مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

File No: 100.1591

Date: 9 / 2 / 2019

Date: 9 / 2 / 2019

File Number: 100159 1

Patient Name: Kamil Ali إسم المريض:

Date Of Birth (تاريخ الميلاد) 9 / 10 1991 Gender (الجنس) (M) / F

Marital Status:(الحالة الاجتماعية)

Nationality (الجنسية): EGY

Occupation (الوظيفة):

Address (العنوان):

Phone No. (رقم الهاتف): 056-6205913

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 ستروئيدات او مثبطات للمناعة؟		لا
Allergies هل لديك أي حساسية؟		لا
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 انيميا (فقر الدم)، لوكيميا (سرطان الدم)		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؟		
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؟		لا
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

مـركــز أوركــيــد الــطــبــي
ORCHID MEDICAL CENTER

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

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 are Irregular

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

Crowding of U/L Anterior
Moderate crowding – upper
Severe in lower.
Impression as done
Class I Molar

File No: ....   Date: /   /

11/2/2019

Treatment Plan خطة العلاج

Upper Non Extraction

Lower $\overline{4|4}$ Extraction (may be $\frac{4|4}{4|4}$)

Tt time – 1-1½

Tt Cost 3500 + Retainer Cost 1000 Extra

Doctor's Signature and Stamp

....

PATIENT NAME: FILE NO#:

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
11/2/2019	upper / Lower Impression done	200		
	200 Advance Paid			
24/2/2019	upper bonding done in 018 Roth Gemini 012 NiTi Ligated	800		
10/3/2019	Activation done for derotation of $\lfloor^3$	300		
19/3/2019	Scalling & polishing	150		Dr. Dalia
29/4/2019	lower Bonding done 012 NiTi ligated .014 upper NiTi	300		
27/5/2019	$\frac{6}{6}$ Tube bonded $\frac{3}{3}$ tighten for derotated 1:0 Wax given for Trauma	300		
7/7/2019	.016 NiTi upper Same in low	300		
28/7/2019	016x022 with Coil Spring upper, 016 NiTi lower	300		

REDAD DATA

cAEAIOEBAA83ODQxO

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	Kamel,Aly Abdelmotaal Aly,,,Elfawy	**IDN:**	784199159697251	**Mother Name:**	
Name (Ar)	كامل,علي عبد المتعال علي,,,الفوى	**Card Number:**	081233808	**Mother Name (Ar):**	
Title:		**Nationality:**	EGY	**Family ID:**	
Title (Ar):		**Nationality (Ar):**	مصر		
Issue Date:	14/12/2016	**Sex:**	M	**Sponsor Type:**	06
Expiry Date:	12/12/2019	**Date of Birth:**	09/10/1991	**Sponsor Name:**	ايديا ارت انتيريور ديزاين - سلطه الابداعيه
Marital Status:	01	**Husband IDN:**		**Sponsor Number:**	00
Residency Type:	07	**Residency Number:**	20120167251553	**Residency Expiry:**	12/12/2019
ID Type:	IL	**Occupation:**	98	**Occupation Field:**	00
Photo		**Signature Image**	Kamel Aly		

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-002631

AED 200.00 **RECEIPT VOUCHER**

Date: 11-02-2019

Receive from Mr./Mrs./M/s. **1001591 - KAMIL ALI - 971566205913**

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

By Cash **0.00** / By Credit Card **200.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

Being **200 ADV TAKEN FOR BRACES/FOR IMPRESSION**

Made by **Ghada**

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

مـركـــز أوركـــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

No: REC-002750

AED 800.00 **RECEIPT VOUCHER**

Date: 24-02-2019

Receive from Mr./Mrs./M/s. **1001591 - KAMIL ALI - 971566205913**

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

By Cash **0.00** / By Credit Card **800.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

Being **FIRST PAYMENT OF BRAISES TREATMENT**

Made by **Rana**

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

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ORCHID MEDICAL CENTER

315.00 **RECEIPT VOUCHER (No.REC-002918)** **Date:10-03-2019**

Receive from Mr./Mrs./M/s. **1001591 - KAMIL ALI - 971566205913**

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: **10-03-2019**

Being **BRACES FOLLOW UP + VAT**

Made by **Hiba**

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www.omc1.ae

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ORCHID MEDICAL CENTER

AED 157.50 **RECEIPT VOUCHER (No.REC-003015)** **Date:19-03-2019**

Receive from Mr./Mrs./M/s. **1001591 - KAMIL ALI - 971566205913**

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

By Cash **0.00** / By Credit Card **157.50** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **19-03-2019**

Being **SCALING & POLISHING + 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 : **1001591 - KAMIL ALI - 971566205913**

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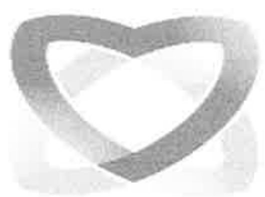

مـركـــز أوركـــيــد الــطــبــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-003494)** **Date:29-04-2019**

Receive from Mr./Mrs./M/s. **1001591 - KAMIL ALI - 971566205913**

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: **29-04-2019**

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 : **1001591 - KAMIL ALI - 971566205913**

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-003798)** **Date:27-05-2019**

Receive from Mr./Mrs./M/s. **1001591 - KAMIL ALI - 971566205913**

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: **27-05-2019**

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 : **1001591 - KAMIL ALI - 971566205913**

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ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004311)** **Date:03-07-2019**

Receive from Mr./Mrs./M/s. **1001591 - KAMIL ALI - 971566205913**

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: **03-07-2019**

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 : **1001591 - KAMIL ALI - 971566205913**

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ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004530)** **Date:28-07-2019**

Receive from Mr./Mrs./M/s. **1001591 - KAMIL ALI - 971566205913**

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: **28-07-2019**

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 : **1001591 - KAMIL ALI - 971566205913**

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ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-005235)** **Date:28-09-2019**

Receive from Mr./Mrs./M/s. **1001591 - KAMIL ALI - 971566205913**

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: **28-09-2019**

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 : **1001591 - KAMIL ALI - 971566205913**

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مـركــز أوركـــيـــد الــطــبــي
ORCHID MEDICAL CENTER

AED 315.00 RECEIPT VOUCHER (No.REC-006129) **Date:25-11-2019**

Receive from Mr./Mrs./M/s. **1001591 - KAMIL ALI - 971566205913**

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: **25-11-2019**

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 : **1001591 - KAMIL ALI - 971566205913**

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ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-007367)** **Date:31-01-2020**

Receive from Mr./Mrs./M/s. **1001591 - KAMIL ALI - 971566205913**

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: **31-01-2020**

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 : **1001591 - KAMIL ALI - 971566205913**

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