



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

Date: 2019 / 05 / 01

File Number: 1001404

Patient Name: Aseel Khalid Ishaq

اسم المريض:

Date Of Birth (تاريخ الميلاد): 01/12/2003

Marital Status (الحالة الاجتماعية): M / F

Nationality (الجنسية): Jordan

Occupation (الوظيفة):

Address (العنوان): Sharjah

Phone No. (رقم الهاتف): 0509126605

E-MAIL: Google

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 حديثة؟	لا	
Corticosteroids/Immunosuppressant هل تتعاطى أي ستيرويدات أو مثبطات للمناعة؟	لا	
Allergies هل لديك أي حساسية؟	لا	
Surgical Operations, Serious illness هل أجريت أي عمليات جراحية أو تعاني من أي أمراض؟	لا	
Cardiac surgery, Rheumatic fever, Endocarditis, Artificial heart valve, Congenital heart disease جراحة قلب، حمى روماتويد، التهاب شغاف القلب، صمام قلب صناعي، أمراض القلب	لا	
High Blood Pressure, Bleeding disorders, Anticoagulants هل لديك ارتفاع في ضغط الدم، مشاكل في النزيف أو تتعاطى أي مميعات الدم؟	لا	
Anemia, Leukemia (فقر الدم)، لوكيميا (سرطان الدم)	لا	
Chest disease, Asthma, Bronchitis, TB, Other أمراض صدرية، أزمة تنفسية، التهاب في الشعبات، السل، أمراض أخرى	لا	
Renal, Urinary, Sexually transmitted disease هل تعاني من أي أمراض في الكلى أو أمراض بولية أو تناسلية؟	لا	
Pregnancy, Contraceptive pill, Menstrual problems هل أنت حامل؟ هل تتعاطين أي ملتح للحمل؟ هل تعانين من مشاكل في الدورة الشهرية؟	لا	
Hepatitis, Jaundice, Other liver diseases التهاب الكبد الوبائي، الصفراء، أي أمراض كبدية أخرى	لا	
Peptic ulcer, Crohn's ulcerative colitis, Other قرحة معوية، داء كرون، أي أمراض معوية أخرى؟	لا	
Epilepsy, or any other neurological disease هل تعاني من الصرع أو أي أمراض في الجهاز العصبي؟	لا	
Thyroid Diseases, Diabetes هل تعاني من مرض السكري أو أمراض الغدة الدرقية؟	لا	
Other conditions HSV, HIV...etc	لا	



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: ... / ... /

نموذج اقرار طبي

- أوافق و أسمح للطبيب بعلاج حالتي المرضية التي تم شرحها لي من قبل الطبيب المختص و الممول.
- 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 ذكر في الفحص الأولي و التي قد تتطلب إجراءات إضافية أو مختلفة عن تلك المخطط لها.
- أفوض 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 لنتائج العلاجات و الإجراءات الطبية أو التجميلية المقدمة لي، كما أتفهم الاخطار و المضاعفات الناتجة عن عدم استكمال علاج حالتي المرضية.
- أتفهم تماماً كافة الاخطار و المضاعفات التي قد تكون مصاحبة للفحوصات و الإجراءات العلاجية و الجراحية.
- و ادرك ان بعض الإجراءات 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 لي تخفي للعلف صحيحة و أتفهم ان أي معلومات تتعلق بحالتي الصحية ستبقى سرية تماماً 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 اراضي

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

التاريخ: ١٠ / ١٩٨٠ / ٢٠١٩

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

سبب زيارة المريض للعيادة Chief Complaint

التاريخ المرضي: Disease History

Thumb Sucking

الحساسية Allergies

الأدوية Medications

الحمل Pregnancy

Previous Surgeries, Hospitalization
عمليات سابقة , ادخال للمستشفى

Smoking (التدخين): Y / N

Alcohol (الكحول): Y / N

Drugs (العقاقير): Y / N

الملاحظات العامة و السريرية General & Clinical Findings

الفحص Examination

الصور الشعاعية Radiography

Impression: photo

التشخيص Diagnosis

Class II Div I Maloc
With 6 mm overjet

Treatment Plan خطة العلاج

5/1/2019

4c. Teeth looks out.

E.O → Convex profile.

Deep mentalabial sulcus.

Recessive lower jaw

Pq. 6 mm overjet, upper bracketed.

Class II Molar, Lower Ant. crowding
Carious 6

Adv- fixed Ortho TE with 4/4 Extraction

TE Cost - 4000 A.D

Down lay - 1000 A.D

TE time - 1 yr.



5/1/2019

Upper lower Impression done
Nv - Clearing 2 Upper Bonding

Doctor's Signature and Stamp

.....

PATIENT NAME:

FILE NO#:

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
	(Braces full amount 4000)	1000	4	
8/1/2019	Upper bonding in - O18 slot Roth, 012 NiTi lig. Photo, Imp done			
30-1-2019	ligation changed, Activation done refer to Dr Dalig for 4/4 Extraction	300		
2/2/2019	Extraction of 4/1 + 4/4 teeth.	900		
11-2-2019	Lower Bonding done - 012 NiTi: ligation	300		Dr. Dalig
	Patient will pay next time he will pay 300 + what Dr. will charge			
5/3/2019	016 NiTi: upper & 012 / same in lower	last. 300 + 300		
9-7-2019	Pt came without 4/1 arch wire - 014 NiTi upper finished back Rebonding 3rd bracket from New kit & 012 NiTi: lig		300	

REDAD DATA

cAEAlOEBA83ODQyMl

Confirm Data

Public Data Readed Succ

SHOW READED 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	Aseel,Khalid,A Q.,Ishaq	IDN:	784200338685751	Mother Name:	
Name (Ar)	اسيل، خالد، عبدالقادر، اسحاق	Card Number:	084659681	Mother Name (Ar):	
Title:		Nationality:	JOR	Family ID:	
Title(Ar):		Nationality (Ar):	الأردن		
Issue Date:	31/07/2017	Sex:	F	Sponsor Type:	03
Expiry Date:	25/07/2020	Date of Birth:	01/12/2003	Sponsor Name:	خالد عبدالقادر احمد اسحاق
Marital Status:	01	Husband IDN:		Sponsor Number:	10376877
Residency Type:	03	Residency Number:	20120143129973	Residency Expiry:	25/07/2020
ID Type:	IL	Occupation:	98	Occupation Field:	00

Photo



Signature Image

No signature / بدون إمضاء / بدون

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

1/5/2019



مركز أوركييد الطبي
ORCHID MEDICAL CENTER

1,050.00

RECEIPT VOUCHER (No.REC-002195)

Date:05-01-2019

Receive from Mr./Mrs./M/s. 1001404 - ASEEL Q ISHAQ - 971509126240

The sum of Dhs. One Thousand Fifty Dirhams and Zero Fils Only

By Cash 0.00 / By Credit Card 1,050.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 05-01-2019

Being

Made by Ghada

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



مركز أوركيڤد الطبي
ORCHID MEDICAL CENTER

No: REC-002476

RECEIPT VOUCHER

AED 315.00

Date: 30-01-2019

Receive from Mr./Mrs./M/s. 1001404 - ASEEL Q ISHAQ - 971509126240

The sum of Dhs. **Three Hundred Fifteen Only**By Cash **0.00** / By Credit Card **315.00** (Bank Charges: **0.00**) / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

Being **ADVANCE 315 INCLUDING 5% VAT COLLECTED- NOW TOTAL 1000+300 COLLECTED**Made by **Ghada**

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www.omc1.ae



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

200.00

RECEIPT VOUCHER (No. REC-002503)

Date: 02-02-2019

Receive from Mr./Mrs./M/s. 1001404 - ASEEL Q ISHAQ - 97159582476

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

By Cash 0.00 / By Credit Card 200.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 02-02-2019

Being

Made by Ghada

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

315.00

RECEIPT VOUCHER (No.REC-002868)

Date:05-03-2019

Receive from Mr./Mrs./M/s. 1001404 - ASEEL Q ISHAQ - 971589582476

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**By Cash **0.00** / By Credit Card **315.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No.

Date: **05-03-2019**Being **BRACES FOLLOW UP + VAT**Made by **Hiba**

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 300.00

RECEIPT VOUCHER (No.REC-003291)

Date:09-04-2019

Receive from Mr./Mrs./M/s. 1001404 - ASEEL Q ISHAQ - 971589582476

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: 09-04-2019

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 : 1001404 - ASEEL Q ISHAQ - 971589582476

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No. REC-003428)

Date: 24-04-2019

Receive from Mr./Mrs./M/s. 1001404 - ASEEL Q ISHAQ - 971589582476

The sum of Dhs. Three Hundred Fifteen 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 315.00

Bank: Cheque No.

Date: 24-04-2019

Being BRACES FOLLOW UP + VAT FOLLOW UP DONE ON JAN 30-2019

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 : 1001404 - ASEEL Q ISHAQ - 971589582476

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No. REC-003827)

Date: 28-05-2019

Receive from Mr./Mrs./M/s. 1001404 - ASEEL Q ISHAQ - 971589582476

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

By Cash **315.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No.

Date: 28-05-2019

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 : 1001404 - ASEEL Q ISHAQ - 971589582476

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مركز أوركيڤد الطبي
ORCHID MEDICAL CENTER

AED 300.00

RECEIPT VOUCHER (No.REC-004312)

Date:03-07-2019

Receive from Mr./Mrs./M/s. 1001404 - ASEEL Q ISHAQ - 971589582476

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: 03-07-2019

Being **BRACES FOLLOW UP**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 : 1001404 - ASEEL Q ISHAQ - 971589582476

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-004648)

Date:05-08-2019

Receive from Mr./Mrs./M/s. 1001404 - ASEEL Q ISHAQ - 971589582476

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

By Cash 315.00 / By Credit Card 0.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 05-08-2019

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 : 1001404 - ASEEL Q ISHAQ - 971589582476

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مركز أوركيد الطبي
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AED 315.00

RECEIPT VOUCHER (No. REC-004957)

Date: 02-09-2019

Receive from Mr./Mrs./M/s. **1001404 - ASEEL Q ISHAQ - 971589582476**

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

By Cash **315.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No.

Date: **02-09-2019**

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 : **1001404 - ASEEL Q ISHAQ - 971589582476**

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-006175)

Date:27-11-2019

Receive from Mr./Mrs./M/s. 1001404 - ASEEL Q ISHAQ - 971589582476

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

By Cash 315.00 / By Credit Card 0.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 27-11-2019

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 : 1001404 - ASEEL Q ISHAQ - 971589582476

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