مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

File No: 1001937

Date: 31/3/2019

Date: 31/3/2019

File Number: 1001937

Patient Name: Atefa

إسم المريض: عاطفة أغنياني

Date Of Birth (تاريخ الميلاد) 29/4/1989

Gender (الجنس): M (F)

Marital Status: (الحالة الاجتماعية) ....

Nationality (الجنسية): إيران

Occupation (الوظيفة): ....

Address (العنوان): الشارقة-القادسية

Phone No. (رقم الهاتف): 0561443998

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؟	No	
Cortisteroids/Immunosuppressant هل تتعاطى أي ستيرويدات 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 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.

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

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

Class I Bimaxillary protrusion

File No: .... Date: / /

Treatment Plan خطة العلاج

Doctor's Signature and Stamp

....

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
	ORTHO up/L w EX 4/4 4/4 } 800			
16/4/2019	Fix Braces + band tube } → 3500 ctt 0.12			
	Br. maxillary protrusion	500	3000	
	DR Aledrisi			
24/4/2019	TSC Rebonding New			
27/5/2019	Pt from Dr Chinoo wants to continue with us Tx Today her 4/4 Extraction done by Dr Dalia & 016 U/L N.T. ligated	300+300 of Extraction of 2 teeth		
24/6/2019	Extraction of 4/4 150 + 150 = 300		300 300 600	Today
	5/1 bonding 016 Upper N.T. 014 Lower			
28/7/2019 →	016 Lower N.T. PC in U/L N.T.	300		

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 162.75 **RECEIPT VOUCHER (No.REC-008635)** **Date:30-04-2020**

Receive from Mr./Mrs./M/s. **1001937 - ATEFEH AGHNIAEI - 971561443998**

The sum of Dhs. **One Hundred Sixty-Two Dirhams and Seventy-Five Fils Only**

By Cash **162.75** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **30-04-2020**

Being

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 : **1001937 - ATEFEH AGHNIAEI - 971561443998**

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

مـركـــز أوركـــيـــد الــطــبــي
ORCHID MEDICAL CENTER

AED 525.00 **<u>RECEIPT VOUCHER (No.REC-003367)</u>** **Date:16-04-2019**

Receive from Mr./Mrs./M/s. **1001937 - ATEFA 0 - 971561443998**

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

By Cash **0.00** / By Credit Card **525.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **16-04-2019**

Being **BRACES FIRST PAYMENT 500 + VAT TOTAL PRICE 3500**

Made by **Super Administrator**

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 : **1001937 - ATEFA 0 - 971561443998**

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

مـركـــز أوركــــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

AED 615.00 **RECEIPT VOUCHER (No.REC-003799)** **Date:27-05-2019**

Receive from Mr./Mrs./M/s. **1001937 - ATEFA 0 - 971561443998**

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

By Cash **0.00** / By Credit Card **615.00** / 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+ 2 TEETH EXTRACTION**

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 : **1001937 - ATEFA 0 - 971561443998**

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

مـركــز أوركـــيــد الــطــبــي
ORCHID MEDICAL CENTER

AED 615.00 RECEIPT VOUCHER (No.REC-004171) **Date:24-06-2019**

Receive from Mr./Mrs./M/s. **1001937 - ATEFA 0 - 971561443998**

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

By Cash **0.00** / By Credit Card **615.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **24-06-2019**

Being **extraction + 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 : **1001937 - ATEFA 0 - 971561443998**

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

مـركــز أوركـــيـد الــطـبــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004524)** **Date:28-07-2019**

Receive from Mr./Mrs./M/s. **1001937 - ATEFEH AGHNIAEI - 971561443998**

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: **28-07-2019**

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 : **1001937 - ATEFEH AGHNIAEI - 971561443998**

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

United Arab Emirates دولة الإمارات العربية المتحدة

Resident Identity Card — بطاقة هوية مقيم

ID Number / رقم الهوية

784-1989-9418760-1

الإسم: عاطفه احمد نور اغنياني

Name: Atefeh Ahamad Noor Aghniaei

الجنسية: جمهورية ايران الإسلامية

Islamic Republic of

مـركــز أوركـــيـد الــطــبــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-007434)** **Date:03-02-2020**

Receive from Mr./Mrs./M/s. **1001937 - ATEFEH AGHNIAEI - 971561443998**

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: **03-02-2020**

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 : **1001937 - ATEFEH AGHNIAEI - 971561443998**

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-004852) **Date:26-08-2019**

Receive from Mr./Mrs./M/s. **1001937 - ATEFEH AGHNIAEI - 971561443998**

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: **26-08-2019**

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 : **1001937 - ATEFEH AGHNIAEI - 971561443998**

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

مـركــز أوركـــيــد الـــطــبــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-005408)** **Date:05-10-2019**

Receive from Mr./Mrs./M/s. **1001937 - ATEFEH AGHNIAEI - 971561443998**

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: **05-10-2019**

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 : **1001937 - ATEFEH AGHNIAEI - 971561443998**

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

مـركـــز أوركــــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-006200)** **Date:28-11-2019**

Receive from Mr./Mrs./M/s. **1001937 - ATEFEH AGHNIAEI - 971561443998**

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: **28-11-2019**

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 : **1001937 - ATEFEH AGHNIAEI - 971561443998**

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-006804) **Date:30-12-2019**

Receive from Mr./Mrs./M/s. **1001937 - ATEFEH AGHNIAEI - 971561443998**

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: **30-12-2019**

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 : **1001937 - ATEFEH AGHNIAEI - 971561443998**

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

مـركـــز أوركــــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-007990)** **Date:04-03-2020**

Receive from Mr./Mrs./M/s. **1001937 - ATEFEH AGHNIAEI - 971561443998**

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: **04-03-2020**

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 : **1001937 - ATEFEH AGHNIAEI - 971561443998**

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