مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

File No: ....

Date: 27/5/19

File Number: 1002197

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

Patient Name: Ahmet ALP :إسم المريض

Date Of Birth (تاريخ الميلاد) 24/1/93 Gender (الجنس) : M / (F) Marital Status:(الحالة الاجتماعية) ....

Nationality (الجنسية): Turkey .... Occupation (الوظيفة) : ....

Address (العنوان) :.. Phone No. (رقم الهاتف) 058 1776768

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 ستروديات 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 الحلأ البسيط	No	

مـركــز أوركــيــد الــطــبــي
ORCHID MEDICAL CENTER

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

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: 27/5/19

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 أن 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

Irregular teeth

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

Calculus Plaque
Stains of Smoking

Examination الفحص

Radiography الصور الشعاعية

OPG Lt. Ceph

Diagnosis التشخيص

Edge to Edge bite
Crowding severe in upper & Mild in lower
+2 blocked in 6+
Missing 6+.

File No: .... Date: / /

Treatment Plan خطة العلاج

26 yr Male Pt.

Invisalign, With Expansion & IPR with attachment

Tt cost 22000 in 4 Time in 6 Months

Nv– cleaning, photo, Impression

Advice for OPG & Ceph

Doctor's Signature and Stamp

....

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

PATIENT NAME:

FILE NO#:

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
26/6/2019	Scaling, polishing photo, Impression done for Invisalign last time he payed 500 today he will pay 2500	2500	9000	[signature]
7/8/2019	→ Already he paid 6000 now balance 6000 + Retainer charge. U/L Impression done for second Attachment, IPR & 1st Aligner delivered, 2nd & 3rd given to him		6000	[signature]
31/8/2019	5 Aligner delivered Now he is on 2nd		0000	[signature]
		1	6000	
28/11	all 25 aligner given		00.	
	[signature] Today he is on 11th photo take. only vat remaining.			[signature]

REDAD DATA

cAEAIOEBAA83ODQxO

Confirm Data

Public Data Readed Succ

SHOW READED DATA

Public Data Verification report

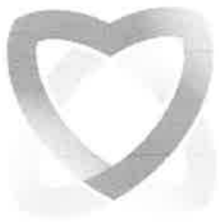
File	Valid Signature?
Non-Modifiable Data (SF3)	False
Modifiable Data (SF5)	False
Holder Signature Image (SF7)	False
Photography	False
Home Address	False
Work Address	False

Card Holder Information

Name	Ahmet Alp,,,,Kasirga	**IDN:**	784199342435403	**Mother Name:**	
Name (Ar)	احمد الف,,,,كاسيرجا	**Card Number:**	087929536	**Mother Name (Ar):**	
Title:		**Nationality:**	TUR	**Family ID:**	
Title (Ar):		**Nationality (Ar):**	تركيا		
Issue Date:	28/02/2018	**Sex:**	M	**Sponsor Type:**	06
Expiry Date:	26/02/2020	**Date of Birth:**	24/01/1993	**Sponsor Name:**	جونال انشاءات تجارت وصناعى انونيم شيركيتى (فرع دبي)
Marital Status:	02	**Husband IDN:**		**Sponsor Number:**	00
Residency Type:	02	**Residency Number:**	20120182038220	**Residency Expiry:**	26/02/2020
ID Type:	IL	**Occupation:**	2143	**Occupation Field:**	00

Photo

Signature Image



مـركــز أوركـــيــد الــطــبــي
ORCHID MEDICAL CENTER

No: REC-003801

AED 500.00 **RECEIPT VOUCHER** Date: 27-05-2019

Receive from Mr./Mrs./M/s. **1002197 - AHMET KASIRGA - 971581776768**

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 INVISALINE BRACES**

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

PATIENT NAME: **Mr Ahmet alp** #8872479

DOCTOR: Mahesh Sagar

Lite Package

PRESCRIPTION

PATIENT TYPE	**Adult**
BILLING ADDRESS	**Orchid Medical Centre** **Al Khan Palace Tower** **Flat 201** **Sharjah, AE**
SHIPPING ADDRESS	**Orchid Medical Centre** **Al Khan Palace Tower** **Flat 201** **Sharjah, AE**
ALIGNER MATERIAL: SmartTrack	
ARCH TO TREAT WITH INVISALIGN ALIGNERS	**Both**
TOOTH MOVEMENT RESTRICTIONS	**These specific teeth should not be moved** **Tooth # 1.8 1.7 1.6 2.6 2.7 2.8 3.8 3.7 3.6 4.6 4.7 4.8**
ATTACHMENTS	**Place attachments as needed**
ANTERIOR-POSTERIOR (A-P) RELATIONSHIP	**RIGHT: Maintain** **LEFT: Maintain**
OVERJET	**Show resulting overjet after alignment**
OVERBITE	**Show resulting overbite after alignment**
BITE RAMPS	**None**
MIDLINE	**Improve mid-line with IPR:** **- Upper to patient's right**

SPACING & CROWDING (ARCH LENGTH DISCREPANCY)

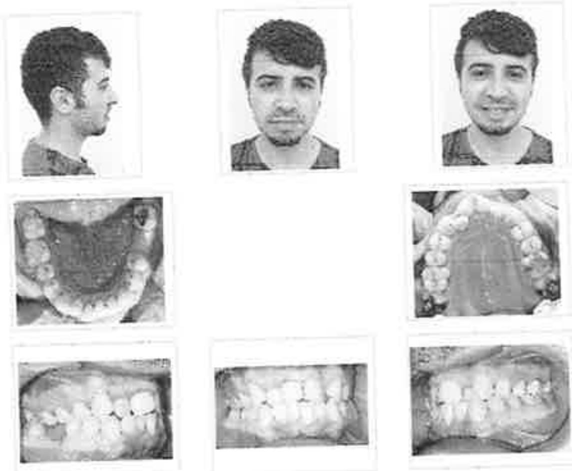
SPACING	**Close all spaces**	
CROWDING	**Resolve Upper**	
	Expand	**As needed**
	Procline	**Primarily**
	IPR-Anterior	**As needed**
	IPR-Posterior Right	**None**
	IPR-Posterior Left	**None**
	Resolve Lower	
	Expand	**None**
	Procline	**None**
	IPR-Anterior	**As needed**
	IPR-Posterior Right	**None**
	IPR-Posterior Left	**None**
EXTRACTIONS	**None**	

SPECIAL INSTRUCTIONS	**Dear technician:** **1- Please maintain the space of tooth #4.6.**
SPECIAL OFFERS/DISCOUNTS	**None**

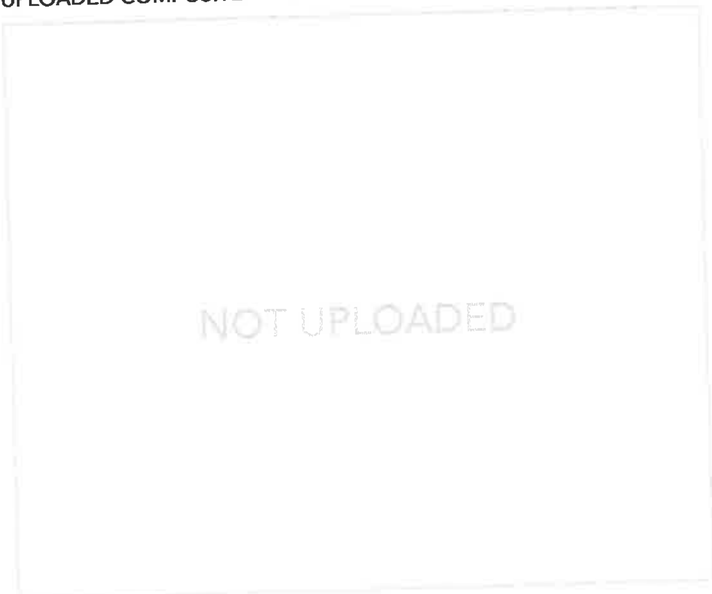
Lite Package

PATIENT RECORDS

UPLOADED INDIVIDUAL PHOTOS



UPLOADED COMPOSITE PHOTO



NOT UPLOADED

UPLOADED RADIOGRAPHS

NOT UPLOADED

NOT UPLOADED

مركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

No: REC-004202

AED 2,500.00 **RECEIPT VOUCHER** Date: 26-06-2019

Receive from Mr./Mrs./M/s. **1002197 - AHMET KASIRGA - 971581776768**

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

By Cash **0.00** / By Credit Card **2,500.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

Being **advance for invesline braces total amount 12000+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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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-004438

AED 3,000.00 **RECEIPT VOUCHER**

Date: 20-07-2019

Receive from Mr./Mrs./M/s. **1002197 - AHMET KASIRGA - 971581776768**

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

By Cash **3,000.00** / 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:

Being **ADVANCE FOR INVISALIGN BRACES**

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

Ahmet Alp KASIRGA

مركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

No: REC-005000

AED 6,000.00 **RECEIPT VOUCHER**

Date: 07-09-2019

Receive from Mr./Mrs./M/s. **1002197 - AHMET KASIRGA - 971581776768**

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

By Cash **0.00** / By Credit Card **6,000.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

Being **ADVANCE FOR INVESLINE BRACES**

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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مـركــز أوركـــيـد الــطـبــي
ORCHID MEDICAL CENTER

AED 6,000.00 **RECEIPT VOUCHER (No.REC-005266)** **Date:29-09-2019**

Receive from Mr./Mrs./M/s. **1002197 - AHMET KASIRGA - 971581776768**

The sum of Dhs. **Six 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 **6,000.00**

Bank: Cheque No. Date: **29-09-2019**

Being **INVISALIGN BRACES TOTAL 12000**

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 : **1002197 - AHMET KASIRGA - 971581776768**

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مـركـــز أوركـــيـــد الـــطـبـــي
ORCHID MEDICAL CENTER

AED 3,000.00 **RECEIPT VOUCHER (No.REC-005267)** **Date:29-09-2019**

Receive from Mr./Mrs./M/s. **1002197 - AHMET KASIRGA - 971581776768**

The sum of Dhs. **Three 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 **3,000.00**

Bank: Cheque No. Date: **29-09-2019**

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 : **1002197 - AHMET KASIRGA - 971581776768**

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مـركـــز أوركـــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

AED 2,500.00 **<u>RECEIPT VOUCHER (No.REC-005268)</u>** **Date:29-09-2019**

Receive from Mr./Mrs./M/s. **1002197 - AHMET KASIRGA - 971581776768**

The sum of Dhs. **Two Thousand 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 **2,500.00**

Bank: Cheque No. Date: **29-09-2019**

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 : **1002197 - AHMET KASIRGA - 971581776768**

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مـركــز أوركـــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

AED 500.00 **RECEIPT VOUCHER (No.REC-005269)** **Date:29-09-2019**

Receive from Mr./Mrs./M/s. **1002197 - AHMET KASIRGA - 971581776768**

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: **29-09-2019**

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 : **1002197 - AHMET KASIRGA - 971581776768**

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