 years old and above.

III. REGISTRATION: Registration can be done through the iDoc Hotline (09175771288/5771858) or any of the iDoc healthcare representatives

IV. ACCESS: Telehealth System is accessible daily from 9:00 AM to 7:00 PM

V. PAYMENT TERMS: Payment can be made via banking services. Present accredited bank is Bank of the Philippine Island (BPI). Payment process will be provided upon registration.

VI. VALIDITY: One (1) year upon confirmation of membership.

TO VIEW FULL CONTENT OF TERMS AND CONDIITIONS PLEASE VISIT OUR WEBSITE AT WWW.HUGSPH.COM OR REQUEST FOR A COPY FROM OUR IDOC COORDINATORS.

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THE TERMS AND CONDITIONS AND THAT ALL INFORMATION PROVIDED ON THE THIS FORM IS AUTHENTIC AS REQUISITE TO MY MEMBERSHIP FOR THE DOKTOR B TELEHEALTH SERVICE.

Signature over printed name

Date / /

powered by: HUGS Healthcare United Global Solutions

watsons HI-PRECISION diagnostics ASIAN EYE INSTITUTE

For inquiry, please contact us at iDoc hotline: (0917) 577 1288 or (02) 5771858 and/or
email us at racarmona@hugsph.com.

Office address:
Suite 1405 Jollibee Plaza, F. Ortigas Avenue,
Ortigas CBD, Pasig City Philippines

APPLICATION FORM

PERSONAL INFORMATION

Name: _____

Nickname: _____

Address: _____

_____

_____

Birthdate: _____

Age: _____ **Gender:** _____

Civil Status: _____

Mobile Number: _____

Landline: _____

Alternative Mobile Number: _____

Email Address: _____

Occupation: _____

Educational Attainment: _____

Emergency Contact Person

Name: _____

Address: _____

Mobile Number: _____

Landline: _____

Relationship: _____

MEDICAL INFORMATION

Height: _____

Weight: _____

Race: _____

Past Medical History

Hospitalization: ☐YES ☐NO

Diagnosis	Year / Month

Operation: ☐YES ☐NO

Operation Done	Year / Month

Injuries: ☐YES ☐NO

Injury	Year / Month

Past Medical Condition/s:

Disease	Month / Year	Status

Present Medical History
Please check if you have any of the following:
Existing Medical Condition:

- ☐ Hypertension
- ☐ Heart Disease: _____
- ☐ Blood Disorder: _____
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Liver Disease: _____
- ☐ Bronchial Asthma
- ☐ Pulmonary Tuberculosis
- ☐ Pneumonia
- ☐ Lung Disease: _____
- ☐ Peptic Ulcer Disease
- ☐ Urinary Tract Infection
- ☐ Kidney Stones
- ☐ Kidney Disease: _____
- ☐ Cancer: _____
- ☐ Diabetes (Type 1 or 2)
- ☐ Seizure
- ☐ STD

Others: _____

_____

Allergies:

_____

Medication:

_____

_____

_____

Family History of Disease

Father:

_____

Mother:

_____

Social History

Smoking: ☐YES ☐NO

No. of Stick per day: _____

No. of packs per Month: _____

Drinking: ☐YES ☐NO

No. of bottle per day: _____

No. of bottles per month: _____

Exercise: ☐YES ☐NO

Exercise Type: _____

Frequency: _____

Kilometers of Walking per day: _____

Illicit Drug: ☐YES ☐NO

Type: _____

Dietary

Meals per day: _____

Glasses of water per day: _____

On special diet: ☐YES ☐NO

Type of diet: _____

Menstrual Cycle (For Female Clients)

Length: _____

Interval: _____

Dysmenorrhea: ☐YES ☐NO

Menopause: ☐YES ☐NO

Year: _____

Pregnancy: _____

Live Birth: _____

Mischarge: _____

Visual and Hearing Condition

Wearing Glasses: ☐YES ☐NO

Year started: _____

Grade: Left: Right:

Color Blindness: ☐YES ☐NO

Year diagnosed: _____

Hearing Problem: ☐YES

☐NO

☐ Right ☐ Both

☐ Left

Year Diagnosed: _____

Vaccination History

Vaccine	Status	Date / Year
Standard Childhood Vaccine	☐YES ☐NO	
Hepatitis A	☐YES ☐NO	
Hepatitis B	☐YES ☐NO	
Tuberculosis	☐YES ☐NO	
Flu / Influenza	☐YES ☐NO	
MMR	☐YES ☐NO	
Tetanus	☐YES ☐NO	
Chicken Pox	☐YES ☐NO	