مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

File No: 1001873

Date: 4 / 4 / 2019

Date: 4 / 4 / 2019 File Number: 1001873

Patient Name: Sawsan Saeed الحبسي سوسن سعيد إسم المريض:

Date Of Birth (تاريخ الميلاد): 20 / 5 / 1998 Gender (الجنس): M / F Marital Status:(الحالة الاجتماعية) متزوج

Nationality (الجنسية): الجزائر Occupation (الوظيفة): ربة منزل

Address (العنوان): العامرات الحبس Phone No. (رقم الهاتف): 0566211125

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 ستيرويدات 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 (سرطان الدم) انيميا (فقر الدم)، لوكيميا	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؟	لا	
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	

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 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

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

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

التاريخ: ٢٠١٩/١١/٢٠

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

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

File No: ..... Date: / /

Treatment Plan خطة العلاج

1. Scaling & polishing
2. Composite Filling on 17
3. veneers (20 tooth)

Doctor's Signature and Stamp

Dr. Dalia

ORCHID MEDICAL CENTER
مركز أوركيد الطبي

PATIENT NAME:

FILE NO#:

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
4/4/2019	~~C~~ Impression for veneers. (20 tooth)			Dr. Dalia
11/4/2019	preparation of [20] tooth for veneers. + Impression + bite registration * minimal preparation is done Shade BL1	9900 + VAT 495 / Cash 4000 cash 1395 card.	Balance = 2500 + 2 [illegible]	Dr. Dalia
22/4/2019	cementation of 20 tooth veneers			~~Dr. Dalia~~
5/5/19	Laser consultation P. fucidin	Dr. Wesam Marwan Al Tabbac / د. وسام مروان الطباع / Dermatology specialist / اخصائي جلدية / MOH License No.: V826 / Orchid Medical Centre		
5/5/19	LHR under arms ND YAG 13J/20 20 spot			
4/5/2019	cleaning of the veneers.			Dr. Dalia
2/6/2019	polishing of veneers			Dr. Dalia

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
2/6/19	LHR axilla (Deka)			Beer
	Yag- 16J/15 ms.			
4/7/2019				
	came to replace			
	Cracked veneer. 41			~~Dr. Daig~~
08/07/19	LHR U A (Deka) - 16J/14.5 ms.			
8/7/2019				
	Cementation of veneer			~~Dr. Daig~~
	For 41 tooth			
	BL1			
25-2-2020	Last free S+P			
	scalling + polishing			Amik
25/2/20	Ear piercing done. fucidin cream applied			

د. وسام مروان الطباع
Dr. Wesam Marwan Al Tabbaa
اخصائي طب الأسنان
Dermatology Specialist
ترخيص رقم: 826
Orchid Medical Center

د. اميرة حسن
Dr. Amira Hassan
ممارس عام - طبيب اسنان عام
G.P General Dentist
MOH License No.: D57288 ترخيص رقم:
Orchid Medical Centre مركز اوركيد الطبي

REDAD DATA

cAEAIOEBAA83ODQxO

Public Data Readed Succ

SHOW READED DATA

Confirm Data

Public Data Verification report

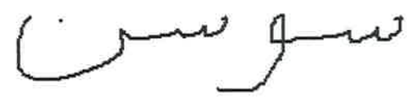
File	Valid Signature?
Non-Modifiable Data (SF3)	False
Modifiable Data (SF5)	False
Holder Signature Image (SF7)	False
Photography	False
Home Address	False
Work Address	False

Card Holder Information

Name	Sawsan,Saeed,Mohammed,Bin Alwan,Alhebsi	**IDN:**	784199063147906	**Mother Name:**	
Name (Ar)	سوسن,سعيد,محمد,بن علوان,الحبسي	**Card Number:**	088007861	**Mother Name (Ar):**	
Title:		**Nationality:**	ARE	**Family ID:**	609002481
Title(Ar):		**Nationality (Ar):**	الإمارات العربية المتحدة		
Issue Date:	05/03/2018	**Sex:**	F	**Sponsor Type:**	
Expiry Date:	05/03/2028	**Date of Birth:**	20/05/1990	**Sponsor Name:**	
Marital Status:	02	**Husband IDN:**		**Sponsor Number:**	
Residency Type:		**Residency Number:**		**Residency Expiry:**	
ID Type:	ID	**Occupation:**	99	**Occupation Field:**	00

Photo

Signature Image



مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-003225

AED 5,395.00

RECEIPT VOUCHER

Date: 04-04-2019

Receive from Mr./Mrs./M/s. **1001873 - SAWSAN SAEED - 971553737173**

The sum of Dhs. **Five Thousand Three Hundred Ninety Five Only**

By Cash **4,000.00** / By Credit Card **1,395.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

eing **ADVANCE FOR VENEERS OFFER 4900 + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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Bank: Cheque No. Date:

being **ADVANCE FOR VENEERS OFFER 4900 + 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

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www.omc1.ae

Sawsan Saeed File no: (100873)

ORCHID MEDICAL CENTER

MODE OF PAYMENT RECEIVED FOR LAB PROCEDURE

NO: TEETH	RATE / TEETH	TOTAL AMT OF TREATMENT:	ADVANCE COLLECTED	CASH	CARD	CHEQUE	BALANCE
Veneers 9900 offer	495	9900	advance collected 5395/-	4000	1395		

BALANCE AMOUNT

INSTALLMENT DETAILS

BANK NAME	DT: CHQ	CHQ #	INSTALLMENT AMT	CHQ REPLACEMENT DETAILS
NBAD	1-5-19	000125	2500	
NBAD	1-6-19	000139	2500	
TOTAL			5000	

→ collected - L. Rajim.

Rema 11-4-19

CHQ COLLECTED FROM FRONT DESK:

NAME & SIGNATURE WITH DT :

22/04/2019


United Arab Emirates

Identity Card

دولة الإمارات العربية المتحدة

بطاقة هوية

رقم الهوية / ID Number

784-1986-2684135-1

الإسم: خليفه راشد محمد الخنبولي الشحي

Name: Khalifa Rashed Mohammed Alkhanbooli Alshehhi

الجنسية: الإمارات العربية المتحدة

Nationality: United Arab Emirates

فرع النخيل - رأس الخيمة
AL NAKHEEL

بنك أبوظبي الوطني
NATIONAL BANK OF ABU DHABI
Public Joint Stock Company

000125

Date 01/05/2019 التاريخ

Pay against this cheque to or the Bearer — ادفعوا بموجب هذا الشيك الى أو لحامله

Orchid Medical Center

Dirhams Two Thousand Five Hundred درهم — 2500/—

Only

KHALIFA RASHED MOHAMED ALKHANBOOLI

Signature التوقيع
Please do not sign or print below this line

⑈000125⑈ ⑆403560170⑆ ⑈6201718632⑈

Done

فرع النخيل - رأس الخيمة
AL NAKHEEL

NATIONAL BANK OF ABU DHABI
بنك أبوظبي الوطني

000139

Date 01/06/2019 التاريخ

Elite

Pay against this cheque to or the Bearer
ادفعوا بموجب هذا الشيك الى أو لحامله

Orchid Medical Center

Dirhams Two Thousand Five Hundred درهم

AED 2500/—

Only

KHALIFA RASHED MOHAMED ALKHANBOOLI

Signature التوقيع
Please do not sign or print below this line

⑈000139⑈ ⑆403560170⑆ ⑈6201718632⑈

Cheque Returned and Received the Amount 2500.00 Cancel on - 02/06/19

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-003225

AED 5,395.00

RECEIPT VOUCHER

Date: 04-04-2019

Receive from Mr./Mrs./M/s. **1001873 - SAWSAN SAEED - 971554669663**

The sum of Dhs. **Five Thousand Three Hundred Ninety Five Only**

By Cash **4,000.00** / By Credit Card **1,395.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

. ng **ADVANCE FOR VENEERS OFFER 4900 + 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

Veneer Treatment Form **طلب تركيب فينير الاسنان**

Colour Been Chosen BL1 اللون الذي تم اختياره.....

Design Been Chosen Normal shape as her origional teeth. التصميم الذي تم اختياره .....

Quantity Agreed to Order 20 العدد المتفق على تركيبه.....

Notes: **ملاحظات أخرى:**.....

I have red and agreed to the mentioned specifications above and Orchid Medical Center is not responsible of any change that not matching the above mentioned Specs.

لقد قرأت و أوافق على المواصفات التي تم الإشارة إليها في هذه الورقة و أخلي مسؤولية مركز اوركيد الطبي من أي تغيير لا يطابق المواصفات المشار اليها.

Patient Name: SAW SAN SAEED **اسم المريض:** .....

Date: 22 / 4 /2019 **التاريخ:** 2019 / /

Signature:..... **التوقيع:** .....

Dr. Daha

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 5,395.00 **RECEIPT VOUCHER (No.REC-003420)** **Date:22-04-2019**

Receive from Mr./Mrs./M/s. **1001873 - SAWSAN SAEED - 971554669663**

The sum of Dhs. **Five Thousand Three Hundred Ninety-Five 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 **5,395.00**

Bank: Cheque No. Date: **22-04-2019**

Being **TOTAL AMOUNT FOR 20 TOOTH VENEER OFFER 9900 + VAT PAID 5395 AND THE BALANCE 5000 BY 2 CHEQUES**

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 : **1001873 - SAWSAN SAEED - 971554669663**

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

مـركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-003554)** **Date:04-05-2019**

Receive from Mr./Mrs./M/s. **1001873 - SAWSAN SAEED - 971554669663**

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: **04-05-2019**

Being **3 SESSION UNDER ARMS + 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 : **1001873 - SAWSAN SAEED - 971554669663**

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

أنا صاحب الشيك / سلاح الشيخ

فرع النخيل – رأس الخيمة
AL NAKHEEL

NATIONAL BANK OF ABU DHABI

000139

Date 01/06/2019

Elite

Pay against this cheque to or the Bearer — Orchid Medical Center

ادفعوا بموجب هذا الشيك الى أو لحامله

Dirhams — Two Thousand Five Hundred — درهم

AED 2500/—

Only

KHALIFA RASHED MOHAMED ALKHANBOOLI

Signature التوقيع

Please do not sign or print below this line

⑈000139⑆403560170⑆620171863 2⑈

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 2,500.00 **RECEIPT VOUCHER (No.REC-003925)** **Date:02-06-2019**

Receive from Mr./Mrs./M/s. **1001873 - SAWSAN SAEED - 971554669663**

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

By Cash **0.00** / By Credit Card **2,500.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **02-06-2019**

Being **AMOUNT RECD AGAINST CHQ # 000139/01.06.2019 & CHQ RETUNED TO PATIENT**

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 : **1001873 - SAWSAN SAEED - 971554669663**

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

EMIRATES ISLAMIC BANK

Cheque Return Memo

مذكرة إعادة شيـــك

Dated	02/06/2019	التاريخ:
Ref	034152003010016	الإشارة:
Branch Name	QASIMIYAH BRANCH	اسـم الفرع:
Beneficiary Name	ORCHID MEDICAL CENTRE	أسـم المستفيد:
Beneficiary Address		عنوان المستفيد:
Beneficiary Account	3708204945401	حساب المستفيد:

The cheque, details as indicated below was returned unpaid for the reason stated by the drawn on bank.

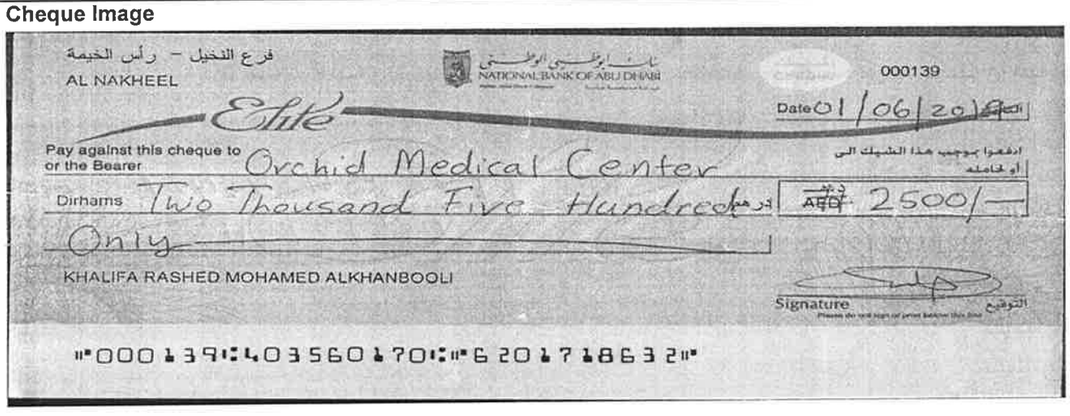
نفيد بهذا أن الشـيك الواردة تفاصيله أدنـاه قد أعيد دون سداد، وذلك للأسباب التي أوردها البنك المسحوب عليه الشيك.

Drawn On Bank	NATIONAL BANK OF ABU DHABI	البنك المسحوب عليه الشيك
Drawn On Bank Branch	AL NAKHEEL	فرع البنك المسحوب عليه الشيك
Drawn On Account	6201718632	حساب المسحوب عليه الشيك
Date of Return	01/06/2019	تاريخ إرجاع الشيك
Cheque Number	000139	رقم الشيك
Cheque Amount	2,500.00	مبلغ الشيك
	N	
Return Reason Code	A	رمز إعادة الشيك

Return Reason Description — *وصف أسباب إعادة الشيك*

Insufficient Funds (INF)	عدم كفاية الرصيد

Cheque Image



إشعار يصدر آليا – لا يتطلب توقيع

Advice System Generated - No Signature Required

مـركـــز أوركـــيـــد الـــطـبـــي
ORCHID MEDICAL CENTER

AED 2,500.00 **RECEIPT VOUCHER (No.REC-004405)** **Date:16-07-2019**

Receive from Mr./Mrs./M/s. **1001873 - SAWSAN SAEED - 971554669663**

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

By Cash **0.00** / By Credit Card **0.00** / By Cheque **2,500.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. **000125** Date: **16-07-2019**

Being **CHQ NO:000125 NBAD CHQ DATE 1-5-2019**

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 : **1001873 - SAWSAN SAEED - 971554669663**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

7522-0100
Stainless
Tiff 4mm
Cubic Zirconia

SYSTEM
EAR PIERCING EARRINGS

STUDEX

Classic are stainless, gold plated
EC/FDA Compliant

Sterile: Lot Number & Exp.

1614523019 AUG2029

LOS ANGELES, CA 90245-5012 U.S.A.

0 48675 64100 5

Piercing Consent Form

Clinic Name: ORCHID MEDICAL CENTRE

Clinic Address: SHARJAH

City: Country

Customers Name: Ms. AHLAM WALEED

Date of Birth: / / 4/7/85. SAWSAN SAEED If under 24 months old, had their vaccinatio

Customer Address: 100873.

Mobile: 0504342585. E-mail:

Sterilization Lot Number: 1 6 1 4 5 2 3 0 19 Product Code: 7 5 2 2 0 1 0 0

I hereby authorized to have my / my child / my grandchild _____ to be pierced, I have read and understand the following information which is very important in limiting or reducing post piercing problems during aftercare. By my signature below, I declare the following;

- I /He / She is not under the care of Medical Doctor/s for any medical condition or otherwise prohibiting from piercing procedure.
- I / He/ She do not suffer from Diabetes, Epilepsy, Hepatitis, HIV /AIDS, Hemophilia, Dizziness or any heart condition, further not under the influence or regular prescribe medication such as blood thinning medication.
- I am not under the influence of drugs or alcohol. I am not pregnant.
- I have been informed about the piercing procedure and given a copy of piercing after care Instructions, which I have read and understand. I understand that after piercing care procedure varies depending on whether the piercing is of the ear lobe / ear cartilage / nose or belly / naval. I have noted the differences.
- I understand that the possibility or infection may exist due to improper hygiene, metal sensitivity or other causes, however the most common is due to a failure to carefully follow to recommend After Care Procedure.
- I understand and accept that ear piercing in the ear cartilage may carry a greater possible risk of redness, swelling and infection due to the nature of piercing the area of the ear and I knowingly accept this risk.
- I understand that due to the nature of the piercing, exposure of newly pierced area to certain environments such as swimming and participation in athletic events (exercising) may increase the likelihood of infection.
- I will follow Piercing after Care Procedure.
- In case of belly/naval piercing, I am aware that my skin/ body may reject the foreign metal causing for piercing to close.
- I am over the age of _____ or consent on behalf of a minor, under the age of consent, that I am the parent or legal guardian of such minor understand that a minor signing as commits an act of fraud.

By signing this Piercing Consent Form, I hereby acknowledge that I understand the AFTERCARE procedure and the risk of infection. Knowing the risks, I consent to having my/ daughter / son _____ pierced by a medical professional of this clinic and as consideration for the clinic agreeing to pierce my/ ~~daughter~~ _____ and to the extent permissible by law I willfully assume all responsibility for injury or loss, of any kind, that may be associated with this piercing procedure. If signing as parent or legal guardian on behalf of a minor, I will hold myself liable and will indemnify the clinic and its staff/s, manufacturer, importers, distributor, promoters and will I further understand that making a false statement constitutes an act of fraud.

_____ Date: _____
Customer/ Parent/ Legal guardian Signature (if customer is under the legal age, this must be signed by the parent or legal guardian)

_____ Date: _____
Medical Professional.

Beer 25/2/20

Clinic file copy, keep safe for customer records, attached products sterilization reference here.