مـركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

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

File No: 1002270

Date: 2/6/2019

Date: 2/6/2019

File Number: 1002270

Patient Name: Areej Al-Madhoun :إسم المريض

Date Of Birth (تاريخ الميلاد) : 15/5/1987 Gender (الجنس) : M / (F)

Marital Status:(الحالة الاجتماعية) Married

Nationality (الجنسية): Jordan

Occupation (الوظيفة) :

Address (العنوان) : Shj.

Phone No. (رقم الهاتف): 0522118802

E-MAIL: areej.almadhoun@hotmail.com

How did you know about us: Hiba.

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 ستروىدات 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	

مـركـــز أوركــــيـــد الــطــبــي
ORCHID MEDICAL CENTER

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

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: 2 / 6 / 2019

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: 2 / 9 / 2019

Treatment Plan خطة العلاج

Doctor's Signature and Stamp

....

مـركــز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
16/7/2019	Facial	250		د. وسام مروان الطباع Dr. Wesam Marwan Al Tabbaa Dermatology specialist MOH License No.: [illegible] Orchid Medical Centre
	50 Piercing 17/10/2019 100 Discount from Maha			
	Hiba Sister			

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	Areej,Ramzi,Mohammad,,Al Madhoun	**IDN:**	784198773160530	**Mother Name:**	
Name (Ar)	اريج,رمزي,محمد,,المدهون	**Card Number:**	090857666	**Mother Name (Ar):**	
Title:		**Nationality:**	JOR	**Family ID:**	
Title (Ar):		**Nationality (Ar):**	الأردن		
Issue Date:	17/09/2018	**Sex:**	F	**Sponsor Type:**	03
Expiry Date:	05/07/2020	**Date of Birth:**	15/05/1987	**Sponsor Name:**	ربحي صبحي ربحي عبدالقادر
Marital Status:	02	**Husband IDN:**		**Sponsor Number:**	26588492
Residency Type:	03	**Residency Number:**	20120143109252	**Residency Expiry:**	05/07/2020
ID Type:	IL	**Occupation:**	99	**Occupation Field:**	00

Photo

Signature Image

مـركـــز أوركـــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

AED 262.50 **RECEIPT VOUCHER (No.REC-004220)** **Date:27-06-2019**

Receive from Mr./Mrs./M/s. **1002270 - AREEJ ALMAHOUN - 971522118802**

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: **27-06-2019**

Being **Pro-Facial tratment + 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 : **1002270 - AREEJ ALMAHOUN - 971522118802**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

Piercing Consent Form

Clinic Name: ORCHID MEDICAL CENTRE

Clinic Address: SHARJAH

City: ______ Country: ______

Customers Name: AREEJ AL MADHOUN.

Date of Birth: __/__/__ If under 24 months old, had their vaccination shots: [Y] [N]

Customer Address: SHARJAH

Mobile: 0522118802 E-mail: ______

Sterilization Lot Number: 1 5 8 8 9 4 1 3 1 9 APR - 2029 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 or consent to pierce ________ 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.

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. Date: 17/10/19.

7522-0100
Stainless
Tiff 4mm
Cubic Zirconia

SYSTEM 75
EAR PIERCING EARRINGS

Clasps are stainless, gold plated
EC/FDA Compliant

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

مـركــز أوركـــيــد الــطــبـي
ORCHID MEDICAL CENTER

AED 52.50 **RECEIPT VOUCHER (No.REC-005562)** **Date:17-10-2019**

Receive from Mr./Mrs./M/s. **1002270 - AREEJ ALMAHOUN - 971522118802**

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

By Cash **0.00** / By Credit Card **52.50** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **17-10-2019**

Being **EAR PIERCING + VAT (50% DISCOUNT)**

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 : **1002270 - AREEJ ALMAHOUN - 971522118802**

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www.omc1.ae