مـوكـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

File No#: 1000611 Date: 02/06/18

Patient Name: RANDA NEZAR ALLAWI :اسم المريض

Date of Birth (تاريخ الميلاد): 02/01/1983 Gender (الجنس): M / (F)

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

Marital Status (الحالة الاجتماعية): M Phone No. ((رقم الهاتف: 0526155 3303

E.MAIL: _____

How Did You Know About Us?

_____

Weight: _____ Height: _____ Blood Type: _____

Chief Complaint:

_____

_____

_____

Medical History السجل الطبي

Diseases: _____ Medication: _____

Allergies: _____ Pregnancy: _____

Hospitalization: _____ Family History: _____

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

Remarks: _____

_____

Clinical Findings: _____

_____

Radiography: _____

_____

Examination : _____

_____

Diagnosis: _____

_____

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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** | Randa,Nezar,,,Allawi | **IDN:** | 784198329862480 | **Mother Name:** | |
| **Name (Ar)** | رندە,نزار,,,علاوى | **Card Number:** | 087737607 | **Mother Name (Ar):** | |
| **Title:** | | **Nationality:** | SYR | **Family ID:** | |
| **Title (Ar):** | | **Nationality (Ar):** | الجمهورية العربية السورية | | |
| **Issue Date:** | 15/02/2018 | **Sex:** | F | **Sponsor Type:** | 03 |
| **Expiry Date:** | 14/02/2020 | **Date of Birth:** | 02/01/1983 | **Sponsor Name:** | حمدى شومل |
| **Marital Status:** | 02 | **Husband IDN:** | | **Sponsor Number:** | 0128214649 |
| **Residency Type:** | 03 | **Residency Number:** | 20120173721192 | **Residency Expiry:** | 14/02/2020 |
| **ID Type:** | IL | **Occupation:** | 99 | **Occupation Field:** | 00 |

**Photo**

**Signature Image**

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ORCHID MEDICAL CENTER

**DOCTOR NOTE**

1. Needs Scaling & polishing
2. Composite Fillings specially in 16 + 51 and other teeth.

Dr. Datiq

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**PATIENT NAME:** **FILE NO#:**

| DATE | TREATMENT | PAYMENT | BALANCE | SIGNATURE |
|---|---|---|---|---|
| | 2/5/2019 | | | |
| | Composite Filling in L6 | 75 | | Dr. Dalia |
| | | 2/05/2019 | | |
| | 8/7/2019 | | | |
| | RCT in L5 tooth Formacresol + T.F | | | Dr. Dalia |
| | 22-7-19 RCT L5 + CaOH | | | D. Amira |
| | 15/8/19 | | | |
| | Rct L5 + CaOH 2 visite | 250 | | Dr. Amira |
| | | 2/ | | |
| | 5-9-2019 Composite | 150 | | |
| | | 75 | | |
| | | 3/ | | |
| | | 8/9/2019 | | |

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

**AED 75.00** **RECEIPT VOUCHER (No.REC-003552)** **Date:02-05-2019**

Receive from Mr./Mrs./M/s. **1000611 - RANDA NEZAR ALLAWI - 0561553303**

The sum of Dhs. **Seventy-Five Dirhams and Zero Fils Only**

By Cash **75.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **02-05-2019**

Being **composite filling 50% discount**

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 : **1000611 - RANDA NEZAR ALLAWI - 0561553303**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

**AED 225.00** **RECEIPT VOUCHER (No.REC-005391)** **Date:05-10-2019**

Receive from Mr./Mrs./M/s. **1000611 - RANDA NEZAR ALLAWI - 0561553303**

The sum of Dhs. **Two Hundred Twenty-Five Dirhams and Zero Fils Only**

By Cash **225.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **05-10-2019**

Being **ROOT CANAL TREATMENT 50 % DISCOUNT**

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 : **1000611 - RANDA NEZAR ALLAWI - 0561553303**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
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5/10/2019 Discount

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

**AED 75.00** **RECEIPT VOUCHER (No.REC-005496)** **Date:12-10-2019**

Receive from Mr./Mrs./M/s. **1000611 - RANDA NEZAR ALLAWI - 0561553303**

The sum of Dhs. **Seventy-Five Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **75.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **12-10-2019**

Being **COMPOSITE FILLING 50 % DISCOUNT**

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 : **1000611 - RANDA NEZAR ALLAWI - 0561553303**

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