مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

Date: 15 / 11 / 2018 File Number: 100194

Patient Name: Chaumissa Berguem إسم المريض:

Date Of Birth (تاريخ الميلاد) 14 / 6 / 1982 Gender (الجنس) : M / F Marital Status:(الحالة الاجتماعية) .....

Nationality (الجنسية): Morocco Occupation (الوظيفة) : 0561355202

Address (العنوان) : Sharjah Phone No. (رقم الهاتف): 0543007571

E-MAIL: ..... How did you know about us: .....

Medical History التاريخ الطبي

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

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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 الاضافية قد تكون ضرورية من أجل تزويدي بالعلاج الأمثل و الخدمة الافضل.

أتفهم أنه من الممكن أن يكتشف الطبيب خلال العلاج أمورا مختلفة عن ما ذكر في الفحص الأولي و التي قد تتطلب إجراءات إضافية أو مختلفة عن تلك المخطط لها.

أفوض الطبيب المعالج باتخاذ كل الاجراءات الطبية و العلاجات اللازمة و المطلوبة بحكم خبرته المهنية و العلمية.

اقر أنه لم يتم تقديم اي ضمانات او تأمين لنتائج العلاجات و الاجراءات الطبية او التجميلية المقدمة لي، كما اتفهم الاخطار و المضاعفات الناتجة عن عدم استكمال علاج حالتي المرضية.

أتفهم تماما كافة الاخطار و المضاعفات التي قد تكون مصاحبة للفحوصات والاجراءات العلاجية و الجراحية.
و ادرك ان بعض الاجراءات التشخيصية و العلاجية و الجراحية قد تؤدي الى .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 ان تسدد بالكامل قبل الانتهاء من العلاج.

أقر أن كافة المعلومات الطبية و التاريخ الطبي الذي قدمته لدى فتحي للملف صحيحة. و اتفهم ان اي معلومات تتعلق بحالتي الصحية ستبقى سرية تماما ولا يمكن الاطلاع عليها دون موافقتي

أقر أن لدي المعلومات الكاملة لتقديم هذا الاقرار و ان هذا النموذج قد تم شرحه لي بالكامل و اني قد قرأت و فهمت جميع تفاصيله بالكامل و اني وقعت عليه بكامل ارادتي

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

التاريخ: ... / ... / .....

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: ... / ... / .....

Patient Assesment Form استمارة تقييم المريض

Vital Signs المؤشرات الحيوية

Weight (الوزن): ..... Kg	Height (الطول): ..... cm	Blood Type (فصيلة الدم) : .....
Pulse (النبض): ..... ppm	Blood Pressure (ضغط الدم) : ... / ...	Blood Sugar (سكر الدم) : .....

Chief Complaint سبب زيارة المريض للعيادة

Disease History :التاريخ المرضي	.....
Allergies الحساسية	.....
Medications الأدوية	.....
Pregnancy الحمل	.....
Previous Surgeries, Hospitalization عمليات سابقة ، ادخال للمستشفى	.....

Smoking (التدخين) : Y / N Alcohol (تعاطي الكحول) : Y / N Drugs (تعاطي العقاقير): Y / N

General & Clinical Findings الملاحظات العامة و السريرية

Examination الفحص

Radiography الصور الشعاعية

Diagnosis التشخيص

File No: ..... Date: / /

Treatment Plan خطة العلاج

- Removal of Retained roots of $\overline{5|}$ + $\overline{6|}$ + $\overline{|5}$ + $\overline{|6}$ + $\overline{|7}$
- R.C.T for $\overline{7|}$ tooth + post and core.
- Filling of $\underline{|6}$ + $\underline{|7}$ + $\underline{7|}$ teeth.
- bridge 4 unit For $\overline{4\ 5\ 6\ 7|}$ teeth.
- Implant . For lower left side.

Doctor's Signature and Stamp

Dr. Dalia

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
	- Consultation + antibiotic prescription			Dr. Daly
6/5/2019				
	(1) - scalling + polishing			
	(2) - Composite Fillings For 1|1|2 one surface each one	300		Dr. Daly
7/5/2019				
	Composite For 6|5|3| 3 teeth	450		Dr. Daly

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

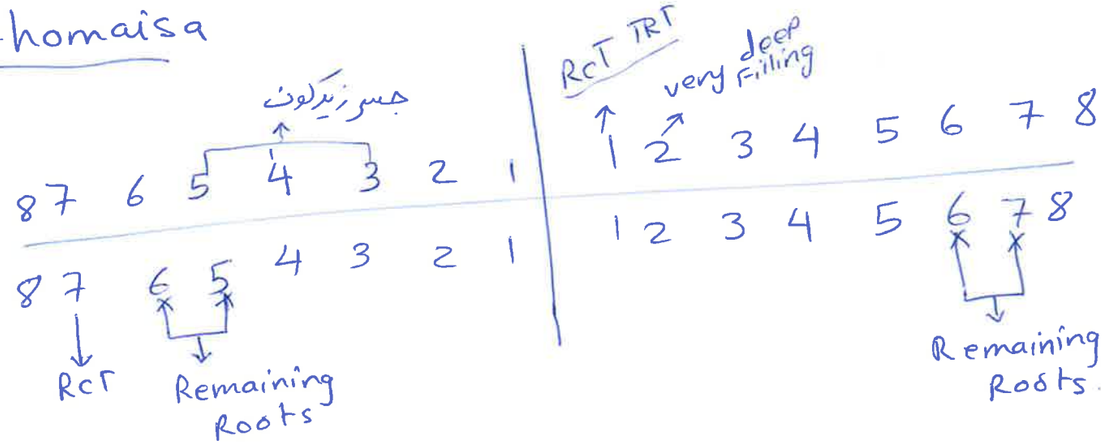
Card Holder Information

Name	Choumissa,,,,Berguem	**IDN:**	784198287598795	**Mother Name:**	
Name (Ar)	شميسه,,,,بركم	**Card Number:**	082238576	**Mother Name (Ar):**	
Title:		**Nationality:**	MAR	**Family ID:**	
Title(Ar):		**Nationality (Ar):**	المغرب		
Issue Date:	23/02/2017	**Sex:**	F	**Sponsor Type:**	03
Expiry Date:	07/02/2019	**Date of Birth:**	14/06/1982	**Sponsor Name:**	محمود غسان عبدالهادى
Marital Status:	02	**Husband IDN:**		**Sponsor Number:**	15599790
Residency Type:	03	**Residency Number:**	20120163813628	**Residency Expiry:**	07/02/2019
ID Type:	IL	**Occupation:**	99	**Occupation Field:**	00

Photo

Signature Image

chomaisa



* Dr. Khino part of Treatment (Implantation) :-

① Extraction of Remaining Roots of these teeth. ↑(Free given)

6 5	6 7

② Implants on each side of Lower Jaw : (2 implants on each side).

Total 4 Implants

4 x 1800 per implant = 7,200 + 4 Zirconium crown on each Implant ↓ 4 x 1000 per one Zirconia = 4000

So, 7,200 + 4000 = 10200

Implants cost = (11,200) Dhs.

* Dr. Dalia part :-

① RCT treatment For tooth No 12 = 450 ↓ single canal

Note *** (may be not required, depends upon patients' symptoms)

② veneers For teeth Nos

Total 14 tooth

14 x 600 per tooth

=

4 3 2 1	1 2 3 4 5

Continue →

- Veneer = 14 X 495 = 6930
- Implant = 10,200
- Crown & Bridge = 3750

Total = 20,880

X 5% / 1044

= 21,924

20.8.2019

- Examination

second stage surgery will be planned after seeing the OPG

15.10.19

Follow up after placing healing Abutments ~~10 days~~ 2 weeks ago

ORCHID MEDICAL CENTER

TREATMENT PLAN

PATIENT NAME	OMC FILE #	TREATMENT TYPE

TREATMENT PLAN	AMOUNT	NO: OF STEPS
4 implant	7800	
25/6/2019 first Impl		
Next visit Abutment impress 2/7/2019		
TOTAL AMOUNT	0	

Prepared By :

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-003285

AED 4,000.00

RECEIPT VOUCHER

Date: 09-04-2019

Receive from Mr./Mrs./M/s. **1001194 - CHOOUMISSA BERGUEM - 971543007571**

The sum of Dhs. **Four Thousand Only**

By Cash **1,000.00** / By Credit Card **3,000.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

ng **ADVANCE FOR 14 VENEER TOTAL 6930 + IMPLANT 10200 + CROWN AND BRIDGE 3750 + 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

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-003368

AED 2,000.00

RECEIPT VOUCHER

Date: 16-04-2019

Receive from Mr./Mrs./M/s. **1001194 - CHOOUMISSA BERGUEM - 971543007571**

The sum of Dhs. **Two Thousand Only**

By Cash **0.00** / By Credit Card **2,000.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

ıg **ADVANCE FOR DENTAL TREATMENT**

Made by **Super Administrator**

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

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 2,000.00 **RECEIPT VOUCHER (No.REC-003511)** **Date:30-04-2019**

Receive from Mr./Mrs./M/s. **1001194 - CHOOUMISSA BERGUEM - 971543007571**

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

By Cash **0.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **2,000.00**

Bank: Cheque No. Date: **30-04-2019**

Being

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 : **1001194 - CHOOUMISSA BERGUEM - 971543007571**

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 5,200.00 **RECEIPT VOUCHER (No.REC-003510)** **Date:30-04-2019**

Receive from Mr./Mrs./M/s. **1001194 - CHOOUMISSA BERGUEM - 971543007571**

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

By Cash **0.00** / By Credit Card **1,200.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **4,000.00**

Bank: Cheque No. Date: **30-04-2019**

Being **4 DENTAL IMPLANT**

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 : **1001194 - CHOOUMISSA BERGUEM - 971543007571**

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 300.00 **RECEIPT VOUCHER (No.REC-003605)** **Date:06-05-2019**

Receive from Mr./Mrs./M/s. **1001194 - CHOOUMISSA BERGUEM - 971543007571**

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

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

Bank: Cheque No. Date: **06-05-2019**

Being **composite filling for 2 tooth one surface each**

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 : **1001194 - CHOOUMISSA BERGUEM - 971543007571**

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-003608

AED 500.00

RECEIPT VOUCHER

Date: 07-05-2019

Receive from Mr./Mrs./M/s. **1001194 - CHOOUMISSA BERGUEM - 971543007571**

The sum of Dhs. **Five Hundred Only**

By Cash **0.00** / By Credit Card **500.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

Being **ADVANCE FOR COMPOSITE FILLINGS**

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

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 450.00 **RECEIPT VOUCHER (No.REC-003609)** **Date:07-05-2019**

Receive from Mr./Mrs./M/s. **1001194 - CHOOUMISSA BERGUEM - 971543007571**

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

By Cash **0.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **450.00**

Bank: Cheque No. Date: **07-05-2019**

Being **Composite Filling 1 Surface EACH FOR 3 TOOTH**

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 : **1001194 - CHOOUMISSA BERGUEM - 971543007571**

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-003604

AED 500.00

RECEIPT VOUCHER

Date: 06-05-2019

Receive from Mr./Mrs./M/s. **1001194 - CHOOUMISSA BERGUEM - 971543007571**

The sum of Dhs. **Five Hundred Only**

By Cash **500.00** / By Credit Card **0.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

B.g advance for scaling polishing and composite filling + 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

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

TAX INVOICE (NO. INV-C004412)

Patient File #	:	**1001194**	Visit Date	:	**06-05-2019**
Patient Name	:	**CHOOUMISSA BERGUEM**	Insurance	:	**Cash**
Doctor	:	**DR.DALIA**	Invoice Date	:	**06-05-2019**
VAT Reg #	:	**100479302000003**			

Sl.No	Code	Service	Unit Price	Quantity	Gross	Discount	VAT %	VAT Amount	Net
1.	CPT010	Composite Filling 1 Surface	150.00	2	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**
		Balance (in AED)							**0.00**
		Advance Balance (in AED)							**-300.00**

Prepared By Rana

composite filling for 2 tooth one surface each

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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PAID 6200
INV 7950
BALANCE 250 FOR Patient

8200

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

TAX INVOICE (NO. INV-C004340)

Patient File #	:	**1001194**	Visit Date	:	**30-04-2019**
Patient Name	:	**CHOOUMISSA BERGUEM**	Insurance	:	**Cash**
Doctor	:	**DR.MOHAMED AL CHINO**	Invoice Date	:	**30-04-2019**
VAT Reg #	:	**100479302000003**			

Sl.No	Code	Service	Unit Price	Quantity	Gross	Discount	VAT %	VAT Amount	Net
1.	IMP01	DENTAL IMPLANT	1,800.00	4	7,200.00	0.00	0.00	0.00	7,200.00

Gross Total (in AED)	**7,200.00**
Discount (in AED)	**0.00**
Net Total (in AED)	**7,200.00**
VAT TOTAL	**0.00**
NET + VAT TOTAL	**7,200.00**
Paid (in AED) **(Credit Card)**	**-1,200.00**
Balance (in AED)	**0.00**
Advance Balance (in AED)	**-2,000.00**

Prepared By Rana

4 DENTAL IMPLANT

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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