



File No: .....

Date: 02/04/19

Date: 27/07/2019

File Number: 1001856

Patient Name: Naima Bahadav

اسم المريض: نعيمة

Date Of Birth: 23/06/1965 Gender: M / F Marital Status: Married

Marital Status: Married

Nationality: Moroccan

Marital Status: Married

Address: Sng, Atqachisa, Villa, Morocco

Phone No. (رقم الهاتف): 051729728

E-MAIL: Aulam.Almazraoui@gmail.com

How did you know about us: Google + Newspaper

التاريخ الطبي	Medical History	Yes/No نعم / لا	If 'YES' give details إذا كانت الإجابة نعم أذكر بالتفصيل
الحالة الطبية Medical Condition	Recent or current drugs/Medical Treatment هل تتعاطى أي أدوية أو تتلقى أي علاجات حثيثاً؟	✓	
Cortisteroids/Immunosuppressant هل تتعاطى أي سترويدات أو مثبطات المناعة؟	Allergies هل لديك أي حساسية؟	✓	
Surgical Operations, Serious Illness هل أجريت أي عمليات جراحية أو تعاني من أي أمراض؟	Cardiac surgery, Rheumatic fever, Endocarditis, Artificial heart valve, Congenital heart disease جراحة قلب، حمى روماتويد، التهاب شغاف القلب، صمام قلب صناعي، أمراض القلب	✓	المولودة
High Blood Pressure, Bleeding disorders, Anticoagulants هل لديك ارتفاع في ضغط الدم، مشاكل في النزيف أو تتعاطى أي مميعات الدم؟	Anemia, Leukemia (سرطان الدم)	✓	
Chest disease, Asthma, Bronchitis, TB, Other أمراض صدرية، أزمة تنفسية، التهاب في الشعبات، السل، أمراض أخرى	Renal, Urinary, Sexually transmitted disease هل تعاني من أي أمراض في الكلى أو أمراض بولية أو تناسلية؟	✓	
Pregnancy, Contraceptive pill, Menstrual problems هل أنت حامل؟ هل تتعاطين أي مانع للحمل؟ هل تعاني من مشاكل في الدورة الشهرية؟	Hepatitis, Jaundice, Other liver diseases التهاب الكبد الوبائي، الصفراء، أمراض كبدية أخرى	✓	
Peptic ulcer, Crohn's ulcerative colitis, Other قرحة معوية، داء كرون، أي أمراض معوية أخرى؟	Epilepsy, or any other neurological disease هل تعاني من الصرع أو أي أمراض في الجهاز العصبي؟	✓	
Thyroid Diseases, Diabetes هل تعاني من مرض السكري أو أمراض الغدة الدرقية؟	Other conditions HSV, HIV...etc	✓	

### 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: ... / ... / .....

### 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 بالمعالج الأمثل و الخدمة الأفضل.
- أتفهم أنه من الممكن أن يكتشف 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 الطبية.
- أقر أنه لم يتم تقديم اي ضمانات أو تأمين لنتائج العلاج و الإجراءات الطبية أو التجريبية 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 الاجراءات العلاجية و الجراحية.
- و ادرك ان بعض الاجراءات التشخيصية و العلاجية و الجراحية قد تقوي الي مضاعفات كالالتهاب أو التوريم أو النزيف أو الالام 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 قمته لي تخفي للملف صحية و اتفهم ان اي 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 بأكمل ارادتي
- انا على دراية تامة أن أي مدفوعات للمركز هي غير قابلة للاسترداد

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

التاريخ: ٢٠١٩ / ٠٩ / ٢٤

استمارة تقييم المريض Patient Assessment Form

المؤشرات الحيوية Vital Signs

Weight (الوزن): 72 Kg	Height (الطول): cm	Blood Type (دمية الدم):
Pulse (النبض): ppm	Blood Pressure (دمية الضغط): /	Blood Sugar (دمية السكر):

سبب زيارة المريض للعيادة Chief Complaint

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 (تعاظي العقاقير): Y / N

الملاحظات العامة و السريرية General & Clinical Findings

الفحص Examination

الصور الشعاعية Radiography

التشخيص Diagnosis







REDAD DATA

cAEAlOEBA830DQxO

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	Naima,,,Lahdar	IDN:	784196546398320	Mother Name:	
Name (Ar)	نعيمية,,,لاهدار	Card Number:	082376273	Mother Name (Ar):	
Title:		Nationality:	MAR	Family ID:	
Title(Ar):		Nationality (Ar):	المغرب		
Issue Date:	05/03/2017	Sex:	F	Sponsor Type:	02
Expiry Date:	01/03/2020	Date of Birth:	23/06/1965	Sponsor Name:	احلام محمد خليفة المزروعى العيوى
Marital Status:	02	Husband IDN:		Sponsor Number:	399081
Residency Type:	03	Residency Number:	60119983120297	Residency Expiry:	01/03/2020
ID Type:	IL	Occupation:	99	Occupation Field:	00



Photo

Signature Image

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

4/2/2019





مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

AED 3,200.00

RECEIPT VOUCHER

No: REC-004070

Date: 16-06-2019

Receive from Mr./Mrs./M/s. 1001856 - NAEEMA LAHDAR - 971501729728

The sum of Dhs. Three Thousand Two Hundred Only

By Cash 3,200.00 / 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 **ADVANCE FOR 24 TEETH \*550 + 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](mailto:info@omc1.ae)**  
**[www.omc1.ae](http://www.omc1.ae)**





مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

AED 500.00

RECEIPT VOUCHER

No: REC-003198

Date: 02-04-2019

Receive from Mr./Mrs./M/s. 1001856 - NAEEMA LAHDAR - 971501729728

١٥٠٠

The sum of Dhs. Five Hundred Only

By Cash 500.00 / 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:

Paying ADVANCE FOR IMPLANT

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

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e - mail : [info@omc1.ae](mailto:info@omc1.ae)  
[www.omc1.ae](http://www.omc1.ae)



مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

AED 11,000.00

RECEIPT VOUCHER (No.REC-003244)

Date:06-04-2019

Receive from Mr./Mrs./M/s. **1001856 - NAEEMA LAHDAR - 971501729728**The sum of Dhs. **Eleven Thousand Dirhams and Zero Fils Only**By Cash **10,500.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **500.00**

Bank:

Cheque No.

Date: **06-04-2019**Being **6 TOOTH IMPLANT WITHOUT 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 : **1001856 - NAEEMA LAHDAR - 971501729728**

**Tel : + 9716 555 8337, Fax: + 9716 528 8130, e - mail : [info@omc1.ae](mailto:info@omc1.ae)**  
**[www.omc1.ae](http://www.omc1.ae)**



مركز أوركيديد الطبي  
ORCHID MEDICAL CENTER

AED 500.00

RECEIPT VOUCHER (No. REC-003325)

Date: 13-04-2019

Receive from Mr./Mrs./M/s. 1001856 - NAEEMA LAHDAR - 971501729728

The sum of Dhs. Five Hundred Dirhams and Zero Fils Only

By Cash 500.00 / By Credit Card 0.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 13-04-2019

Being PT PAID 500 ( REMAINING BALANCE 1700 )

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 : 1001856 - NAEEMA LAHDAR - 971501729728

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e - mail : [info@omc1.ae](mailto:info@omc1.ae)  
[www.omc1.ae](http://www.omc1.ae)



مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

No: REC-003409

RECEIPT VOUCHER

Date: 20-04-2019

AED 500.00

Receive from Mr./Mrs./M/s. 1001856 - NAEEMA LAHDAR - 971501729728

1000

The sum of Dhs. **Five Hundred Only**By Cash **500.00** / 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 advance for dental treatment

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 500.00

RECEIPT VOUCHER

No: REC-003695

Date: 16-05-2019

Receive from Mr./Mrs./M/s. 1001856 - NAEEMA LAHDAR - 971501729728

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

By Cash **500.00** / 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 **ADVANCE FOR 2500 PKG RAMADAN OFFER**

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 500.00

RECEIPT VOUCHER (No. REC-003708)

Date: 18-05-2019

Receive from Mr./Mrs./M/s. 1001856 - NAEEMA LAHDAR - 971501729728

The sum of Dhs. **Five Hundred 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 **500.00**

Bank: Cheque No.

Date: 18-05-2019

Being **TOTAL AMOUNT PAID**

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 : 1001856 - NAEEMA LAHDAR - 971501729728

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e - mail : [info@omc1.ae](mailto:info@omc1.ae)  
[www.omc1.ae](http://www.omc1.ae)



مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

AED 1,000.00

RECEIPT VOUCHER

No: REC-003804

Date: 27-05-2019

Receive from Mr./Mrs./M/s. 1001856 - NAEEMA LAHDAR - 971501729728

*Crow*

The sum of Dhs. **One Thousand Only**

By Cash **1,000.00** / 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:

For **g ADVANCE FOR CROWNS**

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

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



مركز أوركيڤد الطبي  
ORCHID MEDICAL CENTER

AED 4,580.00

RECEIPT VOUCHER (No.REC-004802)

Date:20-08-2019

Receive from Mr./Mrs./M/s. **1001856 - NAEEMA LAHDAR - 971501729728**

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

By Cash **0.00** / By Credit Card **0.00** / By Cheque **4,580.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. **000010**

Date: **20-08-2019**

Being **CHEQUE NUMBER 000010 EMIRATES ISLAMIC BACK DATED 15/8/2019**

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 : **1001856 - NAEEMA LAHDAR - 971501729728**

**Tel : + 9716 555 8337, Fax : + 9716 528 8130, e - mail : [info@omc1.ae](mailto:info@omc1.ae)  
[www.omc1.ae](http://www.omc1.ae)**



مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

AED 500.00

RECEIPT VOUCHER (No.REC-004801)

Date:20-08-2019

Receive from Mr./Mrs./M/s. **1001856 - NAEEMA LAHDAR - 971501729728**

The sum of Dhs. **Five Hundred 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 **500.00**

Bank: Cheque No.

Date: **20-08-2019**

Being

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 : **1001856 - NAEEMA LAHDAR - 971501729728**

**Tel : + 9716 555 8337, Fax : + 9716 528 8130, e - mail : [info@omc1.ae](mailto:info@omc1.ae)  
[www.omc1.ae](http://www.omc1.ae)**



مركز أوركيڤد الطبي  
ORCHID MEDICAL CENTER

AED 1,000.00

RECEIPT VOUCHER (No.REC-004800)

Date:20-08-2019

Receive from Mr./Mrs./M/s. 1001856 - NAEEMA LAHDAR - 971501729728

The sum of Dhs. **One Thousand 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 **1,000.00**

Bank: Cheque No.

Date: 20-08-2019

Being

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 : 1001856 - NAEEMA LAHDAR - 971501729728

**Tel : + 9716 555 8337, Fax : + 9716 528 8130, e - mail : [info@omc1.ae](mailto:info@omc1.ae)**  
**[www.omc1.ae](http://www.omc1.ae)**





مركز أوركيبيد الطبي  
ORCHID MEDICAL CENTER

AED 3,200.00

RECEIPT VOUCHER (No.REC-004799)

Date:20-08-2019

Receive from Mr./Mrs./M/s. **1001856 - NAEEMA LAHDAR - 971501729728**

The sum of Dhs. **Three Thousand Two Hundred 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 **3,200.00**

Bank: Cheque No.

Date: **20-08-2019**

Being **24 CERAMIC CROWN 550 PER UNIT + 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 : **1001856 - NAEEMA LAHDAR - 971501729728**

**Tel : + 9716 555 8337, Fax : + 9716 528 8130, e - mail : [info@omc1.ae](mailto:info@omc1.ae)  
[www.omc1.ae](http://www.omc1.ae)**





مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

AED 500.00

RECEIPT VOUCHER

No: REC-003198

Date: 02-04-2019

Receive from Mr./Mrs./M/s. 1001856 - NAEEMA LAHDAR - 971501729728

The sum of Dhs. **Five Hundred Only**By Cash **500.00** / 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 advance for dental treatment

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

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e - mail : [info@omc1.ae](mailto:info@omc1.ae)  
[www.omc1.ae](http://www.omc1.ae)



مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

No: REC-003409

Date: 20-04-2019

**RECEIPT VOUCHER**

AED 500.00

Receive from Mr./Mrs./M/s. **1001856 - NAEEMA LAHDAR - 971501729728**The sum of Dhs. **Five Hundred Only**By Cash **500.00** / 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:

**Benig advance for dental treatment**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

No: REC-003695

**RECEIPT VOUCHER**

Date: 16-05-2019

AED 500.00

Receive from Mr./Mrs./M/s. **1001856 - NAEEMA LAHDAR - 971501729728**The sum of Dhs. **Five Hundred Only**By Cash **500.00** / 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: \_\_\_\_\_

ⓧ **ig advance for dental treatment**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](mailto:info@omc1.ae)**  
**[www.omc1.ae](http://www.omc1.ae)**

orchidsvr/orchid2/receipts\_advances.aspx

orcl

1/1

1/1





مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

No: REC-004070

RECEIPT VOUCHER

AED 3,200.00

Date: 16-06-2019

Receive from Mr./Mrs./M/s. **1001856 - NAEEMA LAHDAR - 971501729728**The sum of Dhs. **Three Thousand Two Hundred Only**By Cash **3,200.00** / 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 **advance for dental treatment**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**

2u Crown

↳ 22 x 550 = 12100



---

2300 → 2 Cheques

Accounts Details of Naeema-File # 1001856

Date	Treatment	LAB	Amount
31.08.2019	Implant Healing	MAC	2,250.00
09.09.2019	Implant Analog	MAC	95.00
21.09.2019	Implant & Accessories	MAC	4,470.00
03.10.2019	Screw Retainer On Implant 4x300	Manhattan	1,200.00
03.10.2019	Zircon Crown 8x250	Manhattan	2,000.00
19.10.2019	Zircon Crown 8x250	Manhattan	2,000.00
19.10.2019	screw Retainer On Implant 1x300	Manhattan	300.00
19.10.2019	Cement Retainer 1x300	Manhattan	300.00
19.10.2019	Customisation Zircon Abutment 1x400	Manhattan	400.00
old accounts	Temperory Crown	Crown	960.00
old accounts	Temperory Crown	Thuria	880.00
old accounts	Implant 6x550	Chino	3,300.00
		<b>Total</b>	<b>18,155.00</b>

Amount to be Charged for Crown Treatment 13,200.00

Amount to be Charged for Implant Treatment 13,200.00

**Total 26,400.00**

Amount Collected as on date

**17,240.00**

Balance to be Collected

**9,160.00**

Balance amount available with us as on date treatment **(915.00)**

OMC profit after all treatment & Final Payment(withour Dr. Share) **8,245.00**



نعمة النور

Name: .....

Rx

Naema Cahdar

8 upper Crowns Delivered (4, 5, 6, 8, 9, 10, 11, 12)

2 upper Crowns over Implant (3, 7)

8 Lower Crowns Delivered (21, 22, 23, 24, 25, 26, 27, 32)

4 unit Implant supported Bridge (28, 29, 30, 31)

all work re-prepared and Delivered to patient

14.1.2020  
patient came with loose Crown over Implant #7  
and severe sensitivity #13  
Crown #7 re cemented using temp bond  
patient Referred to Dr. Amira to check on #13

**Bill To**

**Orchid Medical Center**  
Al Khan Korniche, Al Khan Palace Tower  
201 Sharjah – Sharjah, Sharjah- UAE  
Tel No. : 06 555 8337  
TRN NO.

**TAX INVOICE**

TRN No.: 100006313900003  
Invoice No: 14449  
Invoice Date: 21-Sept-19  
Page: 1

Customer ID	Delivery Note No.	Sales Rep ID	Payment Terms	Due Date	
DENOMD		ADMIN	Payment upon Delivery		
NO.	Item ID	Description	Qty	Unit Price	Amount
1	DI8035-05	Legacy Closed-Tray Implant Transfer 3.5Mmd	1	150.00	150.00
2	DI8045-05	Legacy Implant Transfer 4.5Mmd	1	150.00	150.00
3	DI8035-06	Legacy Implant Analog 3.5Mmd	8	95.00	760.00
4	DI8045-06	Legacy Implant Analog 4.5Mmd	4	95.00	380.00
5	DI8035-08	Legacy Implant Open Tray Transfer 3.5Mmd	4	150.00	600.00
6	DI8035-15	Legacy Healing Collar: 3.5Mmd X 5MmI	5	150.00	750.00
7	DI8045-15	Legacy Healing Collar: 4.5Mmd X 5MmI	1	150.00	150.00
9	DI8045-31	Legacy Straight Contoured 4.5Mmd X 1MmI	1	390.00	390.00
10	DI8045-51	Legacy Angled Abutment: 4.5Mmd X 0.75MmI	1	390.00	390.00
11	DI8035-51	Legacy Angled Contoured Abutment: 3.5Mmd Platform/.75Mm Collar Height	1	390.00	390.00
12	DI8035-21	Legacy Straight Abutment , Fixation Screw 3.5Mmd X 1MmI	5	390.00	1,950.00
Payment in AED:					
Sub Total					6,060.00
VAT(0%)					-
<b>Total</b>					<b>6,060.00</b>

\*Goods once sold will not be taken back or exchanged.  
\* This bill must be settled as per agreed terms.  
\* Please affix company's stamp, certifying that goods have been received in good condition.  
\* Payment by cheque must be in favor of - **MAC DIGITAL DENTAL SYSTEMS, LLC**

Customer Signature & stamp

Authorized Signature

Sales Rep. Signature

THANKS VERY MUCH FOR YOUR BUSINESS!  
**Exclusive Distributor for:**

**BIOLASE 3shape**

Global Leader in Lasers

**NewTom**  
Cone Beam 3D Imaging



Reference : AD/Inv/6001



المركز الدولي للأشعة  
INTERNATIONAL  
RADIOLOGY CENTRE

# Tax Invoice COPY

Bill Number: 397901



297401

TRN: 1003629001000003

International Radiology Centre, First Floor, Crystal Plaza, Buhairah, SHJ - UAE

Patient : Naima Lahdar

Patient ID : 297401

Job Order Date : 22/09/2019

Job Order No : 473652

S.N.	Procedure T	List Price	Applied Price	VAT	Net Price	Paid		Pre Paid	Total Paid	Balance
						Cash	Visa			
1	CBCT	1,000.00	750.00	0	750.00	0.00	750.00	0.00	750.00	0.00
Total		1,000.00	750.00	0	750.00	0.00	750.00	0.00	750.00	0.00

Gross Total : 750.00

VAT Total : 0

Net Total : 750.00

Paid Amount : 750.00

Due Amount : 0.00

[WWW.IRC.AE](http://WWW.IRC.AE)

Print Date: 22/09/2019 2:47 PM



2019/12/16

إقرار مخالصة نهائية

أقر أنا الموقع أدناه نعيمة لحضر الجنسية المغرب  
هوية رقم: 784196546398320

انا السيدة/ نعيمة لحضر لقد استلمت من مركز اوركيد الطبي جميع الشيكات والعلاج الكامل المدفوع من قبلي  
وهذا الإقرار يعتبر مخالصة نهائية لا يحق لي بعدها مطالبة مركز اوركيد الطبي بأي شئى لا مادياً ولا معنوياً.  
وعلى ذلك أوقع،،

ارقام الشيكات المستلمة من مركز اوركيد الطبي

الشيك الاول تاريخ 2019/09/15 رقم الشيك (000009)  
الشيك الثاني تاريخ 2019/08/15 رقم الشيك (000010)

وتم دفع المتبقي 2300 درهم اماراتي من قبل السيدة نعيمة للسادة/مركز اوركيد الطبي.



المقر بما فيه ،،،  
السيدة/ نعيمة لحضر  
التوقيع:

العيادة 22 Tooth = 12100  
 x 550 =

العيادة = 2 X Implants  
 2200 = (4400)

X-RAY = (700)

---

دفع 12100  
 (4700)  
 (4400)  
 (700)

العيادة 2300  
 650









مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

AED 2,300.00

RECEIPT VOUCHER

No: REC-006556

Date: 16-12-2019

Receive from Mr./Mrs./M/s. **1001856 - NAEEMA LAHDAR - 971501729728**

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

By Cash **2,300.00** / 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 **ADVANCE FOR DENTAL TREATMENT**

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](mailto:info@omc1.ae)**

**[www.omc1.ae](http://www.omc1.ae)**

