مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

File No: 1001751

Date: 11 / 3 / 2019

Date: 11 / 3 / 2019 File Number: 1001751

Patient Name: Ahmed Ali احمد علي حميد :إسم المريض

Date Of Birth (تاريخ الميلاد) : 1 / 7 / 2004 Gender (الجنس) : M / F Marital Status:(الحالة الاجتماعية) .....

Nationality (الجنسية): العراق Occupation (الوظيفة) : طالب

Address (العنوان) : العراق Phone No. (رقم الهاتف): 052 888 3093

E-MAIL: ..... How did you know about us: google

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؟	X	
Cortisteroids/Immunosuppressant هل تتعاطى أي ستيرويدات او مثبطات للمناعة؟	X	
Allergies هل لديك أي حساسية؟	X	
Surgical Operations, Serious Illness هل اجريت أي عمليات جراحية او تعاني من اي امراض؟	X	
Cardiac surgery, Rheumatic fever, Endocarditis, Artificial heart valve, Congenital heart disease جراحة قلب، حمى روماتويد، التهاب شغاف القلب، صمام قلب صناعي، امراض القلب	X	
High Blood Pressure, Bleeding disorders, Anticoagulants هل لديك ارتفاع في ضغط الدم، مشاكل في النزيف او تتعاطى أي مميعات للدم؟	X	
Anemia, Leukemia (سرطان الدم) انيميا (فقر الدم)، لوكيميا	X	
Chest disease, Asthma, Bronchitis, TB, Other امراض صدرية، ازمة تنفسية، التهاب في القصبات، السل، امراض اخرى	X	
Renal, Urinary, Sexually transmitted disease هل تعاني من اي امراض في الكلى او امراض بولية او تناسلية؟	X	
Pregnancy, Contraceptive pill, Menstrual problems هل انت حامل؟ هل تتعاطين اي مانع للحمل؟ هل تعانين من مشاكل في الدورة الشهرية؟	X	
Hepatitis, Jaundice, Other liver diseases التهاب الكبد الوبائي ، الصفراء، اي امراض كبدية اخرى	X	
Peptic ulcer, Crohn's ulcerative colitis, Other قرحة معوية، داء كرون، أي امراض معوية أخرى؟	X	
Epilepsy, or any other neurological disease هل تعاني من الصرع او اي امراض في الجهاز العصبي؟	X	
Thyroid Diseases, Diabetes هل تعاني من مرض السكري او امراض الغدة الدرقية؟	X	
Other conditions هل تعاني من أي أمراض أخرى؟ HSV, HIV...etc فيروس الايدز، فيروس الحلأ البسيط	X	

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

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

انا على دراية تامة أن أي مدفوعات للمركز هي غير قابلة للاسترداد

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

التاريخ: ... / 3 / ...١٠

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.

I am fully aware that any payments is NON refundable

Patient's Signature/ Guardians (In case of minors):

Date: ١٧ / 3 / .....

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

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

Senec Crowding
Class III Malocclusion
-1 Reverse Overjet

File No: .....

Date: / /

Treatment Plan خطة العلاج

24 - 3 - 2019

Tt time — 1 - 1½ yr.

Tt Cost — 4000 AD + Retainer Cost Extra

Tt plan ¼ ¼ Ext. , Upper Expansion.

Doctor's Signature and Stamp

.....

PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
11/3/2019	Composite Filling ⌈7 tooth one surface	150		Dr. Dalia
26/3/2019	Upper bonding done in -018 Roth Gemini (3M) 012 Ni Ti Ligated Case refer to Dr Dalia for 4th Extraction	1000		
28/3/2019	Extraction of two teeth ⌈4⌉ + ⌈4	150 + 150		
	Total →	300		Dr. Dalia
1/5/2019	Upper Activation done	300		
27/5/2019	016 upper N.T. in R Coil Spring for 3 Spaces 014 lower N.T.	300		
24.6.2019	Activation done 0 Ties ligated	300		
28/7/2019	016x022 for ⌈3 root upright Coil Spring for ⌈3	300		
28/8/2019	Wide Expanded, mild RCS in 016 x022 with Coil Spring for upper ant. proclination (3 Months Same arch) PC in lower	300		

REDAD DATA

cAEAIOEBAA83ODQyMI

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	Ahmed,Ali,Hameed,,Al Shammari	**IDN:**	784200449613601	**Mother Name:**	
Name (Ar)	احمد,علي,حميد,,الشمري	**Card Number:**	092646795	**Mother Name (Ar):**	
Title:		**Nationality:**	IRQ	**Family ID:**	
Title (Ar):		**Nationality (Ar):**	العراق		
Issue Date:	17/01/2019	**Sex:**	M	**Sponsor Type:**	03
Expiry Date:	12/01/2022	**Date of Birth:**	01/07/2004	**Sponsor Name:**	على حميد سلمان الشمرى
Marital Status:	01	**Husband IDN:**		**Sponsor Number:**	28933283
Residency Type:	03	**Residency Number:**	20120183412752	**Residency Expiry:**	12/01/2022
ID Type:	IL	**Occupation:**	98	**Occupation Field:**	00

Photo

Signature Image

No signature / بدون إمضاء

التاريخ: 11 / 3 / 2019

الموضوع: لا مانع من التصوير و النشر

أنا الموقع أدناه _____ لا مانع لدي من تصوير و نشر صور او فيديو لي تم تصويره داخل مركز اوركيد الطبي على حسابات مركز اوركيد الطبي على وسائل التواصل الاجتماعية و الانترنت ولهم كامل الموافقة في النشر.

الاسم: شروق عبدالفتاح ولي الأمر

التوقيع: _____

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 150.00 **RECEIPT VOUCHER (No.REC-002939)** **Date:11-03-2019**

Receive from Mr./Mrs./M/s. **1001751 - AHMED ALI - 971528883093**

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: **11-03-2019**

Being **Composite Filling**

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 : **1001751 - AHMED ALI - 971528883093**

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

مـركـــز أوركـــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

AED 1,050.00 **RECEIPT VOUCHER (No.REC-003081)** **Date:26-03-2019**

Receive from Mr./Mrs./M/s. **1001751 - AHMED ALI - 971528883093**

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: **26-03-2019**

Being **BRACES DOWN PAYMENT + 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 : **1001751 - AHMED ALI - 971528883093**

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www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 300.00 **RECEIPT VOUCHER (No.REC-003115)** **Date:28-03-2019**

Receive from Mr./Mrs./M/s. **1001751 - AHMED ALI - 971528883093**

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

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

Bank: Cheque No. Date: **28-03-2019**

Being **EXTRUCTION 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 : **1001751 - AHMED ALI - 971528883093**

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-003527)

Date:01-05-2019

Receive from Mr./Mrs./M/s. **1001751 - AHMED ALI - 971528883093**

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: **01-05-2019**

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 : **1001751 - AHMED ALI - 971528883093**

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-003800)** **Date:27-05-2019**

Receive from Mr./Mrs./M/s. **1001751 - AHMED ALI - 971528883093**

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: **27-05-2019**

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 : **1001751 - AHMED ALI - 971528883093**

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

مـركـــز أوركـــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004181)** **Date:24-06-2019**

Receive from Mr./Mrs./M/s. **1001751 - AHMED ALI - 971528883093**

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: **24-06-2019**

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 : **1001751 - AHMED ALI - 971528883093**

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www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004526)** **Date:28-07-2019**

Receive from Mr./Mrs./M/s. **1001751 - AHMED ALI - 971528883093**

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 **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 : **1001751 - AHMED ALI - 971528883093**

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www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004873)** **Date:28-08-2019**

Receive from Mr./Mrs./M/s. **1001751 - AHMED ALI - 971528883093**

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: **28-08-2019**

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 : **1001751 - AHMED ALI - 971528883093**

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www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-005399)** **Date:05-10-2019**

Receive from Mr./Mrs./M/s. **1001751 - AHMED ALI - 971528883093**

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: **05-10-2019**

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 : **1001751 - AHMED ALI - 971528883093**

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-006112)** **Date:23-11-2019**

Receive from Mr./Mrs./M/s. **1001751 - AHMED ALI - 971528883093**

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: **23-11-2019**

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 : **1001751 - AHMED ALI - 971528883093**

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www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-006777)** **Date:28-12-2019**

Receive from Mr./Mrs./M/s. **1001751 - AHMED ALI - 971528883093**

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: **28-12-2019**

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 : **1001751 - AHMED ALI - 971528883093**

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-007384)** **Date:01-02-2020**

Receive from Mr./Mrs./M/s. **1001751 - AHMED ALI - 971528883093**

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: **01-02-2020**

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 : **1001751 - AHMED ALI - 971528883093**

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