مركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

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

File No: ....

Date: 26/8/19

Date: 26/8/2019 File Number: 1002746

Patient Name: Abdul Shamraiz Khan إسم المريض:

Date Of Birth (تاريخ الميلاد): 28/07/2003 Gender (الجنس): M / F Marital Status: (الحالة الاجتماعية) Single

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

Address (العنوان): Buhairah Corniche (Bukamsen tower) Phone No. (رقم الهاتف): 0568801936

E-MAIL: .... How did you know about us: From a Friend

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 ستيرويدات 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	

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

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

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

Examination الفحص

Radiography الصور الشعاعية

Diagnosis التشخيص

Upper And. Crowding & proclination
Carious +G
Class I Molar

File No: .....

Date: / /

Treatment Plan خطة العلاج

1 yr.
3500 + 700 for retainer (Metal braces)
First Non Extraction after 4 months
may be 4th Ext.

Doctor's Signature and Stamp

.....

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
	سحب عصب ضرس خلفي			
2.9.2019	RCT +6			D.Amira
7-9-2019	الجلسة الثانية عصب			
11/9/2019	الجلسة الثالثة والأخيرة عصب			
5/10/2019	Photo done	1000	Paid	
	No kit			
31/10/2019 →	up/lr bonely —	0000		
	AO .018 Slot			
	.014 Thermal Ni Ti			
	Ligature			
14.3.2020	EXT 4			D.Amira

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-004943

AED 300.00

RECEIPT VOUCHER

Date: 02-09-2019

Receive from Mr./Mrs./M/s. **1002746 - ABDUL SHAMRAIZ KHAN - 971508801936**

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

By Cash **300.00** / 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 **RCT FIRST 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
www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-005005

AED 200.00

RECEIPT VOUCHER

Date: 07-09-2019

Receive from Mr./Mrs./M/s. **1002746 - ABDUL SHAMRAIZ KHAN - 971508801936**

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 **RCT SECOND SESSION**

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

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

www.omc1.ae


United Arab Emirates
Resident Identity Card
ID Number / رقم الهوية
784-2003-0561474-9
Name: Abdul Shamraiz Khan Abdul Qahir
Nationality: Pakistan

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 200.00 **RECEIPT VOUCHER (No.REC-005061)** **Date:11-09-2019**

Receive from Mr./Mrs./M/s. **1002746 - ABDUL SHAMRAIZ KHAN - 971508801936**

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: **11-09-2019**

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 : **1002746 - ABDUL SHAMRAIZ KHAN - 971508801936**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 450.00 **RECEIPT VOUCHER (No.REC-005060)** **Date:11-09-2019**

Receive from Mr./Mrs./M/s. **1002746 - ABDUL SHAMRAIZ KHAN - 971508801936**

The sum of Dhs. **Four 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 **300.00**

Bank: Cheque No. Date: **11-09-2019**

Being **RCT**

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 : **1002746 - ABDUL SHAMRAIZ KHAN - 971508801936**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-005403

AED 1,000.00

RECEIPT VOUCHER

Date: 05-10-2019

Receive from Mr./Mrs./M/s. **1002746 - ABDUL SHAMRAIZ KHAN - 971508801936**

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

By Cash **1,000.00** / 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 BRACES FIRST PAYMENT + 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

AED 315.00 **RECEIPT VOUCHER (No.REC-006380)** **Date:07-12-2019**

Receive from Mr./Mrs./M/s. **1002746 - ABDUL SHAMRAIZ KHAN - 971508801936**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **315.00** / By Credit Card **0.00** / 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 : **1002746 - ABDUL SHAMRAIZ KHAN - 971508801936**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-008189)** **Date:18-03-2020**

Receive from Mr./Mrs./M/s. **1002746 - ABDUL SHAMRAIZ KHAN - 971508801936**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **315.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **18-03-2020**

Being **1 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 : **1002746 - ABDUL SHAMRAIZ KHAN - 971508801936**

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

مـركـــز أوركـــيـــد الـــطـبـــي
ORCHID MEDICAL CENTER

AED 20.00

RECEIPT VOUCHER

No: REC-007264

Date: 25-01-2020

Receive from Mr./Mrs./M/s. **1002746 - ABDUL SHAMRAIZ KHAN - 971508801936**

The sum of Dhs. **Twenty Only**

By Cash **20.00** / 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 NO CHANGE**

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

AED 315.00

RECEIPT VOUCHER (No.REC-007262)

Date:25-01-2020

Receive from Mr./Mrs./M/s. **1002746 - ABDUL SHAMRAIZ KHAN - 971508801936**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **315.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **25-01-2020**

Being **BRACES FOLLOW UP + 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 : **1002746 - ABDUL SHAMRAIZ KHAN - 971508801936**

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