



مركز أوركييد الطبي
ORCHID MEDICAL CENTER

صحة... ابتسامة... جمال
Health ... Smile ... Beauty

File No: 100/014

Date: 6/10/2018

Date: 6/10/2018

File Number: 100/014

Patient Name: Menatalia El. Saleh

Date Of Birth (تاريخ الميلاد): 8/7/1994

Marital Status: (الحالة الاجتماعية): Single

Nationality (الجنسية): Egypt

Phone No. (رقم الهاتف): 0545518892

Address (العنوان): Kalba Shafah

How did you know about us: Google

E-MAIL: dr.menatalia@hotmail.com

التاريخ الطبي Medical History		
الحالة الطبية Medical Condition	Yes/No نعم / لا	If 'YES' give details إذا كانت الإجابة نعم اذكر بالتفصيل
Recent or current drugs/Medical Treatment هل تتعاطى أي أدوية أو تتلقى أي علاجات حثيثاً؟	Yes	Vibramycin
Corticosteroids/Immunosuppressant هل تتعاطى أي سترويدات أو مثبطات للمناعة؟	No	
Allergies هل لديك أي حساسية؟	No	
Surgical Operations, Serious illness هل أجريت أي عمليات جراحية أو تعاني من أي أمراض؟	No	
Cardiac surgery, Rheumatic fever, Endocarditis, Artificial heart valve, Congenital heart disease جراحة قلب، حمى روماتويد، التهاب شغاف القلب، صمام قلب صناعي، أمراض القلب	No	
High Blood Pressure, Bleeding disorders, Anticoagulants هل لديك ارتفاع في ضغط الدم، مشاكل في النزيف أو تتعاطى أي مميعات للدم؟	No	
Anemia, Leukemia (سرطان الدم)، انيميا (فقر الدم)، لوكيميا (سرطان الدم)	No	
Chest disease, Asthma, Bronchitis, TB, Other أمراض صدرية، أزمة تنفسية، التهاب في الشعبات، السل، أمراض أخرى	No	
Renal, Urinary, Sexually transmitted disease هل تعاني من أي أمراض بولية أو تناسلية؟	No	
Pregnancy, Contraceptive pill, Menstrual problems هل أنت حامل؟ هل تتعاطين أي مانع للحمل؟ هل تعانين من مشاكل في الدورة الشهرية؟	No	
Hepatitis, Jaundice, Other liver diseases التهاب الكبد الوبائي، الصفراء، أي أمراض كبدية أخرى	No	
Peptic ulcer, Crohn's ulcerative colitis, Other قرحة معوية، داء كرون، أي أمراض معوية أخرى؟	No	
Epilepsy, or any other neurological disease هل تعاني من الصرع أو أي أمراض في الجهاز العصبي؟	No	
Thyroid Diseases, Diabetes هل تعاني من مرض السكري أو أمراض الغدة الدرقية؟	No	
Other conditions HSV, HIV...etc هل تعاني من أي أمراض أخرى؟ فيروس الإيدز، فيروس الحلا البسيط etc	No	



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 any procedures which are advisable in their professional judgment.
- I understand that no warranty or guarantee has been made to me as a result or cure just as there may be risks and hazards in continuing my present condition without treatment.
- I understand that there are also risks and hazards to the performance of the diagnostic and/or surgical procedures.
- I realize that common surgical or diagnostic procedures are potential for an infection, swelling, bleeding, pain or allergic reaction.
- I understand that there are minimal fees to be paid per service and that all fees must be paid in full before the completion of treatment.
- I consent that all medical history and information I provided in my medical file is true and I understand that any information I provide regarding my medical status will be kept confidential and anonymous.
- I believe that I have sufficient information to give this consent. I certify that this form has been fully explained to me and that I have read it and I understand its' content and I sign it with all my will.

Patient's Signature/ Guardians (In case of minors):

Date: 6/10/2018

نموذج اقرار طبي

- أوافق و أسمح للطبيب بعلاج حالتي المرضية التي تم شرحها لي من قبل الطبيب المختص و المؤهل،
- أتفهم أن بعض الإجراءات الطبية والتشخيصية الإضافية قد تكون ضرورية من أجل ترويدي بالعلاج الأمثل و الخدمة الأفضل.
- أتفهم أنه من الممكن أن يكشف الطبيب خلال العلاج أموراً مختلفة عن ما فكرت في الفحص الأولي و التي قد تتطلب إجراءات إضافية أو مختلفة عن تلك المخطط لها.
- أقرض الطبيب المعالج باتخاذ كل الإجراءات الطبية و العلاجات اللازمة و المطلوبة بحكم خبرته المهنية و العلمية.
- أقر أنه لم يتم تقديم أي ضمانات أو تأمين لتفادي العلاجات و الإجراءات الطبية أو التجميلية المقامة لي، كما أتفهم الأخطار و المضاعفات الناتجة عن عدم استكمال علاج حالتي المرضية.
- أتفهم تماماً كافة الأخطار و المضاعفات التي قد تكون مصاحبة للفحوصات و الإجراءات العلاجية و الجراحية.
- و أدرك أن بعض الإجراءات التشخيصية و العلاجية و الجراحية قد تؤدي إلى مضاعفات كالالتهاب أو التورم أو النزيف أو الألم أو الحساسية
- أتفهم أن هناك رسوم بالحد الأدنى يجب علي دفعها مقابل الخدمة العلاجية و أن جميع الرسوم المطلوبة يجب أن تسدد بالكامل قبل الانتهاء من العلاج.
- أقر أن كافة المعلومات الطبية و التاريخ الطبي الذي تقدمته لي تخفي للهدف صحفية و أتفهم أن أي معلومات تتعلق بحالتي الصحية ستبقى سرية تماماً و لا يمكن الأطلاع عليها دون موافقتي
- أقر أن لدي المعلومات الكاملة لتقديم هذا الأقرار و أن هذا النموذج قد تم شرحه لي بالكامل و اني قد قرأت و فهمت جميع تفاصيله بالكامل و اني وقعت عليه بكامل ارتياحي

توقيع المريض / ولي الأمر (من هم دون السن القانونية):

التاريخ: ... / ... /

استمارة تقييم المريض Patient Assessment Form

المؤشرات الحيوية Vital Signs

الوزن (الكلغ): Weight (Kg)	الطول (السم): Height (cm)	نوعية الدم (Blood Type): الدمية (Blood Type)
النبض (النبضات): Pulse (ppm)	الضغط الدم (mmHg): Blood Pressure	سكر الدم (Blood Sugar): السكر (Blood Sugar)

سبب زيارة المريض للحلقة Chief Complaint

having braces (Ceramic) Since 24th.
Wants to complete it.

التاريخ المرضي: Disease History

الحساسيات: Allergies

الأدوية: Medications

الحمل: Pregnancy

عمليات سابقة، الجراحات، عمليات المستشفى: Previous Surgeries, Hospitalization

التدخين (Smoking): Y / N

الكحول (Alcohol): Y / N

الأدوية (Drugs): Y / N

الملاحظات العامة والسريية: General & Clinical Findings

الفحص: Examination

Ceramic .Orz Roth ice brackets

الصور الشعاعية: Radiography

التشخيص: Diagnosis

Class I Bimaxillary protrusion
Crowding in incisor region

Treatment Plan خطة العلاج

Extraction of $\frac{4}{4}$
 Correction of crowding & protrusion
 Tt time 12-15 Monthly
 Tt Cost 4000 AD, 400 per month.

~~Dr. Mahesh Sagar~~

1/12/2018

Photo taken
 Advice for $\frac{4}{4}$ Extraction
 5t Rebonding
 $\frac{4}{4}$ bracket removed for extraction
 .OH NiTi upper, 012 NiTi lower
 for retainer + alignment & 2t leveling
 400 AD to pay!

Doctor's Signature and Stamp

.....

PATIENT NAME:

FILE NO#:

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
<u>17/12/2018</u>				
	Extraction of <u>I4 + 71</u> two teeth	300	0	Dr. Dakia
<u>31/1/2019</u>				
	Extraction of <u>41 +</u> <u>41</u> teeth	300		Dr. Dakia
<u>9/2/2019</u>	<u>51</u> Rebonding 016 1/2 N.F. with PC	400		
<u>17/2/2019</u>	Dr. Change (consider) other case - 016 Replan line - upper PC 2 - 016 N.F. lower	400		
<u>30/7/2019</u>	1 derotation 33 retraction in - 016 Res NiTi upper - 016SS with Curve of Spee in lower for Ant. intrusion	400		
<u>27/8/2019</u>	016 1/016 Res 6/2 with RC force	400		
<u>2/11/2019</u>	PC in both arch	400		



مركز أوركيده الطبي
ORCHID MEDICAL CENTER

400.00

RECEIPT VOUCHER (No.REC-0018663)

Date:01-12-2018

Receive from Mr./Mrs./M/s. 1001014 - MENATALLA ELDESSOUKY - 971503027019

The sum of Dhs. **Four Hundred Dirhams and Zero Fils Only**By Cash **400.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No.

Date: **01-12-2018**

Being

*Faten*Made by **FATEN**

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www.omc1.ae



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

300.00

RECEIPT VOUCHER (No.REC-001993)

Date:17-12-2018

Receive from Mr./Mrs./M/s. 1001014 - MENATALLA ELDESSOUKY - 971503027019

The sum of Dhs. Three Hundred Dirhams and Zero Fils Only

By Cash 300.00 / By Credit Card 0.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 17-12-2018

Being

Made by Ghada

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مركز أوركيدي الطبي
ORCHID MEDICAL CENTER

TAX INVOICE (NO. INV-C003516)

Patient File # : 1001014
 Patient Name : MENATALIA ELDESSOUKY
 Doctor : DR.DALIA
 VAT Reg # : 100479302000003
 Visit Date : 31-01-2019
 Insurance : Cash
 Invoice Date : 31-01-2019

Sl.No	Code	Service	Unit Price	Quantity	Gross	Discount	VAT %	VAT Amount	Net
1.	CPT024	Extraction (Simple)	300.00	1	300.00	0.00	0.00	0.00	300.00
Gross Total (in AED)									300.00
Discount (in AED)									0.00
Net Total (in AED)									300.00
VAT TOTAL									0.00
NET + VAT TOTAL									300.00
Paid (in AED) (Cash)									-300.00
Balance (in AED)									0.00
Advance Balance (in AED)									0.00

Prepared By Ghada

Patient Signature

Kindly note that this automated and uniquely dated invoice is payable on this visit before leaving the Center deposit will be automatically deducted upon settlement.

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مركز أوركيديد الطبي
ORCHID MEDICAL CENTER

300.00

RECEIPT VOUCHER (No.REC-002483)

Date:31-01-2019

Receive from Mr./Mrs./M/s. 1001014 - MENATALLA ELDESSOUKY - 971503027019

The sum of Dhs. Three Hundred Dirhams and Zero Fils Only

By Cash 300.00 / By Credit Card 0.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 31-01-2019

Being

Made by Ghada

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مركز أوركيك الطبية
ORCHID MEDICAL CENTER

400.00

RECEIPT VOUCHER (No.REC-002601)

Date:09-02-2019

Receive from Mr./Mrs./M/s. 1001014 - MENATALLA ELDESSOUKY - 971503027019

The sum of Dhs. Four Hundred Dirhams and Zero Fils Only

By Cash 400.00 / By Credit Card 0.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 09-02-2019

Being BRACES CHANGED/ FOLLOW UP

Made by Ghada

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 420.00

RECEIPT VOUCHER (No. REC-004271)

Date: 01-07-2019

Receive from Mr./Mrs./M/s. 1001014 - MENATALLA ELDESSOUKY - 971545518832

The sum of Dhs. Four Hundred Twenty Dirhams and Zero Fils Only

By Cash 420.00 / By Credit Card 0.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 01-07-2019

Being BRACES FOLLOW UP + VAT

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 : 1001014 - MENATALLA ELDESSOUKY - 971545518832

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 420.00

RECEIPT VOUCHER (No. REC-004555)

Date: 30-07-2019

Receive from Mr./Mrs./M/s. 1001014 - MENATALLA ELDESSOUKY - 971545518832

The sum of Dhs. Four Hundred Twenty Dirhams and Zero Fils Only

By Cash 420.00 / By Credit Card 0.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 30-07-2019

Being BRACES FOLLOW UP + 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 : 1001014 - MENATALLA ELDESSOUKY - 971545518832

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مركز أوركيد الطبي
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AED 420.00

RECEIPT VOUCHER (No.REC-004867)

Date:27-08-2019

Receive from Mr./Mrs./M/s. 1001014 - MENATALLA ELDESSOUKY - 971545518832

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

By Cash **420.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No.

Date: 27-08-2019

Being **BRACES FOLLOW UP + VAT**

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 : 1001014 - MENATALLA ELDESSOUKY - 971545518832

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مركز أوركيد الطبي
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AED 420.00

RECEIPT VOUCHER (No.REC-006433)

Date:09-12-2019

Receive from Mr./Mrs./M/s. **1001014 - MENATALLA ELDESSOUKY - 971545518832**

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

By Cash **0.00** / By Credit Card **420.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No.

Date: **09-12-2019**

Being **BRACES FOLLOW UP + 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 : **1001014 - MENATALLA ELDESSOUKY - 971545518832**

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 420.00

RECEIPT VOUCHER (No. REC-005806)

Date: 02-11-2019

Receive from Mr./Mrs./M/s. 1001014 - MENATALLA ELDESSOUKY - 971545518832

The sum of Dhs. Four Hundred Twenty Dirhams and Zero Fils Only

By Cash 420.00 / By Credit Card 0.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 02-11-2019

Being braces follow up + vat

Made by Reem

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 : 1001014 - MENATALLA ELDESSOUKY - 971545518832

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REDAD DATA

cAEAlOEBA83ODQxO*

Public Data Readed Suc

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	Menatalla,Mohamed,Naguib,,Eldessouky	IDN:	784199469163879	Mother Name:	
Name (Ar)	منة الله محمد نجيب الصوري	Card Number:	081193511	Mother Name (Ar):	
Title:		Nationality:	EGY	Family ID:	
Title(Ar):		Nationality (Ar):	مصر		
Issue Date:	12/12/2016	Sex:	F	Sponsor Type:	03
Expiry Date:	27/11/2019	Date of Birth:	08/07/1994	Sponsor Name:	محمد نجيب الصوري عبدالرحمن
Marital Status:	01	Husband IDN:		Sponsor Number:	10947295
Residency Type:	03	Residency Number:	20120053080337	Residency Expiry:	27/11/2019
ID Type:	IL	Occupation:	11	Occupation Field:	00



Photo

Signature Image

<http://orchidsvr/EMID/default.aspx>

10/6/2018



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 420.00

RECEIPT VOUCHER (No.REC-007268)

Date:25-01-2020

Receive from Mr./Mrs./M/s. 1001014 - MENATALLA ELDESSOUKY - 971545518832

The sum of Dhs. **Four Hundred Twenty Dirhams and Zero Fils Only**By Cash **420.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No.

Date: 25-01-2020

Being **braces follow up + 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 : 1001014 - MENATALLA ELDESSOUKY - 971545518832

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 420.00

RECEIPT VOUCHER (No.REC-009677)

Date:25-06-2020

Receive from Mr./Mrs./M/s. 1001014 - MENATALLA ELDESSOUKY - 971545518832

The sum of Dhs. Four Hundred Twenty Dirhams and Zero Fils Only

By Cash 0.00 / By Credit Card 420.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 25-06-2020

Being 1 follow up + vat

Made by Reem

- 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 : 1001014 - MENATALLA ELDESSOUKY - 971545518832

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