مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

File No: .....

Date: 12/6/19

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

File Number: 100307

Patient Name: Noura Anwar othman نورة أنور عثمان إسم المريض:

Date Of Birth (تاريخ الميلاد) : ... / ... / ..... Gender (الجنس) : M / F

Marital Status: (الحالة الاجتماعية) عزباء

Nationality (الجنسية): جزائرية Occupation (الوظيفة) : طالبة

Address (العنوان) : الشارقة - البنيه

Phone No. (رقم الهاتف): 0556561235

E-MAIL: Noura_A309@outlook.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؟	نعم	أوراثان
Cortisteroids/Immunosuppressant هل تتعاطى أي ستروييدات 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 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 أن هذا النموذج قد تم شرحه لي بالكامل و اني قد قرأت و فهمت جميع تفاصيله بالكامل و اني وقّعت 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: ... / ... / .....

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

Doctor's Signature and Stamp

.....

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
12/6/2019	: ENDymed Jaw + Double chin 5 sessions			
	1st Session done- Endymed.			
26/6/2019	: 2cd session Endymed			
	2nd Session endymed Chin			
3/7/19	3rd Session endymed Chin			
9/7/19	5th Session endymed Chin			
17/7/19	6th Session endymed Chin			
24/7/19	7th Session endymed Chin			Been
31/7/19	8th Session endymed Session			
7/8/19	9th Session endymed Session			
19/8/19	- 10th Session endymed done.			Been

د. وسام مروان الطباع
Dr. Wesam Marwan Al Tabbaa
اخصائي جلدية
Dermatology specialist
MOH License No.: V826 ترخيص رقم:
Orchid Medical Centre مركز اوركيد الطبي

REDAD DATA

cAEAIOEBAA83ODQyMI

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	Noura,Anwar,,,Usman	**IDN:**	784200064361031	**Mother Name:**	
Name (Ar)	نوره,انور,,,عثمان	**Card Number:**	078953217	**Mother Name (Ar):**	
Title:		**Nationality:**	PAK	**Family ID:**	
Title(Ar):		**Nationality (Ar):**	باكستان		
Issue Date:	22/06/2016	**Sex:**	F	**Sponsor Type:**	03
Expiry Date:	04/06/2019	**Date of Birth:**	19/02/2000	**Sponsor Name:**	انور عثمان عبدالله
Marital Status:	01	**Husband IDN:**		**Sponsor Number:**	05724827
Residency Type:	03	**Residency Number:**	30120073010796	**Residency Expiry:**	04/06/2019
ID Type:	IL	**Occupation:**	02	**Occupation Field:**	00

Photo

Signature Image

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-004020

AED 2,100.00

RECEIPT VOUCHER

Date: 12-06-2019

Receive from Mr./Mrs./M/s. **1002307 - NOURA ANWAR - 971565612351**

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

By Cash **2,100.00** / 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:

ıg **5 ENDYMED SESSION FOR DOUBLE CHIN TRATMENT 400*5 + 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

Piercing Consent Form

Clinic Name; ORCHID MEDICAL CENTRE

Clinic Address; SHARJAH.

Ctiy; Country;

Customers Name: NOURA ANWAR FE.

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

Customer Address:

Mobile; 0565612351. E-mail:

Sterilization Lot Number 1 5 1 5 8 6 1 1 18 Product Code: 7 5 1 1 0 2 6 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/ 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.

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

_____ Date: 3/7/19.
Medical Professional.

Signature back side.

CLINIC COPY

7511-0260
Gold Plated
Bezel 3mm
Cubic Zirconia

SYSTEM 75
EAR PIERCING EARRINGS

STUDEX

Clasps are stainless, gold plated
EC/FDA Compliant
Sterile: Lot Number & EXP:
1515861118 MAR2028
LOS ANGELES, CA 90248-1514 U.S.A.

0 48675 61260 9

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 105.00 **RECEIPT VOUCHER (No.REC-004313)** **Date:03-07-2019**

Receive from Mr./Mrs./M/s. **1002307 - NOURA ANWAR - 971565612351**

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

By Cash **105.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **03-07-2019**

Being **EAR PIERCING + 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 : **1002307 - NOURA ANWAR - 971565612351**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-004415

AED 1,500.00

RECEIPT VOUCHER

Date: 17-07-2019

Receive from Mr./Mrs./M/s. **1002307 - NOURA ANWAR - 971565612351**

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

By Cash **1,500.00** / 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 5 SESSION ENDYMED TOTAL AMOUNT 2000 + 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
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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 200.00

RECEIPT VOUCHER

No: REC-004482

Date: 24-07-2019

Receive from Mr./Mrs./M/s. **1002307 - NOURA ANWAR - 971565612351**

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

By Cash **200.00** / 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 5 SESSION ENDYMED DOUBLE CHIN + 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

No: REC-004579

AED 200.00

RECEIPT VOUCHER

Date: 31-07-2019

Receive from Mr./Mrs./M/s. **1002307 - NOURA ANWAR - 971565612351**

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

By Cash **200.00** / 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 ENDYMED SESSION**

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
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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-004684

AED 200.00

RECEIPT VOUCHER

Date: 07-08-2019

Receive from Mr./Mrs./M/s. **1002307 - NOURA ANWAR - 971565612351**

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

By Cash **200.00** / 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:

ing **ADVANCE FOR 5 SESSION ENDYMED 2000+ 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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 200.00 **RECEIPT VOUCHER (No.REC-005301)** **Date:30-09-2019**

Receive from Mr./Mrs./M/s. **1002307 - NOURA ANWAR - 971565612351**

The sum of Dhs. **Two 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 **200.00**

Bank: Cheque No. Date: **30-09-2019**

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 : **1002307 - NOURA ANWAR - 971565612351**

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

مـركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

AED 200.00 **RECEIPT VOUCHER (No.REC-005300)** **Date:30-09-2019**

Receive from Mr./Mrs./M/s. **1002307 - NOURA ANWAR - 971565612351**

The sum of Dhs. **Two 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 **200.00**

Bank: Cheque No. Date: **30-09-2019**

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 : **1002307 - NOURA ANWAR - 971565612351**

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

مـركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

AED 1,500.00 **RECEIPT VOUCHER (No.REC-005299)** **Date:30-09-2019**

Receive from Mr./Mrs./M/s. **1002307 - NOURA ANWAR - 971565612351**

The sum of Dhs. **One 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 **1,500.00**

Bank: Cheque No. Date: **30-09-2019**

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 : **1002307 - NOURA ANWAR - 971565612351**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 2,100.00 **RECEIPT VOUCHER (No.REC-005298)** **Date:30-09-2019**

Receive from Mr./Mrs./M/s. **1002307 - NOURA ANWAR - 971565612351**

The sum of Dhs. **Two Thousand One 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 **2,100.00**

Bank: Cheque No. Date: **30-09-2019**

Being **10 SESSION ENDYMED SESSION FOR DOUBLE CHIN AREA EACH PKG 5 SESSIONS 2100 TOTAL AMOUNT 4200**

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 : **1002307 - NOURA ANWAR - 971565612351**

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