مـركـــز أوركـــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

صحة... إبتسامة... جمال
Health ... Smile ... Beauty

File No: ....

Date: 25/7/19

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

File Number: 1002557

Patient Name: Mohammed Mekawi [illegible] :إسم المريض

Date Of Birth (تاريخ الميلاد): ١٩٦٢/٧/١٧ Gender (الجنس): M / F

Marital Status:(الحالة الاجتماعية) متزوج

Nationality (الجنسية): مصري Occupation (الوظيفة): صاحب عمل

Address (العنوان): [illegible]

Phone No. (رقم الهاتف): 050 7879767

E-MAIL: mhussain@wasl.ae

How did you know about us: [illegible]

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

مـركــز أوركـــيــد الـــطـــبـــي
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: 25 / 07 / 2019

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

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
		975		D. Amira
25-7-2019	4 composit			
	721|1			
	+ تثبت كراون			
	د. اميرة حسن Dr. Amira Hassan ممارس عام-طبيب اسنان عام G.P General Dentist MOH License No.: D57288 ترخيص رقم: Orchid Medical Centre مركز اوركيد الطبي			
30-5-2020	re filling			D.
29/6/2020	Irrigation (RCT)			Dr Amira

REDAD DATA

cAEAIOEBAA83ODQxO | Public Data Readed Suc | 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	Mohamed,Mekawi,Hussaein,Soliman,Soliman	**IDN:**	784196208285468	**Mother Name:**	
Name (Ar)	محمد,مكاوي,حسين,سليمان,سليمان	**Card Number:**	088751700	**Mother Name (Ar):**	
Title:		**Nationality:**	EGY	**Family ID:**	
Title(Ar):		**Nationality (Ar):**	مصر		
Issue Date:	23/04/2018	**Sex:**	M	**Sponsor Type:**	08
Expiry Date:	19/04/2021	**Date of Birth:**	17/07/1962	**Sponsor Name:**	حكومه دبى - مؤسسه دبى العقاريه
Marital Status:	02	**Husband IDN:**		**Sponsor Number:**	00
Residency Type:	07	**Residency Number:**	20119977017369	**Residency Expiry:**	19/04/2021
ID Type:	IL	**Occupation:**	2411	**Occupation Field:**	00

Photo

Signature Image

مـركــز أوركـــيـد الــطــبــي
ORCHID MEDICAL CENTER

AED 778.75 **<u>RECEIPT VOUCHER (No.REC-004495)</u>** **Date:25-07-2019**

Receive from Mr./Mrs./M/s. **1002557 - MOHAMMED MEKAWI - 971507879767**

The sum of Dhs. **Seven Hundred Seventy-Eight Dirhams and Seventy-Five Fils Only**

By Cash **0.00** / By Credit Card **778.75** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **25-07-2019**

Being **3 TEETH Composite Filling 1 Surface 450 AED + 1 TEETH Composite Filling 2 Surfaces 250 AED + 1 CROWN CEMENTATION 78.75 AED**

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 : 1002557 - MOHAMMED MEKAWI - 971507879767

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

Claim Form

Allianz Worldwide Care Products

To help us provide you with a fast and efficient service, we kindly ask you to note the following:

- A fully completed form will speed up the assessment and payment of your claim.
- Please complete the front page of this form and ask your treating doctor to complete the back page.
- All relevant original invoices must be attached. Unfortunately, photocopies, receipts and credit card slips cannot be accepted.
- If you are submitting invoices which contain details of the diagnoses as well as the nature of your treatment, there is no need to complete the reverse side of this form, simply attach the original invoices.
- A separate Claim Form is required for every patient and each medical condition.
- We recommend that you keep copies of all documents submitted, should you require them at a later date.
- Finally, we kindly ask that you complete this form in BLOCK CAPITALS and post it to the address below no later than six months after the end of the Insurance Year. Beyond this time we are not obliged to settle the claim.

Policyholder's details

Policy number

Title

Surname

First name(s)

Date of birth d d / m m / y y

Correspondence address

Telephone number (day time) COUNTRY CODE – AREA CODE –

Telephone number (evening) COUNTRY CODE – AREA CODE –

Fax COUNTRY CODE – AREA CODE –

Email

Patient's details

Title

Surname

First name(s)

Date of birth d d / m m / y y

Is this claim related to an accident? Yes ☐ No ☐

Payment details

Option 1: Payment to **policyholder/insured** ☐

Payment to be made in: Invoice currency ☐ Other currency (please specify)

Preferred payment method: Cheque ☐ Bank transfer ☐ (please fill in bank details)

Name of bank account

Account no./IBAN

Sort/branch code

Swift code

Bank name

Bank address

Option 2: Payment to **provider of medical service** (e.g. hospital/clinic, specialist)

Please tick if direct billing has been previously agreed with us ☐

Authorization of claimant and release of medical records

I certify that to the best of my knowledge, this Claim Form does not contain any false, misleading or incomplete information. I understand that in the event that this claim is found to be fraudulent in whole or in part, the policy will be invalidated and I will be liable for prosecution. In respect of any medical claim, I hereby authorize any general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Arab Orient Insurance Company or its appointed representatives. I understand that Arab Orient Insurance Company reserves the right to request further information or documents necessary to process this claim and undertake to furnish such information or records at my own expense.

If a minor was treated, a parent or guardian should sign this section.

Signature of claimant ____________________ Date d d / m m / y y

To be completed by the treating doctor in BLOCK CAPITALS unless your invoices contain details of the diagnosis as well as the nature of your treatment.

Medical provider's details

Name of doctor/specialist

Qualifications/credentials

Name of hospital/clinic

Address

Telephone number COUNTRY CODE – AREA CODE –

Fax COUNTRY CODE – AREA CODE –

Email

Medical details

Has pre-authorization been obtained? Yes ☐ No ☐

Indicate type of treatment received Elective ☐ Emergency ☐

Please provide full details of the symptoms/medical condition requiring treatment, including ICD code/DSM-IV

On what date did the patient first present these symptoms to you? d d / m m / y y

On what date would the first onset of symptoms have been apparent to the patient? d d / m m / y y

Has the patient suffered from this condition previously? Yes ☐ No ☐ If yes, when? d d / m m / y y

Are you aware of any treatment given for this or any related illness in the past? Yes ☐ No ☐

If yes, please provide details

Pregnancy:

Estimated date of delivery d d / m m / y y

Is birth of a single baby expected? Yes ☐ No ☐

If you answered **No** to the question above and twins/multiple babies are expected, is the pregnancy a result of medically assisted reproduction other than artificial insemination? Yes ☐ No ☐

If yes, please provide further details

Applicable to dental treatment claims only:

Was the patient suffering from dental pain at the time he/she visited you for treatment? Yes ☐ No ☐

Please sign and authenticate with an official stamp.

Signature of the doctor

Date d d / m m / y y

Official stamp of medical provider

Please send fully completed Claim Forms to:

Arab Orient Insurance Company, Allianz Worldwide Care Products,
Medical Claims Department, P.O. Box 27966, Dubai, UAE

Helpline: +971 (0)56 681 9977
Fax: +971 4 295 0702

The confidentiality of patient and member information is of paramount concern to us. We fully comply with European Data Protection Legislation and International Medical Confidentiality Guidelines. You have a right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date.

FRM-CF-UAE-EN-0410

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Policy number

Title

Surname

First name(s)

Date of birth d d / m m / y y

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Telephone number (day time) COUNTRY CODE – AREA CODE –

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Fax COUNTRY CODE – AREA CODE –

Email

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Title

Surname

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Telephone number COUNTRY CODE – AREA CODE –

Fax COUNTRY CODE – AREA CODE –

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