مـركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

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

Date 27/1/2019 File Number: 1.001523

Patient Name: Saham mohail Sarhani إسم المريض:

Date Of Birth (تاريخ الميلاد) 22/05/1982 Gender (الجنس) : M / (F) Marital Status:(الحالة الاجتماعية) .....

Nationality (الجنسية): Iran Occupation (الوظيفة) : .....

Address (العنوان) : Sharjah Phone No. (رقم الهاتف): 056.1737877

E-MAIL: seedodk@yahoo.com 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 حديثًا؟	No	
Cortisteroids/Immunosuppressant هل تتعاطى أي ستيرويدات او مثبطات للمناعة؟	No	
Allergies هل لديك أي حساسية؟	No	
Surgical Operations, Serious Illness هل اجريت أي عمليات جراحية او تعاني من اي امراض؟	yes	
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 او تتعاطى أي مميعات للدم؟	No	
Anemia, Leukemia (سرطان الدم) انيميا (فقر الدم)، لوكيميا	No	
Chest disease, Asthma, Bronchitis, TB, Other امراض صدرية، ازمة تنفسية، التهاب في القصبات، السل، امراض اخرى	No	
Renal, Urinary, Sexually transmitted disease هل تعاني من اي امراض في الكلى او امراض بولية او تناسلية؟	No	
Pregnancy, Contraceptive pill, Menstrual problems هل انت حامل؟ هل تتعاطين اي مانع للحمل؟ هل تعانين من مشاكل في الدورة الشهرية؟	No	
Hepatitis, Jaundice, Other liver diseases التهاب الكبد الوبائي ، الصفراء، اي امراض كبدية اخرى	No	
Peptic ulcer, Crohn's ulcerative colitis, Other قرحة معوية، داء كرون، أي امراض معوية أخرى؟	No	
Epilepsy, or any other neurological disease هل تعاني من الصرع او اي امراض في الجهاز العصبي؟	No	
Thyroid Diseases, Diabetes هل تعاني من مرض السكري او امراض الغدة الدرقية؟	No	
Other conditions هل تعاني من أي امراض أخرى؟ HSV, HIV...etc فيروس الايدز، فيروس الحلأ البسيط	~~No~~ Na	

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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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

Teeth looks out

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

Class I Type I Bimaxillary Protrusion
lower anterior crowding

File No: .....

Date: 27/1/2019

Treatment Plan خطة العلاج

Tt plan Extraction of $\frac{4/4}{4/4}$

Tt time 1- 1½ hr.

Tt Cost- 3500, Down Payment = 1000 AD

Retainer Extra

- Impression photo done

Upper bonding in .018 Roth

014 Ni Ti Ligature

Doctor's Signature and Stamp

.....

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-008312)** **Date:26-03-2020**

Receive from Mr./Mrs./M/s. **1001523 - SAHAM SARHANI - 971561737877**

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: **26-03-2020**

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 : **1001523 - SAHAM SARHANI - 971561737877**

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

مركز اوركيد الطبي
ORCHID MEDICAL CENTER

PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
27.1	Braces	1666	ϕ	
	10/2/2019			
	Extraction of 47 tooth	150		~~Dr. Dalia~~
	8/5/2019 Pt Came after 3 months	300		
	Still no Extraction of 44			
	advice to Extract 44			
	Upper-Orthodontic N: T.			
	10/5/2019			
	Extraction of two teeth 47 + 34 teeth.	300		~~Dr. Dalia~~
1/7/2019	lower Bonding done Orthodontic N: T. Still she need 4 Extraction	300		
28-7-2019	EXT. 4	150		D. Amira
28-8-2019	تشكي من الم شديد مكان الحج Zoe in Ause			

د. اميرة حسن
Dr. Amira Hassan
ممارس عام - طبيب اسنان عام
G.P General Dentist
MOH License No.: D57288 ترخيص رقم:
Orchid Medical Centre مركز اوركيد الطبي

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	Saham,Mohayl,,,Sarhani	**IDN:**	784198283805269	**Mother Name:**	
Name (Ar)	سهام,محيل,,,مرحاني	**Card Number:**	089278281	**Mother Name (Ar):**	
Title:		**Nationality:**	IRN	**Family ID:**	
Title(Ar):		**Nationality (Ar):**	جمهورية ايران الإسلامية		
Issue Date:	29/05/2018	**Sex:**	F	**Sponsor Type:**	03
Expiry Date:	29/03/2020	**Date of Birth:**	22/05/1982	**Sponsor Name:**	رشيد سعيد فايضى نيا
Marital Status:	02	**Husband IDN:**		**Sponsor Number:**	05727196
Residency Type:	03	**Residency Number:**	20120083182377	**Residency Expiry:**	29/03/2020
ID Type:	IL	**Occupation:**	10	**Occupation Field:**	00

Photo

Signature Image

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

1,050.00 **RECEIPT VOUCHER (No.REC-002424)** **Date:27-01-2019**

Receive from Mr./Mrs./M/s. **1001523 - SAHAM SARHANI - 971561737877**

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: **27-01-2019**

Being

Made by **Ghada**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

150.00 **RECEIPT VOUCHER (No.REC-002605)** **Date:10-02-2019**

Receive from Mr./Mrs./M/s. **1001523 - SAHAM SARHANI - 971561737877**

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

By Cash **150.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **10-02-2019**

Being

Made by **Ghada**

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www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-003621)

Date:08-05-2019

Receive from Mr./Mrs./M/s. **1001523 - SAHAM SARHANI - 971561737877**

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 : **1001523 - SAHAM SARHANI - 971561737877**

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

مـركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

AED 300.00 **RECEIPT VOUCHER (No.REC-003655)** **Date:11-05-2019**

Receive from Mr./Mrs./M/s. **1001523 - SAHAM SARHANI - 971561737877**

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

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

Bank: Cheque No. Date: **11-05-2019**

Being **EXTRACTION OF 2 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 : **1001523 - SAHAM SARHANI - 971561737877**

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-004264)** **Date:01-07-2019**

Receive from Mr./Mrs./M/s. **1001523 - SAHAM SARHANI - 971561737877**

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: **01-07-2019**

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 : **1001523 - SAHAM SARHANI - 971561737877**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 150.00

RECEIPT VOUCHER (No.REC-004539)

Date:29-07-2019

Receive from Mr./Mrs./M/s. **1001523 - SAHAM SARHANI - 971561737877**

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

By Cash **150.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **29-07-2019**

Being **Extraction (Simple)**

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 : **1001523 - SAHAM SARHANI - 971561737877**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
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مـركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004946)** **Date:02-09-2019**

Receive from Mr./Mrs./M/s. **1001523 - SAHAM SARHANI - 971561737877**

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 **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 : **1001523 - SAHAM SARHANI - 971561737877**

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-005699)** **Date:29-10-2019**

Receive from Mr./Mrs./M/s. **1001523 - SAHAM SARHANI - 971561737877**

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 : **1001523 - SAHAM SARHANI - 971561737877**

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www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-006431)** **Date:09-12-2019**

Receive from Mr./Mrs./M/s. **1001523 - SAHAM SARHANI - 971561737877**

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: **09-12-2019**

Being **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 : **1001523 - SAHAM SARHANI - 971561737877**

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www.omc1.ae