مـركــز أوركــيــد الــطــبــي
ORCHID MEDICAL CENTER

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

File No: ....

Date: 1 / 5/ 19

Date: ... / ... / ....

File Number: 100 20 77

Patient Name:....Ahlam Abdulleh.......... أحلام عبدالله فارس عامر ....: إسم المريض

Date Of Birth (تاريخ الميلاد) 27 / 5 / 1993 Gender (الجنس) : M / (F)

Marital Status:(الحالة الاجتماعية) ....عزباء.....

Nationality (الجنسية): ....اردنية......

Occupation (الوظيفة) : ....معلمة لغة عربية........

Address (العنوان) :...........الشارقة - الجادة.........

Phone No. (رقم الهاتف): 0543003173..........

E-MAIL: ahlam2705@yahoo.com............

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

مـركـــز أوركــــيـــد الـــطـــبـــي
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.

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 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: 2019/ 5 / ...

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 III Malocc
2/2 in crossbite

File No: .... Date: / /

Treatment Plan خطة العلاج

✓ 8 - 10 Month

✓ 3500 + 700

Non Extraction, IPR in lower arch

Doctor's Signature and Stamp

....

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

HIBA FRND

PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
1/5/2019	upper bonding done	1000		
	after photo done			
	012 Ni Ti ligated			
	11/5/2019			
	Composite Filling			
	For 6 tooth one	150		Dr. Dali
	Surface.			
11/5/19	lower bonding	100		
	012 Ni Ti			
11/6/2019	· 014 upper Ni Ti	300		
	· 016 lower Ni Ti			
6/7/2019	· 016 upper			
	21/12 PC			
6.7.019	carbon laser			
27-8-2019	PC in lower arch after	250 + VAT 262.50		07/07/2019
	IPR in lower arch			
	016 Ni Ti L/L			
30/9/2019	lower arch figure of	300		
	'8' & 016x022 L/L ligature			

Dr. Wesam Marwan Al Tabbaa
د. وسام مروان الطباع
Dermatology specialist
اخصائي جلدية
MOH License No.: V920
ترخيص رقم
Orchid Medical Centre
مركز أوركيد الطبي

18-11-2019
حشوة كومبوزيت

D. Amie

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	Ahlam,Abdallah,Faris,,Ghanem	**IDN:**	784199302026952	**Mother Name:**	
Name (Ar)	احلام,عبدالله,فارس,,غانم	**Card Number:**	087897290	**Mother Name (Ar):**	
Title:		**Nationality:**	JOR	**Family ID:**	
Title(Ar):		**Nationality (Ar):**	الأردن		
Issue Date:	27/02/2018	**Sex:**	F	**Sponsor Type:**	06
Expiry Date:	25/02/2020	**Date of Birth:**	27/05/1993	**Sponsor Name:**	مدرسه الرساله الامريكيه الدوليه
Marital Status:	02	**Husband IDN:**		**Sponsor Number:**	00
Residency Type:	02	**Residency Number:**	30120182015365	**Residency Expiry:**	25/02/2020
ID Type:	IL	**Occupation:**	2331	**Occupation Field:**	00

Photo

Signature Image

مـركـــز أوركــــيــد الــطـبــي
ORCHID MEDICAL CENTER

AED 1,050.00 **RECEIPT VOUCHER (No.REC-003530)** **Date:01-05-2019**

Receive from Mr./Mrs./M/s. **1002077 - AHLAM ABDULLAH - 971543003173**

The sum of Dhs. **One Thousand Fifty Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **1,050.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **01-05-2019**

Being **FIRST PAYMENT 1000 AED + VAT TOTAL AMOUNT 3500 + 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 : **1002077 - AHLAM ABDULLAH - 971543003173**

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

مـركــز أوركــيـد الـطـبـي
ORCHID MEDICAL CENTER

AED 150.00 **RECEIPT VOUCHER (No.REC-003651)** **Date:11-05-2019**

Receive from Mr./Mrs./M/s. **1002077 - AHLAM ABDULLAH - 971543003173**

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: **11-05-2019**

Being **COMPOSITE FILLING FOR ONE TOOTH ONE SURFACE**

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 : **1002077 - AHLAM ABDULLAH - 971543003173**

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www.omc1.ae

مـركــز أوركـــيــد الــطــبــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004009)** **Date:11-06-2019**

Receive from Mr./Mrs./M/s. **1002077 - AHLAM ABDULLAH - 971543003173**

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: **11-06-2019**

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 : 1002077 - AHLAM ABDULLAH - 971543003173

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

مـركــز أوركــيــد الــطــبــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004332)** **Date:06-07-2019**

Receive from Mr./Mrs./M/s. **1002077 - AHLAM ABDULLAH - 971543003173**

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 : **1002077 - AHLAM ABDULLAH - 971543003173**

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

مـركـــز أوركـــيـــد الـــطـبـــي
ORCHID MEDICAL CENTER

AED 262.50 **RECEIPT VOUCHER (No.REC-004333)** **Date:06-07-2019**

Receive from Mr./Mrs./M/s. **1002077 - AHLAM ABDULLAH - 971543003173**

The sum of Dhs. **Two Hundred Sixty-Two Dirhams and Fifty Fils Only**

By Cash **0.00** / By Credit Card **262.50** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **06-07-2019**

Being **CARBON PEELING + 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 : **1002077 - AHLAM ABDULLAH - 971543003173**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
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مـركـــز أوركـــيــد الــطــبــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004860)** **Date:27-08-2019**

Receive from Mr./Mrs./M/s. **1002077 - AHLAM ABDULLAH - 971543003173**

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: **27-08-2019**

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 : **1002077 - AHLAM ABDULLAH - 971543003173**

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مـركــز أوركـــيـد الــطــبــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-005312)** **Date:30-09-2019**

Receive from Mr./Mrs./M/s. **1002077 - AHLAM ABDULLAH - 971543003173**

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: **30-09-2019**

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 : **1002077 - AHLAM ABDULLAH - 971543003173**

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مـركــز أوركــيــد الــطـبــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-005786)** **Date:02-11-2019**

Receive from Mr./Mrs./M/s. **1002077 - AHLAM ABDULLAH - 971543003173**

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: **02-11-2019**

Being **braces 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 : **1002077 - AHLAM ABDULLAH - 971543003173**

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

مـركــز أوركـــيــد الــطــبــي
ORCHID MEDICAL CENTER

AED 150.00 **RECEIPT VOUCHER (No.REC-006013)** **Date:18-11-2019**

Receive from Mr./Mrs./M/s. **1002077 - AHLAM ABDULLAH - 971543003173**

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

By Cash **0.00** / By Credit Card **150.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **18-11-2019**

Being **1 composite filling + 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 : **1002077 - AHLAM ABDULLAH - 971543003173**

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مـركـــز أوركـــيــد الــطــبــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-006379)** **Date:07-12-2019**

Receive from Mr./Mrs./M/s. **1002077 - AHLAM ABDULLAH - 971543003173**

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: **07-12-2019**

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 : **1002077 - AHLAM ABDULLAH - 971543003173**

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www.omc1.ae