مـركــز أوركــيــد الـطـبـي
ORCHID MEDICAL CENTER

صحة ... إبتسامة ... جمال
Health ... Smile ... Beauty

File No: 1001724 | Date: 5 / 3 / 2019

Date: 5 / 3 / 2019 | File Number: 1001724

Patient Name: Soumia Khademallah :إسم المريض

Date Of Birth (تاريخ الميلاد): 29 / d / 1984 Gender (الجنس): M / F | Marital Status:(الحالة الاجتماعية) Single

Nationality (الجنسية): ALGeRian | Occupation (الوظيفة): AdminisTraTion

Address (العنوان): AL Taawun Sharjah | Phone No. (رقم الهاتف): 058 - 20 - 83477

E-MAIL: | How did you know about us: facebook

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؟	No	
Cortisteroids/Immunosuppressant هل تتعاطى أي ستروريدات او مثبطات للمناعة؟	No.	
Allergies هل لديك أي حساسية؟	No.	
Surgical Operations, Serious Illness هل اجريت أي عمليات جراحية او تعاني من اي 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 او تتعاطى أي مميعات للدم؟	No.	
Anemia, Leukemia انيميا (فقر الدم)، لوكيميا (سرطان الدم)	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 أمراض أخرى؟ HSV, HIV...etc فيروس الايدز، فيروس الحلأ البسيط	No.	

مـركـز أوركـيـد الـطـبـي
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 النتاجة 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: 05/07/2014

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 at smiling

Disease History :التاريخ المرضي	
Allergies الحساسية	
Medications الأدوية	
Pregnancy الحمل	
Previous Surgeries, Hospitalization عمليات سابقة ، ادخال المستشفى	

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

Bimaxillary protrusion

Missing $\frac{76|56}{}$ 8| is very small.

File No: ....   Date: / /

Treatment Plan خطة العلاج

5/3/2019.

Tt Time 1 – 1½ yr.
Tt Cost 4000
Retainer Cost Extra
Extraction Case 4/4
She will bring x Ray.

13/3/19

for Tx of Double chin
- Tear trough

Propose : - lipodissolver
- filler

Dr. MOHAMAD FAYEZ BADAWI
D50047
Specialist Dermatology

Doctor's Signature and Stamp

27/3

1 ml filler under eyes done using 27G Cannula

VOLBELLA w lido
LOT: V15LA80093
EXP: 2020.01
1x1.0mL

Dr. MOHAMAD FAYEZ BADAWI
D50047
Specialist Dermatology

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

Patient Name: ____________________ **File No:** ______________

Date	Treatment	Payment	Balance	Signature
5-3-19	Free Consultation			
10/3/2019	– PH bring OPG	1000.		
	photo taken			
	Upper bonding in 018 Slot			
	& 012 NiTi – upper			
	advice to Extract 4/4 4/4			
30/3/19	·016 upper NiTi	300		
17/6/2019	4/4 ex ORTH	400	DANA	
6/7/2019	Lower Bonding done			
	for 7th to 7th & 7			
	·016×022 upper			
	·014 NiTi – lower			
3/7/2019	·016 RCS lower with PC	300		
2/10/2019	→ 017×025 upper	300		
	NiTi, 016 RCS lower			

REDAD DATA

cAEAIOEBAA83ODQxO

Confirm Data

Public Data Readed Succ

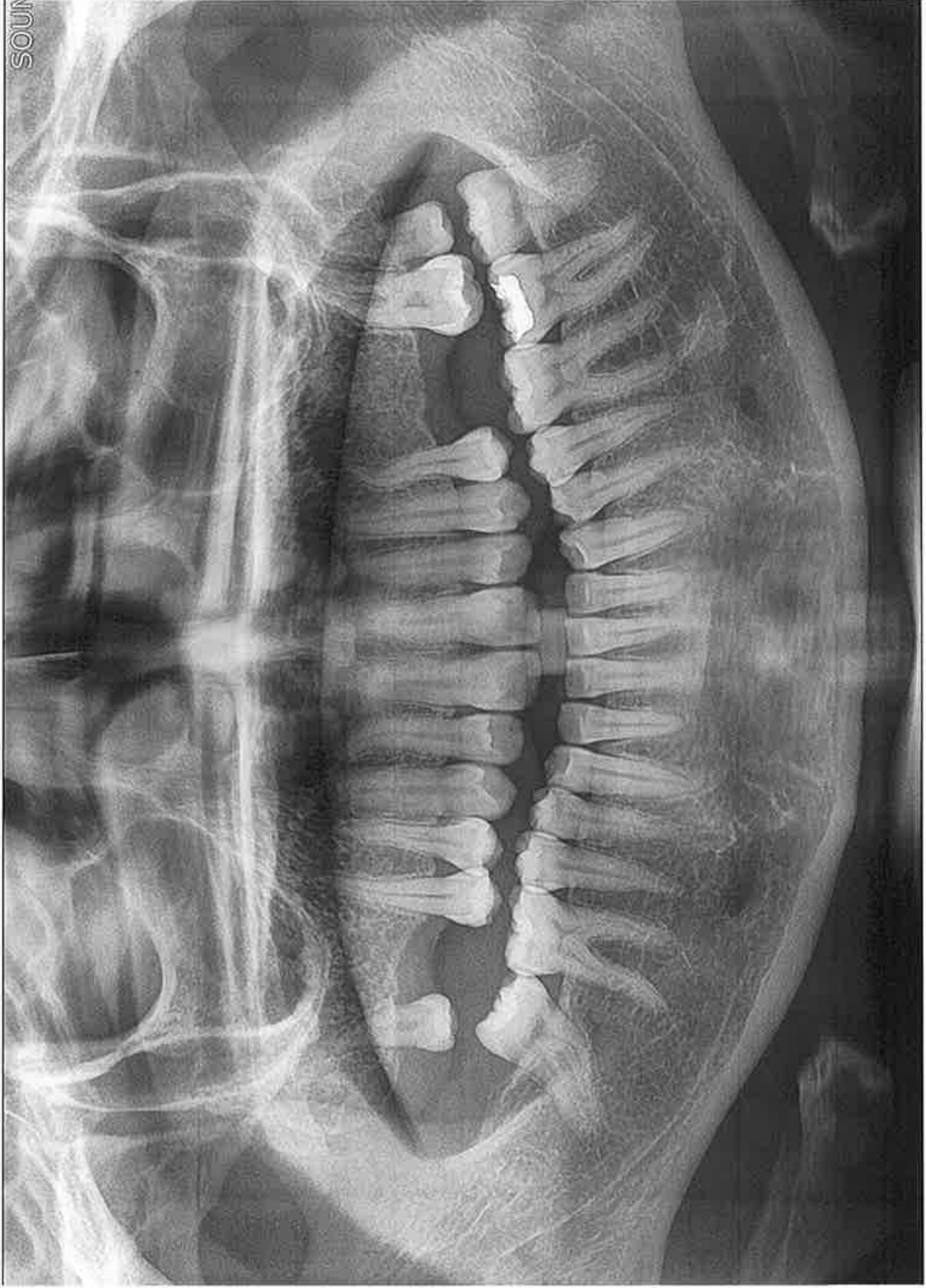
SHOW READED DATA

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	Soumia,,,,Khademallah	IDN:	784198464795412	Mother Name:	
Name (Ar)	سميه,,,,خادم الله	Card Number:	084701341	Mother Name (Ar):	
Title:		Nationality:	DZA	Family ID:	
Title(Ar):		Nationality (Ar):	الجزائر		
Issue Date:	02/08/2017	Sex:	F	Sponsor Type:	06
Expiry Date:	25/07/2019	Date of Birth:	28/01/1984	Sponsor Name:	كوزمتكس للتجاره ذ م م
Marital Status:	01	Husband IDN:		Sponsor Number:	00
Residency Type:	02	Residency Number:	20120172337709	Residency Expiry:	25/07/2019
ID Type:	IL	Occupation:	04	Occupation Field:	00
Photo		Signature Image			



مـركـــز أوركـــيــد الــطـبــي
ORCHID MEDICAL CENTER

1,050.00 **RECEIPT VOUCHER (No.REC-002917)** **Date:10-03-2019**

Receive from Mr./Mrs./M/s. **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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: **10-03-2019**

Being **BRACES DOWN PAYMENT 1000 + 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 220.00

RECEIPT VOUCHER

No: REC-002971

Date: 13-03-2019

Receive from Mr./Mrs./M/s. **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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

By Cash **220.00** / 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 **DOUBLE CHIN TRATMENT 3 SESSION 1200 ADVANCE PAID 220 AED**

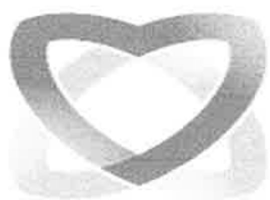
Made by **Rana**

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

Advance Allocated to under eye Filler

No Advance for Double chin Treatment

Ra



مـركــز أوركــيــد الــطــبــي
ORCHID MEDICAL CENTER

AED 1,260.00 **RECEIPT VOUCHER (No.REC-003102)** **Date:27-03-2019**

Receive from Mr./Mrs./M/s. **1001724 - SOUMIA KHADEMALLAH - 971582083477**

The sum of Dhs. **One Thousand Two Hundred Sixty Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **1,040.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **220.00**

Bank: Cheque No. Date: **27-03-2019**

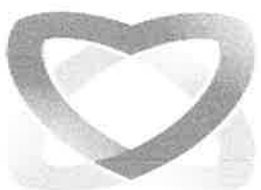
Being **UNDER EYE FILLER + VAT**

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 : **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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



مـركــز أوركـــيــد الــطــبــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-003136)** **Date:30-03-2019**

Receive from Mr./Mrs./M/s. **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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: **30-03-2019**

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 : **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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

مـركــز أوركـــيــد الــطــبــي
ORCHID MEDICAL CENTER

AED 400.00 **RECEIPT VOUCHER (No.REC-004024)** **Date:12-06-2019**

Receive from Mr./Mrs./M/s. **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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

By Cash **0.00** / By Credit Card **400.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **12-06-2019**

Being **EXTRACTION OF 2 TEETH**

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 : **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

12/06/2019

SICK LEAVE CERTIFICATE

This is to certify that MS. SOUMAYA KHADEMALLA file number(1001724) was examined and treated in orchid medical center on 12-6-2019 with the following diagnosis

DENTAL EXTRACTION

And need to have rest from 13-06-2019 to 13-06-2019

Dr. MOHAMED ALCHINO

Tel : +971 6 555 8337, Fax : +971 6 528 8130, E-mail: info@omc1.ae
www.omc1.ae

مـركــز أوركــيــد الــطــبــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004331)** **Date:06-07-2019**

Receive from Mr./Mrs./M/s. **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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: **06-07-2019**

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 : **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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-004561)** **Date:30-07-2019**

Receive from Mr./Mrs./M/s. **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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: **30-07-2019**

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 : **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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

مـركـــز أوركـــيـــد الـــطـبـــي

ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-005345)** **Date:02-10-2019**

Receive from Mr./Mrs./M/s. **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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: **02-10-2019**

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 : **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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

مـركـــز أوركــــيــد الــطــبــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-006364)** **Date:06-12-2019**

Receive from Mr./Mrs./M/s. **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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: **06-12-2019**

Being **bracing 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 : **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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

مــركـــز أوركـــيـــد الــطــبــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-007337)** **Date:29-01-2020**

Receive from Mr./Mrs./M/s. **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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: **29-01-2020**

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 : **1001724 - SOUMIA KHADEMALLAH - 971582083477**

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