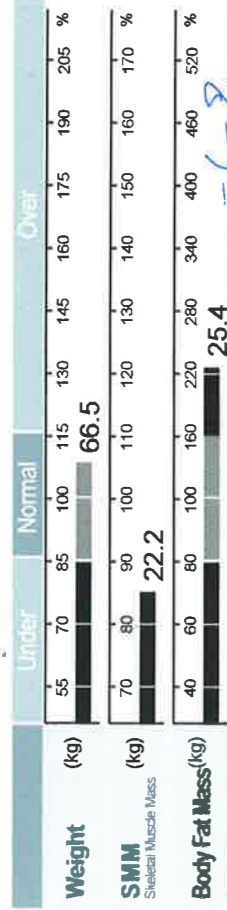


ID 200617-7 Height 169cm Age 20 Gender Female Test Date / Time 17.06.2020. 19:09

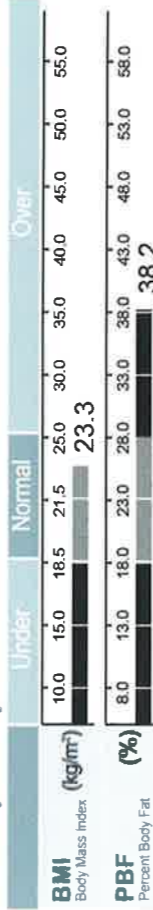
Body Composition Analysis

Total amount of water in body	Total Body Water	(L)	30.1 (31.3~38.3)
For building muscles	Protein	(kg)	8.0 (8.4~10.2)
For strengthening bones	Minerals	(kg)	2.99 (2.90~3.54)
For storing excess energy	Body Fat Mass	(kg)	25.4 (12.3~19.7)
Sum of the above	Weight	(kg)	66.5 (52.2~70.6)

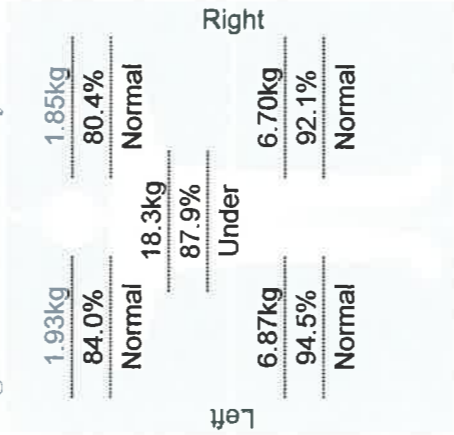
Muscle-Fat Analysis



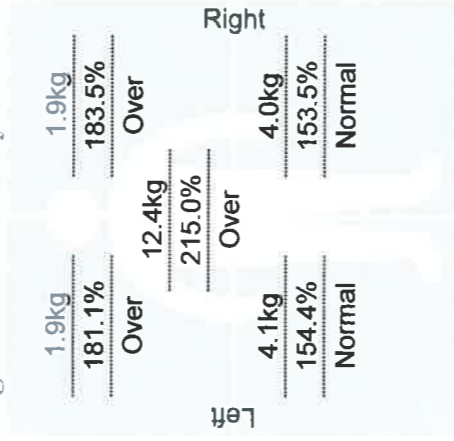
Obesity Analysis



Segmental Lean Analysis



Segmental Fat Analysis



Body Composition History

Weight (kg)	66.5
SMM (kg)	22.2

InBody Score

63 / 100 Points

* Total score that reflects the evaluation of body composition. A muscular person may score over 100 points.

Weight Control

Target Weight	61.4 kg
Weight Control	- 5.1 kg
Fat Control	- 11.3 kg
Muscle Control	+ 6.2 kg

Obesity Evaluation

BMI	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Under	<input type="checkbox"/> Slightly Over	<input type="checkbox"/> Over
PBF	<input type="checkbox"/> Normal	<input type="checkbox"/> Slightly Over	<input checked="" type="checkbox"/> Over	

Waist-Hip Ratio



Visceral Fat Level



Research Parameters

Fat Free Mass	41.1 kg
Basal Metabolic Rate	1258 kcal
Obesity Degree	108 % (90~110)
Recommended calorie intake	1787 kcal

Calorie Expenditure of Exercise

Golf	117	Gateball	126
Walking	133	Yoga	133
Badminton	150	Table Tennis	150
Tennis	200	Bicycling	200
Boxing	200	Basketball	200
Hiking	217	Jumping Rope	233
Aerobics	233	Jogging	233
Soccer	233	Swimming	233
Japanese Fencing	333	Racketball	333
Squash	333	Taekwondo	333

* Based on your current weight
* Based on 30 minute duration

Impedance

RA	LA	TR	RL	LL
Z(ω) 20 kHz	493.8	469.6	29.3	330.8
100 kHz	450.7	429.5	24.9	303.3
			286.0	



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

Date: 8/1/2019 File Number: 1001431
Patient Name: Aya AL Molki اسم المريض
Date Of Birth: 5/4/2000 Gender: M / F (الحالة الاجتماعية):
Nationality: Syria (الوطنية): Occupation: Shafjah
Address (العنوان): Phone No. (رقم الهاتف): 0504523806
E-MAIL: How did you know about us: friend

التاريخ الطبي Medical History	Yes/No نعم / لا	If 'YES' give details إذا كانت الإجابة نعم انكر بالتفصيل
الحالة الطبية Medical Condition		
Recent or current drugs/Medical Treatment هل تتعاطى أي أدوية أو تتلقى أي علاجات حديثاً؟	لا	
Corticosteroids/Immunosuppressant هل تتعاطى أي مثبوتات للمناعة؟	لا	
Allergies هل لديك أي حساسية؟	لا	
Surgical Operations, Serious Illness هل أجريت أي عمليات جراحية أو تعاطى من أي 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 أو تتعاطى أي مسهبات للدم؟	لا	
Anemia, Leukemia (سرطان الدم)، لوكيميا (نقر الدم)، Chest disease, Asthma, Bronchitis, TB, Other امراض صدرية، أزمة تنفسية، التهاب في الشعبات، المل، امراض اخرى	لا	
Renal, Urinary, Sexually transmitted disease هل تعاطى من أي امراض في الكلى أو امراض بولية أو تناسلية؟	لا	
Pregnancy, Contraceptive pill, Menstrual problems هل انت حامل؟ هل تتعاطين اي منع للحمل؟ هل تعاطين من مشاكل في الدورة الشهرية؟	لا	
Hepatitis, Jaundice, Other liver diseases التهاب الكبد الوبائي، الصفراء، أي امراض كبدية اخرى	لا	
Peptic ulcer, Crohn's ulcerative colitis, Other قرحة معوية، داء كرون، أي امراض معوية اخرى؟	لا	
Epilepsy, or any other neurological disease هل تعاطى من الصرع أو أي امراض في الجهاز العصبي؟	لا	
Thyroid Diseases, Diabetes هل تعاطى من مرض السكري أو امراض الغدة الدرقية؟	لا	
Other conditions HIV, HCV, etc هل تعاطى من أي امراض أخرى؟ فيروس الايدز، فيروس الحلا البسيط ...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):

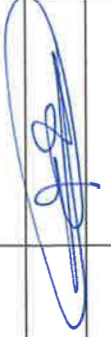

Date: ... / ... /

نموذج اقرار طبي

- أوافق و أسمح للطبيب بعلاج حالتي المرضية التي تم شرحها لي من قبل الطبيب المختص و المؤهل،
- أتفهم أن بعض الإجراءات الطبية والتشخيصية الإضافية قد تكون ضرورية من أجل تزويدي 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 التحليلية 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 الي مضاعفات كالالتهاب أو التورم أو النزيف أو الالم 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 قدمت لي قسمي للملف صحيحة. و أتفهم أن اي 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 ارادتي

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

التاريخ: 2019..11.08

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
30/1/2019	Upper Banding	300		
5/3/2019	. 014 Ni.Ti - upper Tenderness in 11/2			
1/8/2019	Lower Banding done . 014 upper Ni.Ti; 012 Ni.Ti	300		
24/10/19	cut excess wire (I.L.)			
15/1/2019	. 07644/14, 012 lower NV - 123 bracket position?	300		
20/1/2019	. 0762022 upper Ni.Ti; 1234 not in table because of 16 Extruded			
24/6/2019	. 0770025 upper Ni.Ti; 076 lower	300		
27/7/2019	1235 position Changed for leveling of Occlusion 014 Thermal Ni.Ti; - upper			will be give KFXer DAS
5/10/2019	. 016 Ni.Ti; 12/1	300		

المؤشرات الحيوية Vital Signs

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

سبب زيارة المريض للعيادة Chief Complaint

crowding

التاريخ المرضي: Disease History

الحساسية Allergies

الأدوية Medications

الحمل Pregnancy

Previous Surgeries, Hospitalization
عمليات سابقة ، احوال المستشفى

Smoking (التدخين): Y / N

Alcohol (الكحول): Y / N

Drugs (تعاطي العقاقير): Y / N

الملاحظات العامة و السريرية General & Clinical Findings

الفحص Examination

الصور الشعاعية Radiography

التشخيص Diagnosis

*u/u Missing
Crowding*

8/1/2019

Treatment Plan خطة العلاج

4c Irregular teeth
 2/0 missing already $\frac{4}{4}$ $\frac{4}{4}$ ✓
 Lower Midline shift left 2mm
 Upper Rt 2mm
 RA Motor Class I Left Class II
 Tx plan - Non Exl. Time - 1 yr.
 Cost - 3500 + Retainer change Extra

[Signature]

30/1/2019

Upper bonding done
 In DIS Roth GIC
 012 N.f: ligatured

Payment 1000 AD

[Signature]

Doctor's Signature and Stamp

.....

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	Aya,Mhd,Majed,Al Molki	IDN:	784200004149819	Mother Name:	
Name (Ar)	اىه محمد ماجد بن الملقى	Card Number:	090753104	Mother Name (Ar):	
Title:		Nationality:	SYR	Family ID:	
Title (Ar):		Nationality (Ar):	الجمهورية العربية السورية		
Issue Date:	09/09/2018	Sex:	F	Sponsor Type:	03
Expiry Date:	07/09/2020	Date of Birth:	05/04/2000	Sponsor Name:	محمد ماجد محمد عون الملقى
Marital Status:	01	Husband IDN:		Sponsor Number:	10684701
Residency Type:	03	Residency Number:	20120093143132	Residency Expiry:	07/09/2020
ID Type:	IL	Occupation:	11	Occupation Field:	00



Photo

Signature Image

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

5/28/2019



مركز أوركييد الطبي
ORCHID MEDICAL CENTER

1,050.00

RECEIPT VOUCHER (No. REC-002473)

Date: 30-01-2019

Receive from Mr./Mrs./M/s. 1001431 - AYA AL MOLKI - 971504523806

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: **30-01-2019**Being **UPPER BONDRY DOWN**Made by **Ghada**

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

www.omc1.ae



مركز أوركيديد الطبي
ORCHID MEDICAL CENTER

315.00

RECEIPT VOUCHER (No.REC-002867)

Date:05-03-2019

Receive from Mr./Mrs./M/s. 1001431 - AYA AL MOLKI - 971567449437

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**

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-003169)

Date:01-04-2019

Receive from Mr./Mrs./M/s. 1001431 - AYA AL MOLKI - 971567449437

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: 01-04-2019

Being BRACES FOLLOW UP + VAT

Made by Hibba

- 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 : 1001431 - AYA AL MOLKI - 971567449437

Tel : + 9716 555 8337, Fax: + 9716 528 8130, e - mail : info@omc1.ae
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مركز أوركييد الطبي
ORCHID MEDICAL CENTER

AED 630.00

RECEIPT VOUCHER (No.REC-003826)

Date:28-05-2019

Receive from Mr./Mrs./M/s. 1001431 - AYA AL MOLKI - 971567449437

The sum of Dhs. Six Hundred Thirty Dirhams and Zero Fils Only

By Cash 0.00 / By Credit Card 630.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 28-05-2019

Being pt came 1-5-2019 didnt pay today paid for both 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 : 1001431 - AYA AL MOLKI - 971567449437

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-004216)

Date:27-06-2019

Receive from Mr./Mrs./M/s. 1001431 - AYA AL MOLKI - 971567449437

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: 27-06-2019

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 : 1001431 - AYA AL MOLKI - 971567449437

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



مركز أوريد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No. REC-004505)

Date: 27-07-2019

Receive from Mr./Mrs./M/s. 1001431 - AYA AL MOLKI - 971567449437

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: 27-07-2019

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 : 1001431 - AYA AL MOLKI - 971567449437

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e - mail : info@omc1.ae
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مركز أوركيك الطبية
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-004983)

Date:04-09-2019

Receive from Mr./Mrs./M/s. 1001431 - AYA AL MOLKI - 971567449437

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: 04-09-2019

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 : 1001431 - AYA AL MOLKI - 971567449437

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



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 2,900.00

RECEIPT VOUCHER

No: REC-005757

Date: 01-11-2019

Receive from Mr./Mrs./M/s. **1001431 - AYA AL MOLKI - 971567449437**

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

By Cash **900.00** / 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:

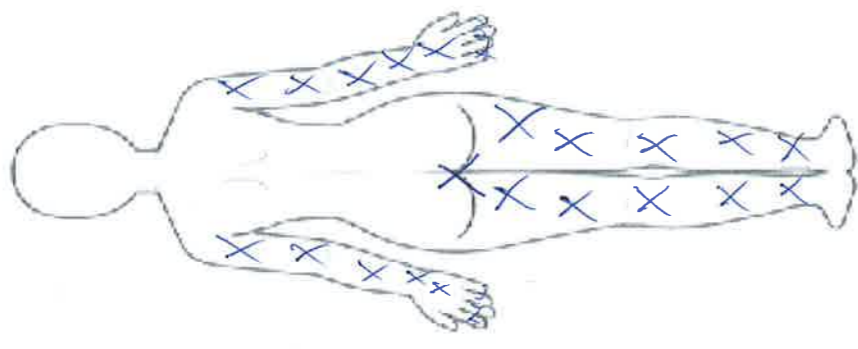
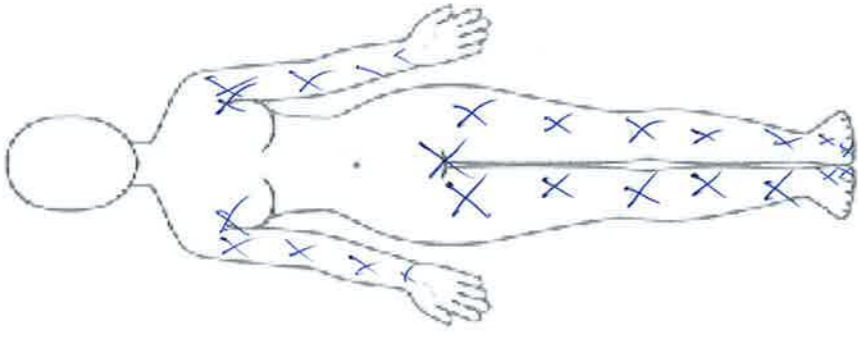
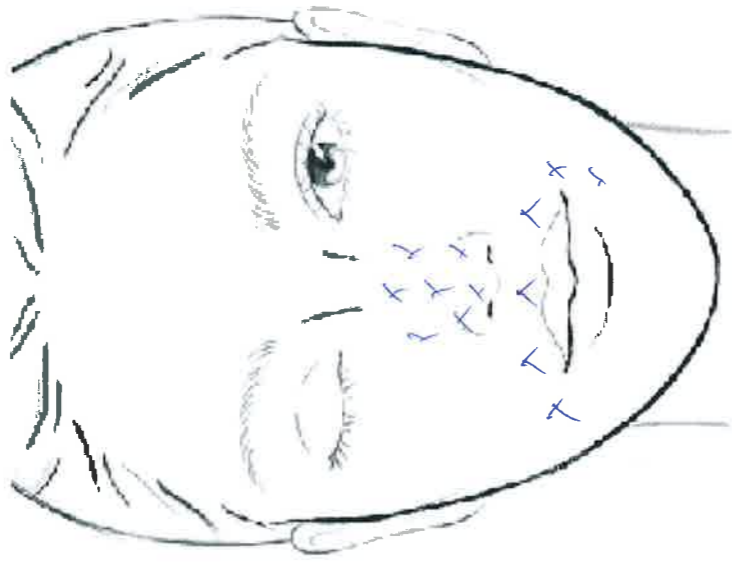
Being **ADVANCE FOR FULL BODY PKG 1 YEAR 4900 12 SESSIONS + VAT BALANCE 2245**

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
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Patient's Name: Ayeli
 File Number: 1001431
 Pain Relief given? Yes / No
 Evaluation and consent form completed? Yes / No
 Pretreatment photography taken? Yes / No



VIKINI

2nd Session

	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6
Treatment Date	11/12/19	31/01/20	3/3/20	4/4/20	5/6/20	
Treatment Area	full body	full body	full body	full body	full body	
Hair Type	DP1/FDP	Alex	Alex do	Alex do	Alex do	
Mode	24-26J	8J/10.5-12ms	8/10ms	9/10ms	9/10ms	
Fluence	7J/SHORT	Bleiss-8/7-13ms	Bikin (Nap)	Bikin YAUZO	Bikin	
Pulse Type	7pm	6:15 pm	22J/domi	1 pass	1 pass	
CNT Pulse	8:30 pm	7:15 pm	7pm	6pm	6pm	
Passes	HIRUDOID	HIRUDOID				
Starting Time						
Finish Time						
Post Treatment						

Ben

Ben

Ben

Therapist Name and Signature



مركز أوركيدي الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-006719)

Date:25-12-2019

Receive from Mr./Mrs./M/s. **1001431 - AYA AL MOLKI - 971567449437**

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: **25-12-2019**

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 : **1001431 - AYA AL MOLKI - 971567449437**

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



مركز أوركيديد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-006720)

Date:25-12-2019

Receive from Mr./Mrs./M/s. **1001431 - AYA AL MOLKI - 971567449437**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: **25-12-2019**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 : **1001431 - AYA AL MOLKI - 971567449437**

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



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 1,000.00

RECEIPT VOUCHER

No: REC-007965

Date: 03-03-2020

Receive from Mr./Mrs./M/s. **1001431 - AYA AL MOLKI - 971567449437**

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

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

Bank:

Cheque No.

Date:

Being advance for full body pkg

Made by **Rana**

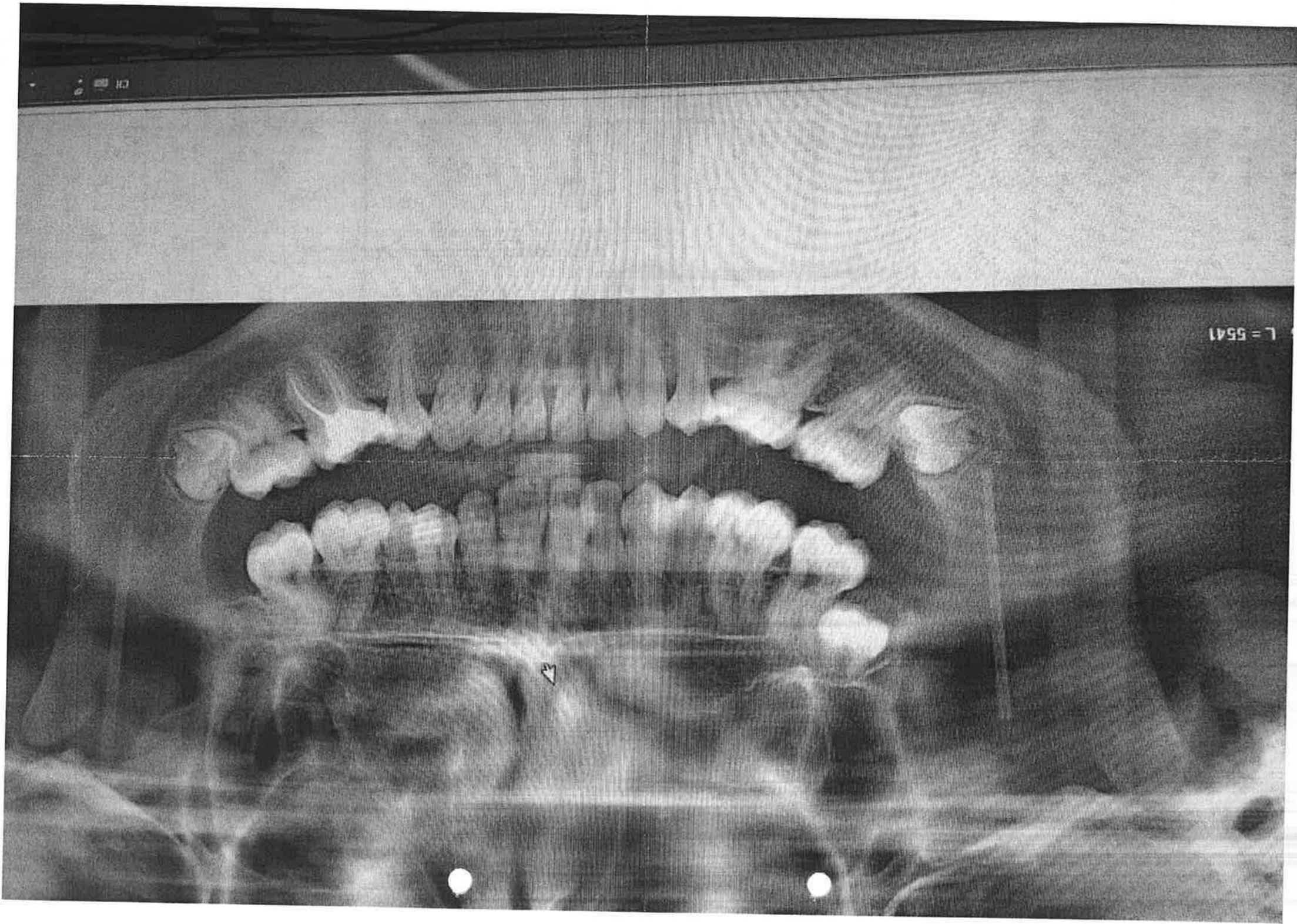
1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.

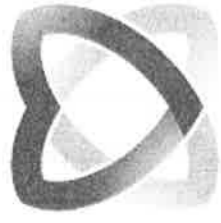
2.Treatment includes lab cost is non-refundable.

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

AED 1,000.00

RECEIPT VOUCHER

No: REC-008403

Date: 04-04-2020

Receive from Mr./Mrs./M/s. **1001431 - AYA AL MOLKI - 971567449437**

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

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

Bank:

Cheque No.

Date:

Being **FULL BODY PKG 1 YEAR TO CHANGE FROM VIKINI TO DEKA LASER**

Made by **Rana**

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- 2.Treatment includes lab cost is non-refundable.
- 3.After 48 hours No refundable accepted

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