



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

File No:

Date: 24/2/19

Date: 24/2/2019

File Number: 100.166.9

Patient Name: MaiaK.hany اسم المريض:

Date Of Birth (تاريخ الميلاد): 17/5/2003 Gender (الجنس): M / (F) Marital Status (الحالة الاجتماعية):
Nationality (الجنسية): Egyptian Student

Address (العنوان): Al.Khan, Shajiah Phone No. (رقم الهاتف): 050.1381770

E-MAIL: maia.k.hany.049@gmail.com How did you know about us:

التاريخ الطبي Medical History		
الحالة الطبية Medical Condition	Yes/No نعم / لا	If 'YES' give details إذا كانت الإجابة نعم انكر بالتفصيل
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؟	No	
Surgical Operations, Serious Illness هل اجريت أي عمليات جراحية أو تعاليت 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 مميعلت للدم؟	No	
Anemia, Leukemia (فقر الدم)، لوكيميا (سرطان الدم)	No	
Chest disease, Asthma, Bronchitis, TB, Other امراض صدرية، أزمة تنفسية، التهاب في القصبات، المل، امراض اخرى	No	
Renal, Urinary, Sexually transmitted disease هل تعاليت من أي امراض في الكلى أو امراض بولية أو تناسلية؟	No	
Pregnancy, Contraceptive pill, Menstrual problems هل انت حامل؟ هل تتعاطين أي ملتح للحمل؟ هل تعالين 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 اخرى؟	No	
Epilepsy, or any other neurological disease هل تعاليت من الصرع أو أي امراض في الجهاز العصبي؟	No	
Thyroid Diseases, Diabetes هل تعاليت من مرض السكرى أو امراض الغدة الدرقية؟	No	
Other conditions HSV, HIV...etc هل تعاليت من أي امراض أخرى؟ فيروس الإيدز، فيروس الحلا البسيط	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: 21. 2. 2019

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 لتنتج 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 النزف أو الالام 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 قدمته لدي قمتي الملف صحيحة. و أتفهم أن 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 ارادتي

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

التاريخ: ... / ... /

استمارة تقييم المريض Patient Assessment Form

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

سبب زيارة المريض للعيادة Chief Complaint

Smile not good

التاريخ المرضي: Disease History

الحساسية Allergies

الأدوية Medications

الحمل Pregnancy

Previous Surgeries, Hospitalization
عمليات سابقة ، ادخال للمستشفى

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

*Midline diastema, high ferrum
Lower mild crowding
Class I Molar
16y/f.*

15/f.

خطة العلاج Treatment Plan

24/2/2019 14 TE. Non Extraction
TE Amount = 3500, Retainer Lost Extra
Nv - upper bandy ofm Photo, Imp.

5/3/2019 Photo, cleaning
upper bandy w. 010 Both hemini:

7/4/2019 -012 NiTi Hygator
lower bandy done
ofm Sealant
012 NiTi Hygator

Doctor's Signature and Stamp

PATIENT NAME:

FILE NO#:

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
5/3/2019	Upper banding after Photo in 010 Roth Gemini 012 NiTi	1000 Paid	Balance 2625	
7/4/2019	Lower banding, 012 NiTi	300		
5/5/2019	Rebanding at 54 012 NiTi; w/adjust	300		
11/6/2018	014 upper NiTi 2142 figure of 8 for MC drasket	300		
9/7/2019	016 - upper NiTi 078 0022 lower NiTi	300		
28/9/2019	Banding at 57 016 1/2 NiTi	300		
29/11/2019	017 X025 NiTi last wrap sprung back after 2 months Deband NW-class 11/2 elastics	350		
25/1/2020	Class 11 1.0 elastic 37 to 73 PC	300	3100	
26/2/2020	PC + 1.0 elastic	300		
1/4/2020	Same mechan NW-Debanding	300		

REDAD DATA

cAEAI0EBAA830DQyM

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	Malak,Hany,Mahmoud,Aly,Abdelal	IDN:	784200328748601	Mother Name:	
Name (Ar)	ملك هاني محمود علي عبدالعل	Card Number:	085645888	Mother Name (Ar):	
Title:		Nationality:	EGY	Family ID:	
Title(Ar):		Nationality (Ar):	مصر		
Issue Date:	07/10/2017	Sex:	F	Sponsor Type:	03
Expiry Date:	29/09/2019	Date of Birth:	17/05/2003	Sponsor Name:	هاني محمود علي عبدالعل
Marital Status:	01	Husband IDN:		Sponsor Number:	65107933
Residency Type:	03	Residency Number:	20120133179394	Residency Expiry:	29/09/2019
ID Type:	IL	Occupation:	98	Occupation Field:	00



Photo

Signature Image

No signature / بدون امضاء

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

2/24/2019



مركز أوركيديد الطبي
ORCHID MEDICAL CENTER

1,050.00

RECEIPT VOUCHER (No.REC-002858)

Date:05-03-2019

Receive from Mr./Mrs./M/s. 1001669 - MALAK MAHER - 971501381770

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

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

Bank: Cheque No.

Date: 05-03-2019

Being BRACES 3500 OFFER REMAINING BALANCE WITH VAT 2625

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

No: REC-003235

RECEIPT VOUCHER

Date: 06-04-2019

AED 420.00

Receive from Mr./Mrs./M/s. 1001669 - MALAK HANI - 971501381770

The sum of Dhs. Four Hundred Twenty Only

By Cash 0.00 / By Credit Card 420.00 (Bank Charges: 0.00) / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No. Date:

ing 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

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



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 420.00

RECEIPT VOUCHER (No. REC-003247)

Date: 07-04-2019

Receive from Mr./Mrs./M/s. 1001669 - MALAK HANI - 971501381770

The sum of Dhs. **Four Hundred Twenty 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 **420.00**

Bank: Cheque No.

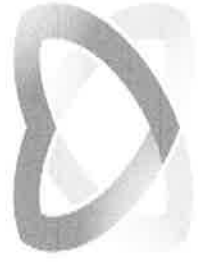
Date: 07-04-2019

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 : 1001669 - MALAK HANI - 971501381770

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

AED 315.00

RECEIPT VOUCHER (No.REC-003598)

Date:06-05-2019

Receive from Mr./Mrs./M/s. 1001669 - MALAK HANI - 971501381770

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: 06-05-2019

Being BRACES FOLLLOW 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 : 1001669 - MALAK HANI - 971501381770

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-004012)

Date:11-06-2019

Receive from Mr./Mrs./M/s. 1001669 - MALAK HANI - 971501381770

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 **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 : 1001669 - MALAK HANI - 971501381770

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-004357)

Date:09-07-2019

Receive from Mr./Mrs./M/s. 1001669 - MALAK HANI - 971501381770

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Filis 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: 09-07-2019

Being **FULL FACE LASER + 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 : 1001669 - MALAK HANI - 971501381770

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-005232)

Date:28-09-2019

Receive from Mr./Mrs./M/s. 1001669 - MALAK HANI - 971501381770

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 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 : 1001669 - MALAK HANI - 971501381770

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

AED 315.00

RECEIPT VOUCHER (No.REC-006233)

Date:29-11-2019

Receive from Mr./Mrs./M/s. 1001669 - MALAK HANI - 971501381770

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: 29-11-2019

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 : 1001669 - MALAK HANI - 971501381770

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-007871)

Date:26-02-2020

Receive from Mr./Mrs./M/s. 1001669 - MALAK HANI - 971501381770

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: 26-02-2020

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 : 1001669 - MALAK HANI - 971501381770

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مركز أوركييد الطبي
ORCHID MEDICAL CENTER

AED 315.00

RECEIPT VOUCHER (No.REC-008369)

Date:01-04-2020

Receive from Mr./Mrs./M/s. 1001669 - MALAK HANI - 971501381770

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: 01-04-2020

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 : 1001669 - MALAK HANI - 971501381770

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www.omc1.ae