



مركز أوركييد الطبي
ORCHID MEDICAL CENTER

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

Date: 8.1.2019

File Number: 10.01429

Patient Name: Mabrouk Al-Seiari

إسم المريض: 10.01429

Date Of Birth (تاريخ الميلاد): 12/1993 M / F

Marital Status (الحالة الاجتماعية):

Nationality (الجنسية): U.S.A

Occupation (الوظيفة):

Address (العنوان): Shariyah

Phone No. (رقم الهاتف): 558803852

E-MAIL:

How did you know about us: INSTANT

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

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 تزويدي بالعلاج الأمثل و الخدمة الأفضل.
- أتفهم أنه من الممكن أن يكتشف الطبيب خلال العلاج أموراً مختلفة عن ما نكره في القصد 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 تامين لنتائج العلاجات و الإجراءات الطبية أو التجميلية المقدمة لي، كما أتفهم الإخطار و المضاعفات الناتجة عن عدم استكمال علاج حالتي المرضية.
- أتفهم تماماً كافة الإخطار و المضاعفات التي قد تكون مصاحبة للفحوصات و الإجراءات العلاجية و الجراحية.
- و أترك أن بعض الإجراءات التشخيصية و العلاجية و الجراحية قد تؤدي إلى مضاعفات كالالتهاب أو التورم أو النزيف أو الألم أو الحساسية المرضية.
- 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 قدمته لدي قنحي الملف صحيحة و أتفهم أن أي معلومات تتعلق بحالتي الصحية ستبقى سرية تماماً ولا يمكن الإفصاح 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 (من هم دون السن القانونية):

التاريخ: 19/11/2018

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

سبب زيارة المريض للعيادة

Teeth looks out

التاريخ المرضي: Disease History

الحساسية Allergies

الأدوية Medications

الحمل Pregnancy

Previous Surgeries, Hospitalization
عمليات سابقة ، ائحال للمستشفى

Smoking (التدخين): Y / N

Alcohol (الكحول): Y / N

Drugs (تعاطي العقاقير): Y / N

General & Clinical Findings الملاحظات العامة و السريرية

الفحص Examination

الصور الشعاعية Radiography

التشخيص Diagnosis

Class I Bimaxillary protrusion

Treatment Plan خطة العلاج

8/1/2019

Class I Type I Malocclusion
 with crowding & mild proclination

TE Time → 1-1/2 yr
 Cost 4wre Metal bracket, retain^{Extra}
 RF plan 4/4 Extraction ✓

3/2/2019

- Extraction of L4 + R4 teeth.

Dr. Daba

Doctor's Signature and Stamp

PATIENT NAME:

FILE NO#:

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
	Braces Down Payment (4000)	500	3500 \$	
<u>14/11/2019</u>	Extraction of 4 + 4 teeth total 200 \$	100 100 <u>200</u> \$		Dr. Dalia
<u>3/2/2019</u>	Extraction of 4 + 4 teeth.	200		Dr. Dalia
<u>24/2/2019</u>	Upper Impression done upper bonding in .010 Roth Gemini - 012 NiTi: Hyalux	500	2500	AK
<u>9/3/2019</u>	Lower bandy done - 014 Upper NiTi: - 012 NiTi: lower	300	2200.	
<u>7/4/2019</u>	.014 Upper New NiTi: Activation for derotation 3/3 uprny	300.		



مركز أوركيڤد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No. REC-008596)

Date: 25-04-2020

Receive from Mr./Mrs./M/s. 1001429 - MABROUK AL SEIARI - 971508038052

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: 25-04-2020

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 : 1001429 - MABROUK AL SEIARI - 971508038052

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



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-008331)

Date:30-03-2020

Receive from Mr./Mrs./M/s. 1001429 - MABROUK AL SEIARI - 971508038052

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: 30-03-2020

Being 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 : 1001429 - MABROUK AL SEIARI - 971508038052

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

REDAD DATA

cAEAlOEBA830DQxO

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	Mabrouk,Salim,Mabrouk,Salmeen,Alsiari	IDN:	784199365250846	Mother Name:	Wadeeah
Name (Ar)	مبروك سالم مبروك سالمين السيارى	Card Number:	086867227	Mother Name (Ar):	وادية
Title:		Nationality (Ar):	الإمارات العربية المتحدة	Family ID:	301016540
Title(Ar):		Sex:	M	Sponsor Type:	
Issue Date:	26/12/2017	Date of Birth:	01/02/1993	Sponsor Name:	
Expiry Date:	26/12/2027	Husband IDN:		Sponsor Number:	
Marital Status:	01	Residency Number:		Residency Expiry:	
ID Type:	ID	Occupation:	11	Occupation Field:	00



Photo

Signature Image

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

1/8/2019



مركز أوركييد الطبي
ORCHID MEDICAL CENTER

AED 500.00

RECEIPT VOUCHER

No: REC-002242

Date: 08-01-2019

Receive from Mr./Mrs./M/s. **1001429 - MABROUK AL SEIARI - 971508038052**

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: _____

Being **ADVANCE FOR BRACES - OFFER 4000 DHS - NON REFUNDABLE**

Made by **Ghada**

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



مركز أوركيده الطبي
ORCHID MEDICAL CENTER

200.00

RECEIPT VOUCHER (No.REC-002319)

Date:14-01-2019

Receive from Mr./Mrs./M/s. 1001429 - MABROUK AL SEIARI - 971508038052

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: 14-01-2019

Being

Made by Ghada

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



مركز أوركيده الطبي
ORCHID MEDICAL CENTER

200.00

RECEIPT VOUCHER (No.REC-002508)

Date:03-02-2019

Receive from Mr./Mrs./M/s. **1001429 - MABROUK AL SEIARI - 971508038052**The sum of Dhs. **Two Hundred Dirhams and Zero Fils Only**By Cash **200.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No.

Date: **03-02-2019**

Being

Made by **FATEN**Tel : + 9716 555 8337, Fax: + 9716 528 8130, e - mail : info@omc1.aewww.omc1.ae



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 525.00

RECEIPT VOUCHER

No: REC-002749

Date: 24-02-2019

Receive from Mr./Mrs./M/s. 1001429 - MABROUK AL SEIARI - 971508038052

The sum of Dhs. Five Hundred Twenty Five Only

By Cash 0.00 / By Credit Card 525.00 (Bank Charges: 0.00) / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank:

Cheque No.

Date:

Being PATIENT PAID THE FIRST PAYMENT OF 2500 FOR BRAISES

Made by Rana

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

www.omc1.ae



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

315.00

RECEIPT VOUCHER (No. REC-002898)

Date: 09-03-2019

Receive from Mr./Mrs./M/s. 1001429 - MABROUK AL SEIARI - 971508038052

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: 09-03-2019

Being **BRACES FOLLOW UP + VAT**Made by **Hiba**

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



مركز أوركيذ الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-003248)

Date:07-04-2019

Receive from Mr./Mrs./M/s. 1001429 - MABROUK AL SEIARI - 971508038052

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: 07-04-2019

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 : 1001429 - MABROUK AL SEIARI - 971508038052

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



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No. REC-003622)

Date: 08-05-2019

Receive from Mr./Mrs./M/s. 1001429 - MABROUK AL SEIARI - 971508038052

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: 08-05-2019

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 : 1001429 - MABROUK AL SEIARI - 971508038052

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

www.omc1.ae



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-004010)

Date:11-06-2019

Receive from Mr./Mrs./M/s. 1001429 - MABROUK AL SEIARI - 971508038052

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: 11-06-2019

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 : 1001429 - MABROUK AL SEIARI - 971508038052

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



مركز أوركيده الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-004528)

Date:28-07-2019

Receive from Mr./Mrs./M/s. 1001429 - MABROUK AL SEIARI - 971508038052

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: 28-07-2019

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 : 1001429 - MABROUK AL SEIARI - 971508038052

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



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No. REC-004855)

Date: 26-08-2019

Receive from Mr./Mrs./M/s. 1001429 - MABROUK AL SEIARI - 971508038052

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: 26-08-2019

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 : 1001429 - MABROUK AL SEIARI - 971508038052

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



مركز أوركييد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-005701)

Date:29-10-2019

Receive from Mr./Mrs./M/s. 1001429 - MABROUK AL SEIARI - 971508038052

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: 29-10-2019

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 : 1001429 - MABROUK AL SEIARI - 971508038052

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



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-006103)

Date:23-11-2019

Receive from Mr./Mrs./M/s. 1001429 - MABROUK AL SEIARI - 971508038052

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: 23-11-2019

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 : 1001429 - MABROUK AL SEIARI - 971508038052

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



مركز أوركيديك الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-007289)

Date:27-01-2020

Receive from Mr./Mrs./M/s. 1001429 - MABROUK AL SEIARI - 971508038052

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: 27-01-2020

Being 1 SESSION 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 : **1001429 - MABROUK AL SEIARI - 971508038052**

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