1.HealthNet Policy Number I038-000-115721598-01 2. Authorizatio Code:

2.Patient Name MYLA GONZALES ELIZARIO

3.Patient Date of Birth & Sex 28-12-81(dd/mm/yy) ☐ M ☐ Fema

Mobile No.0522363934

5.Nature of illness or Injury ☐ Acute ☐ Chronic ☐ Emergency

6.Are You the patient's primary physician ☐ Yes ☐ No

7.Presenting Complaints:

For medication refill.

Complaint of joint pain,

Has a history of hyperuricemia but has not been on medications for over 5months now.

She is known hypertensive controlled on medications and hyperlipidemic patient

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

DiagonosisiEssential (primary) hypertension, Hyperlipidemia, unspecified, Gout, unspecified, Acute upper respiratory infection, unspecified, Cough ICD Code I10, E78.5, M10.9, J06.9, R0

12.Etiology:

13.In case of Injury:mode of Injury/place of Injury

14.Plan / Details of Management

a.ProcedureLipid Panel,Uric Acid Blood,Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patients and/or familys needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family. CPT code80061,84550,9

b.Laboratiry Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Addmission: Date of Discharge:

16.

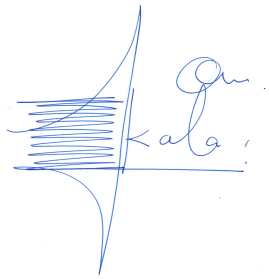
PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	SYRUP (200ML, BOTTLE)	7	Take 10ML 2 Time(s) p 7 Day(s) others

Date: 16-10-24(dd/mm/yy)

Doctor's Name Enomen Goodluck

Signature and Stamp



Physician Code DHA-P-28040827 HNM Code

Authorization

I hereby authorize the Physician, Hospital or Pharmacy to file a claim for medical services on my behalf and I confirm that the above me examination / investigation / therapy is given to me by the doctor. I hereby authorize any Hospital, Physician, Pharmacy or any other per provided medical services to me or my dependents to furnish NGI with any and all information with regard to any medical history, medi or medical services and copies of all medical and hospital records.

A Photocopy or teletax copy of this authorization shall be considered effective any valid as the original

Date: 16-10-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

NATIONAL GENERAL INSURANCE CO. (P.J.S.C)

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