مركز أوركيد الطبي
ORCHID MEDICAL CENTER

File No#: 1000249 Date: 5/3/2018

Patient Name: Kerry Cardenas :اسم المريض

Date of Birth (تاريخ الميلاد): 1/1/1991 Gender (الجنس) : M / F

Nationality (الجنسية): Philippine Occupation (الوظيفة): _____

Marital Status (الحالة الاجتماعية): single Phone No. ((رقم الهاتف: 971544996531

Contact Person in Case of Emergency: _____

How Did You Know About Us? staff

Weight: _____ Height: _____ Blood Type: _____

Chief Complaint: Sore throat for one day

Medical History السجل الطبي

Diseases: / Medication: /
Allergies: / Pregnancy: /
Hospitalization: / Family History: /

Habits: Smoking: Y/N Alcohol: Y/N Drugs: Y/N

Remarks: _____

Clinical Findings: Congested Tonsil

Radiography: _____

Examination : Chest clear Temp 37.8 c

Diagnosis: Tonsilitis

℞

1) Zithromax cap 1000 mg tw.c daily (5 days)
2) Panadol 1g tw.c daily

د. ايمان محسن علي
Dr. Iman Mohsin Ali
ممارس عام - ممارس عام
General practitioner
MOH License No.: D21329 ترخيص رقم
Orchid Medical Centre مركز اوركيد الطبي

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DOCTOR NOTE

REDAD DATA

cAEAIOEBAA83ODQxO

Public Data Readed Succ

SHOW READED DATA

Confirm Data

Public Data Verification report

File	Valid Signature?
Non-Modifiable Data (SF3)	False
Modifiable Data (SF5)	False
Holder Signature Image (SF7)	False
Photography	False
Home Address	False
Work Address	False

Card Holder Information

Name	Kerry,Claire,Balaga,,Cardenas	**IDN:**	784199137963296	**Mother Name:**	
Name (Ar)	كيرى,كلير,بالاجا,,كاردیناس	**Card Number:**	082671450	**Mother Name (Ar):**	
Title:		**Nationality:**	PHL	**Family ID:**	
Title (Ar):		**Nationality (Ar):**	الفلبين		
Issue Date:	23/03/2017	**Sex:**	F	**Sponsor Type:**	06
Expiry Date:	20/03/2019	**Date of Birth:**	01/01/1991	**Sponsor Name:**	الرواسخ للتجاره العامه
Marital Status:	01	**Husband IDN:**		**Sponsor Number:**	00
Residency Type:	02	**Residency Number:**	30120172025116	**Residency Expiry:**	20/03/2019
ID Type:	IL	**Occupation:**	09	**Occupation Field:**	00

Photo

Signature Image

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

Patient Name: **FILE NO#**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
5/3/2018	Consultation	100		[signature]

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

SICK LEAVE CERTIFICATE

Hospital: **ORCHID MEDICAL CENTER**

Date of issue **5/MAR/2018**

Cert No: **OMC1/2018/1007**

Patient's Name: Kerry Cardenas	File Number: 1000249
Age :27	Sex: FEMALE

Unfitness

This is to certify that the above patient visited MEDICAL **CLINIC on 5/MAR //2018**

The patient is unfit to work from 5 **/MAR//2018** till 5 **/MAR //2018**

Diagnosis: TONSILLITIS

Comments:

Doctor's Name**: EMAN MOHSEN ALI**	License Number: D21329
Signature :	Stamp :

Notes :
1- Certificate is invalid if any correction are made.
2- Certificate is Valid only if is signed and stamped.
3- Certificate is issued at patient's request

للاستعمال الرسمي : نصادق على صحة توقيع وختم الطبيب المذكور المرخص من قبل وزارة الصحة دون تحمل إدارة منطقة الشارقة الطبية اي مسؤولية من محتويات هذا التقرير (اعتماد قسم التراخيص الطبية بمنطقة الشارقة الطبية)

Sharjah – cornich alkhan – alkhan palace 201 – near petrofac
Phone : +971 6 555 8337 mobile : +971 50 603 7996

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

Laser Medical History

File No#: 1000249 **Date:** 19/3/18

Patient Name: KERRY CARDENAS اسم المريض:

Date of Birth (تاريخ الميلاد): 01/01/1991 **Gender (الجنس) :** M / (F)

Nationality (الجنسية): FILIPINO **Occupation (الوظيفة):** _____

Marital Status (الحالة الاجتماعية): SINGLE **Phone No. (رقم الهاتف):** 054 4996537

Contact Person in Case of Emergency:

_____

How did you know about us?

_____

*Please answer the following questions:

1. Which phrase best describes your skin type?
   ____ I – Always burns, never tans ✓
   ____II – Always burns, sometimes tans
   ____III – Sometimes burns, always tans
   ____IV – Rarely burns, always tans
   ____V – Moderately pigmented ✓
2. Do you have a history of keloids or unusual scarring? _____ Yes _____ ~~No~~
3. Do you have a history of Herpes Simplex (fever blisters, cold sores) recurring in the area to be treated? _____ Yes _____ No
4. Have you been on Accutane (Isotretinoin) in the last 6 months? _____ Yes _____ No
5. Do you use Retin-A, Glycolic Acid products or Hydroquinone (bleaching agent) on the area(s) to be treated? _____ Yes _____ No
6. Have you had waxing, plucking or electrolysis performed on the area(s) to be treated in the last 6 weeks? _____ Yes _____ No
7. When were you last exposed to the sun (including tanning booths)?
   _____
   _____
8. Do you use sunless tanning lotions? _____ Yes _____ NO When was it last applied?
   _____

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Laser Hair Removal Patient Consent

I consent to the use of VIKING DIODE at the Orchid medical center, Sharjah for the removal of unwanted hair.

I understand that the laser produces a focused beam of light that generates a wavelength of energy that is selectively absorbed by the pigment in the hair follicle. The absorption produces heat, which damages the hair follicle and diminishes its ability to grow hair.

Clinical results may vary depending on individual factors, including medical history, skin and hair type, patient compliance with pre/post treatment instructions, and individual response to treatment. I am aware of alternative methods of hair removal such as shaving, plucking, depilatory creams, waxing and electrolysis. I have made an informed decision to proceed with laser hair removal.

The following points need be paid attention:

. No tanning or self-tanning creams for 4-6 weeks prior to and after treatments due to increased side effects.

. Waxing and plucking should be avoided for 6 weeks prior to treatment.

. Tattoos and permanent makeup in the treatment area can be altered with laser treatments.

. A complete medical history is to be completed including medication, allergies and skin type.

. Individuals who have used Accutane within the past 6 months or who used any medication requiring limited exposure to sunlight are not good candidates for VIKINI procedure.

Skin effects will possibly include temporary redness similar to a sunburn. Some swelling and light crusting may occur. These side effects should resolve within a few hours to several days following treatment. Hypopigmentation or hyperpigmentation is uncommon and rarely permanent. Sun avoidance and use of sunscreen is recommended.

I consent to the taking of photographs and their anonymous use for the purpose medical audit, education and promotion.

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Patient Name: **FILE NO#**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
19/3/18	LHR UNDERARM 20 J/cm², SHORT X 2 PASSES	100	∅	د. غوران يوفانوفيتش Dr. Goran Jovanovic اخصائي - جراحة التجميل Specialist - Plastic Surgeon ترخيص رقم: MOH License No.: V220 مركز اوركيد الطبي Orchid Medical Centre
26/3/18	CARBON PEEL DONE			
	(900)			
	Carbon peel for 3 sessions	450	450	د. غوران يوفانوفيتش Dr. Goran Jovanovic اخصائي - جراحة التجميل Specialist - Plastic Surgeon ترخيص رقم: MOH License No.: V220 مركز اوركيد الطبي Orchid Medical Centre
9/4/18	CARBON PEEL DONE 2nd SESSION	450	∅	
23/4/18	CARBON PEEL DONE 3rd SESSION		∅	