مركز أوركيد الطبي
ORCHID MEDICAL CENTER

File No#: 1000422 Date: 12/04/2018

Patient Name: Takla Ichang :اسم المريض

Date of Birth (تاريخ الميلاد): 1/3/1995 Gender (الجنس): M / (F)

Nationality (الجنسية): Syrian Occupation (الوظيفة): /

Marital Status (الحالة الاجتماعية): / Phone No. (رقم الهاتف): 050/625012

E.MAIL: Taloosh1hang@outlook.com

How Did You Know About Us?

friend

Weight: 60 Height: _____ Blood Type: _____

Chief Complaint:

For check up ? polycystic ovary

Medical History السجل الطبي

Diseases: / Medication: recyttone

Allergies: / Pregnancy: /

Hospitalization: / Family History: /

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

Remarks: /

Clinical Findings: N.A.I

Radiography: _____

Examination : 4/5 → 2.0 foll.ch 2.2 cm, 2.0 mm
ut. normal

Diagnosis: polycystic ovary

د. لميس عبد الحميد عبد المجيد
Dr. Lamees Abdulhameed Abdulmajeed
اخصائي - أ. نساء وولادة
Specialist - OBS / GYN
MOH License No.: V261 ترخيص رقم:
Orchid Medical Centre مركز اوركيد الطبي

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Medical Consent Form

I hereby consent and authorize the doctor to treat my medical condition, which has been explained to me by the qualified physician.

I understand that in order to provide me with the most efficient and enhanced service, diagnostic and other procedures may be deemed necessary.

I understand that my treating doctor may discover other or different conditions, which may require additional or different procedures than those planned.

I authorize my treating doctor to perform such procedure, which are advisable in their professional judgment.

I understand that no warranty or guarantee has been made to me as to a result or cure just as there may be risks and hazards in continuing my present condition without treatment, there are also risk and hazards to the performance of the diagnostic and /or surgical procedure. I realize that common surgical or diagnostic procedure are potential for an infection, swelling, bleeding and allergic reaction.

I understand that there are minimal fees to be paid per service and that all fees must be paid in full after the completion of each treatment.

I understand that any information that I provide regarding my medical status will be kept completely confidential and anonymous.

I believe that I have sufficient information to give this consent. I certify that form has been fully explained to me and that I have read it understand its contents.

Patient Signature/ Guardian (In case of minors):

Date:

Dentist Signature:

نموذج إقرار طبي

- اوافق و اسمح للطبيب بعلاج حالتي المرضية والتي تم شرحها لي من قبل الطبيب المختص و المؤهل.
- أتفهم انه من أجل تزويدي بالعلاج الأمثل و الخدمة الأفضل، فإن بعض التشخيصات و الاجراءات الطبية الاضافية سوف تكون ضرورية لاستكمال العلاج.
- وأنا أتفهم أن من الممكن ان يكتشف الطبيب خلال العلاج حالات أخرى أو مختلفة عن ما ذكر في الفحص الاولي، والتي قد تتطلب إجراءات إضافية أو مختلفة عن تلك المخطط لها.
- أفوض الطبيب المعالج بإجراء العلاجات اللازمة و المطلوبة بحكم خبرتهم المهنية و العلمية.
- أتفهم أنه ليس هنالك أي ضمانات او أي تأمين لنتائج العلاج كما أتفهم ان هناك مخاطر ناتجة عن عدم استكمال علاج حالتي المرضية، و اتفهم تماما كافة الاخطار الناجمة عن الفحصوصات و الاجراءات العلاجية و الجراحية. و اتفهم احتمالية حدوث عدوى أو تورم أو نزيف أو حساسية نتيجة للفحص أو الإجراء الطبي
- أتفهم ان هناك رسوم بالحد الادنى يجب دفعها مقابل الخدمة العلاجية و أن جميع الرسوم المطلوبة يجب سدادها مباشرة بعد الانتهاء من كل علاج.
- إن أي معلومات أقدمها بخصوص حالتي الصحية ستبقى سرية تماما ولا يمكن الاطلاع عليها دون موافقتي.
- أقر أني امتلك المعلومات الكافية لتوقيع هذا الاقرار. و ان هذا النموذج قد تم شرحه لي بالكامل و اني قد قرأت و فهمت جميع تفاصيل هذا الاقرار.

توقيع المريض / الوصي :

التاريخ:

توقيع الطبيب المختص:

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	Taklaa,George,,,Alkhouri	**IDN:**	784199562707101	**Mother Name:**	
Name (Ar)	تقلا,جورج,,,الخورى	**Card Number:**	073407188	**Mother Name (Ar):**	
Title:		**Nationality:**	SYR	**Family ID:**	
Title(Ar):		**Nationality (Ar):**	سوريا		
Issue Date:	28/05/2015	**Sex:**	F	**Sponsor Type:**	03
Expiry Date:	25/05/2018	**Date of Birth:**	01/03/1995	**Sponsor Name:**	جورج فؤاد الخورى
Marital Status:	01	**Husband IDN:**		**Sponsor Number:**	05568265
Residency Type:	03	**Residency Number:**	30120123018142	**Residency Expiry:**	25/05/2018
ID Type:	IL	**Occupation:**	11	**Occupation Field:**	00

Photo

Signature Image

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DOCTOR NOTE

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PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
12/4/18	Consultation & Ultrasound	150	0	
	24/6/2019 : Lips Filler			
	26/6/2019 : fu perfect result			
	20/7/2019 : Anjeoedema from 4 days P. AERIUS			
	2mg Dexamethasone iamp IM. Allegra 1 tab			
	27/7/2019 : Hyaluronidase	0.7	L	

BioScience GmbH 19073 Dümmer, Germany
Genefill SOFT FILL
LOT F-0219/1 2022-01
CE 2409

د. وسام مروان الطباع
Dr. Wesam Marwan Al Tabbaa
اخصائي جلدية
Dermatology specialist
MOH License No.: V826 ترخيص رقم:
Orchid Medical Centre مركز اوركيد الطبي

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ORCHID MEDICAL CENTER

AED 840.00 **RECEIPT VOUCHER (No.REC-004168)** **Date:24-06-2019**

Receive from Mr./Mrs./M/s. **1000422 - TAKLAA GEORGE - 971501625012**

The sum of Dhs. **Eight Hundred Forty Dirhams and Zero Fils Only**

By Cash **840.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **24-06-2019**

Being **LIP FILLER + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1000422 - TAKLAA GEORGE - 971501625012**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 210.00 **RECEIPT VOUCHER (No.REC-004444)** **Date:20-07-2019**

Receive from Mr./Mrs./M/s. **1000422 - TAKLAA GEORGE - 971501625012**

The sum of Dhs. **Two Hundred Ten Dirhams and Zero Fils Only**

By Cash **210.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **20-07-2019**

Being **CONSULTATION + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1000422 - TAKLAA GEORGE - 971501625012**

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www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 100.00

RECEIPT VOUCHER (No.REC-004471)

Date:22-07-2019

Receive from Mr./Mrs./M/s. **1000422 - TAKLAA GEORGE - 971501625012**

The sum of Dhs. **One Hundred Dirhams and Zero Fils Only**

By Cash **100.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **22-07-2019**

Being **INJECTION**

Made by **Hiba**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1000422 - TAKLAA GEORGE - 971501625012**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae