مـركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

Date: ....

Name: .... Age: .... Sex: ....

Rx

Zircon 14,000

5400

20,370

21,630

4200

10450

(12)

Al Khan Corniche, Al Khan Palace Building / Office No. 201
Tel: +971 6 555 8337, Fax: +971 6 528 8130, E-mail: info@omc1.ae

مـركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

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

File No: ....

Date: 21/9/19

Date: 21/9/2019 File Number: 100291

Patient Name: Ali Sultan Al Ali إسم المريض:

Date Of Birth (تاريخ الميلاد) 21/1/1982 Gender (الجنس): (M) / F Marital Status: (الحالة الاجتماعية) متزوج

Nationality (الجنسية): U.A.E Occupation (الوظيفة): عسكري

Address (العنوان): الشارقة – الرفاع Phone No. (رقم الهاتف): 050-3600400

E-MAIL: .... How did you know about us: online

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؟	لا	
Cortisteroids/Immunosuppressant هل تتعاطى أي ستيرويدات 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 انيميا (فقر الدم)، لوكيميا (سرطان الدم)	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؟	—	
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 الحلا البسيط	لا	

مركز أوركيد الطبي
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: ... / ... / .....

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: 21 / 9 / 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: / /

Treatment Plan خطة العلاج

Doctor's Signature and Stamp

....

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

PATIENT NAME:

FILE NO#:

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
21-9-2019	خلع ٢ سن 6/5	300		D. Amira
	د. اميرة حسين / Dr. Amira Hassan / ممارس عام - طبيب اسنان عام / G.P General Dentist / MOH License No.: D57288 ترخيص رقم / Orchid Medical Centre مركز اوركيد الطبي			
22-9-2019	خلع ٢ سن 4/6	300		D. Amira
	د. اميرة حسين / Dr. Amira Hassan / ممارس عام - طبيب اسنان عام / G.P General Dentist / MOH License No.: D57288 ترخيص رقم / Orchid Medical Centre مركز اوركيد الطبي			
14/10/2019	تثبيت 14/11/21 بوبن 12 + Veneer			D. A
	د. اميرة حسين / Dr. Amira Hassan / ممارس عام - طبيب اسنان عام / G.P General Dentist / MOH License No.: D57288 ترخيص رقم / Orchid Medical Centre مركز اوركيد الطبي			
26-6-2019	تم تغيير المثبت (cement) المؤقت للدائم			

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	Ali,Sultan,Ali,Humaid,Al Ali	**IDN:**	784198291416463	**Mother Name:**	Fawziya
Name (Ar)	علي,سلطان,علي,حميد,آل علي	**Card Number:**	088547289	**Mother Name (Ar):**	فوزيه
Title:		**Nationality:**	ARE	**Family ID:**	301020151
Title(Ar):		**Nationality (Ar):**	الإمارات العربية المتحدة		
Issue Date:	10/04/2018	**Sex:**	M	**Sponsor Type:**	
Expiry Date:	10/04/2028	**Date of Birth:**	29/01/1982	**Sponsor Name:**	
Marital Status:	02	**Husband IDN:**		**Sponsor Number:**	
Residency Type:		**Residency Number:**		**Residency Expiry:**	
ID Type:	ID	**Occupation:**	5162	**Occupation Field:**	00
Photo		**Signature Image**			

مـركــز أوركـــيـد الــطــبــي
ORCHID MEDICAL CENTER

No: REC-005153

AED 300.00 **RECEIPT VOUCHER**

Date: 21-09-2019

Receive from Mr./Mrs./M/s. **1002921 - ALI SULTAN - 971503600400**

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

By Cash **0.00** / By Credit Card **300.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

Being **ADVANCE FOR 2 DENTAL EXTRACTION**

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

مـركـز أوركـيـد الـطـبـي
ORCHID MEDICAL CENTER

AED 4,440.00 **RECEIPT VOUCHER (No.REC-005766)** **Date:02-11-2019**

Receive from Mr./Mrs./M/s. **1002921 - ALI SULTAN - 971503600400**

The sum of Dhs. **Four Thousand Four Hundred Forty Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **4,440.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **02-11-2019**

Being **AGAINST CHQ NO 000011 DATED ON 10-11-2019 EMIRATES ISLAMIC**

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 : **1002921 - ALI SULTAN - 971503600400**

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

شركة البحيرة الوطنية للتأمين
Al-Buhaira National Insurance Co.
P.O. BOX 6000
SHARJAH, U.A.E.
Tel.No. 06-5684000, Fax No. 06-5696636

DENTAL EXPENSES CLAIM FORM

To be completed by the treating Dentist.

1. Patient's Name : Ali Sultan Al Ali Date of birth : 29-1-1982

2. Clinical Details

- [ ] ACCIDENT
- [x] NON ACCIDENT

3. Diagnosis irreversible pulpitis

4. Treatment provided

- [x] Consultation
- [ ] Scaling and Polishing
- [ ] Dental X ray
- [ ] I & D of Dental Abscess
- [ ] Gum treatment
- [ ] Crown
- [x] Extraction – specify tooth: 4/6
- [ ] Filling – specify tooth
- [ ] RCT – specify the tooth
- [ ] Application of sealant – specify tooth
- [ ] Others - specify

I certify that I have satisfied myself by personal examination that all the foregoing statements are accurate and correct .

Name of attending physician and Qualification : Amira Signature : [signature] Date : 23-9-2019

DECLARATION : I hereby consent to and authorize the attending physician to provide AL- BUHAIRA NATIONAL INSURANCE COMPANY with complete information , including copies of my records with reference to any sickness or accident , any treatment , examination , advice or hospitalization . Any photocopy of this authorization shall be taken as original copy .

(Stamp: د. أميرة حسن / Dr. Amira Hassan / ممارس عام - طبيب أسنان عام / G.P General Dentist / MOH License No.: D57288 ترخيص رقم / Orchid Medical Centre)

PR NO : ....

Insurance I.D NO. 787-19-[illegible]

Patient's Name Ali Sultan Al Ali

Total amount 300

Signature ....

Date 23-9-19

Claims must be submitted alongwith supporting Documents in the first week of the month following the treatment month

g.i./medclfrm

شركة البحيرة الوطنية للتأمين
Al-Buhaira National Insurance Co.
P.O. BOX 6000
SHARJAH, U.A.E.
Tel.No. 06-5684000, Fax No. 06-5696636

DENTAL EXPENSES CLAIM FORM

To be completed by the treating Dentist.

1. Patient's Name : ALi sulTah AL ALi Date of birth : 29-1-1982

2. Clinical Details

- [ ] ACCIDENT
- [x] NON ACCIDENT

3. Diagnosis Remeaning root

4. Treatment provided

- [x] Consultation
- [ ] Scaling and Polishing
- [ ] Dental X ray
- [ ] I & D of Dental Abscess
- [ ] Gum treatment
- [ ] Crown
- [x] Extraction – specify tooth 4,5
- [ ] Filling – specify tooth
- [ ] RCT – specify the tooth
- [ ] Application of sealant – specify tooth
- [ ] Others - specify

I certify that I have satisfied myself by personal examination that all the foregoing statements are accurate and correct .

Name of attending physician and Qualification : Amira Signature : [signature] Date : 21-9-2019

DECLARATION : I hereby consent to and authorize the attending physician to provide AL- BUHAIRA NATIONAL INSURANCE COMPANY with complete information , including copies of my records with reference to any sickness or accident , any treatment , examination , advice or hospitalization. Any photocopy of this authorization shall be taken as original copy .

Dr. Amira Hassan
G.P General Dentist
MOH License No. D57288

PR NO : ....

Insurance I.D NO. 787-[illegible]-00

Patient's Name Ali Sultan Al Ali

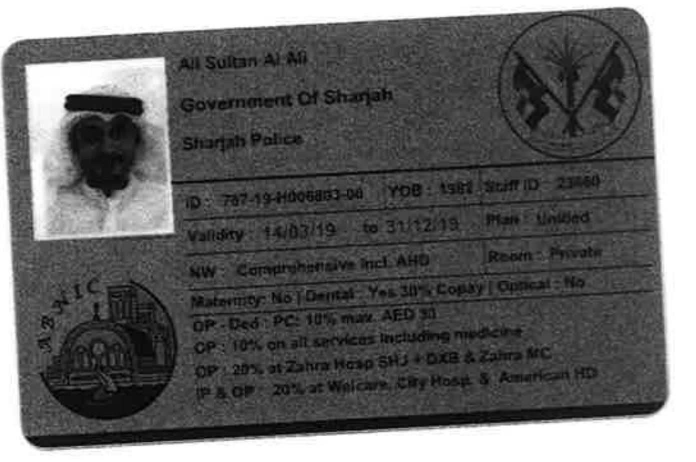
Total amount 300 AED

Signature ....

Date 21-9-19

Claims must be submitted alongwith supporting Documents in the first week of the month following the treatment month

g.i./medclfrm



Ali Sultan Al Ali
Government Of Sharjah
Sharjah Police

ID : 787-19-H006803-00 | YOB : 1982 | Staff ID : 23860
Validity : 14/03/19 to 31/12/19 | Plan : Unified
NW : Comprehensive incl. AHD | Room : Private
Maternity: No | Dental : Yes 30% Copay | Optical : No
OP - Ded : PC: 10% max. AED 30
OP : 10% on all services including medicine
OP : 20% at Zahra Hosp SHJ + DXB & Zahra MC
IP & OP : 20% at Welcare, City Hosp. & American HD

شركة البحيرة الوطنية للتأمين
Al-Buhaira National Insurance Co.
P.O. BOX 6000
SHARJAH, U.A.E.
Tel.No. 06-5684000, Fax No. 06-5696636

DENTAL EXPENSES CLAIM FORM

To be completed by the treating Dentist.

1. Patient's Name : .... Date of birth : ....

2. Clinical Details

☐ **ACCIDENT** ☐ **NON ACCIDENT**

3. Diagnosis ....

....

4. Treatment provided

☐ Consultation ☐ Scaling and Polishing ☐ Dental X ray

☐ I & D of Dental Abscess ☐ Gum treatment ☐ Crown

☐ Extraction – specify tooth ☐ Filling – specify tooth

☐ RCT – specify the tooth ☐ Application of sealant – specify tooth

☐ Others - specify ....

I certify that I have satisfied myself by personal examination that all the foregoing statements are accurate and correct .

Name of attending physician and Qualification : ________________ Signature : __________ Date : ______

DECLARATION : I hereby consent to and authorize the attending physician to provide AL- BUHAIRA NATIONAL INSURANCE COMPANY with complete information , including copies of my records with reference to any sickness or accident , any treatment , examination , advice or hospitalization . Any photocopy of this authorization shall be taken as original copy .

PR NO : .... Insurance I.D NO....................................

Patient's Name .... Total amount ....

Signature .... Date ....

Claims must be submitted alongwith supporting Documents in the first week of the month following the treatment month

g.i./medclfrm

شركة البحيرة الوطنية للتأمين
Al-Buhaira National Insurance Co.
P.O. BOX 6000
SHARJAH, U.A.E.
Tel.No. 06-5684000, Fax No. 06-5696636

DENTAL EXPENSES CLAIM FORM

To be completed by the treating Dentist.

1. Patient's Name : .... Date of birth : ....

2. Clinical Details

☐ ACCIDENT ☑ NON ACCIDENT

3. Diagnosis dental caries

4. Treatment provided

☐ Consultation ☐ Scaling and Polishing ☐ Dental X ray

☐ I & D of Dental Abscess ☐ Gum treatment ☐ Crown

☐ Extraction – specify tooth ☑ Filling – specify tooth 7

☐ RCT – specify the tooth ☐ Application of sealant – specify tooth

☐ Others - specify ....

I certify that I have satisfied myself by personal examination that all the foregoing statements are accurate and correct .

Name of attending physician and Qualification : Amira Signature : [signature] Date : 28-9-2019

DECLARATION : I hereby consent to and authorize the attending physician to provide AL- BUHAIRA NATIONAL INSURANCE COMPANY with complete information , including copies of my records with reference to any sickness or accident , any treatment , examination , advice or hospitalization . Any photocopy of this authorization shall be taken as original copy .

PR NO : .... Insurance I.D NO.....................

Patient's Name .... Total amount ....

Signature ....[signature] Date ....

Dr. Amira Hassan
ممارس عام - طبيب اسنان عام
G.P. General Dentist
MOH License No.: D57288 ترخيص رقم:
Orchid Medical Centre مركز اوركيد الطبي

Claims must be submitted alongwith supporting Documents in the first week of the month following the treatment month

g.i./medclfrm

شركة البحيرة الوطنية للتأمين
Al-Buhaira National Insurance Co.
P.O. BOX 6000
SHARJAH, U.A.E.
Tel.No. 06-5684000, Fax No. 06-5696636

DENTAL EXPENSES CLAIM FORM

To be completed by the treating Dentist.

1. Patient's Name : ALi sulTAn Al ALi Date of birth : 29 - 1 - 1982

2. Clinical Details

☐ ACCIDENT ☑ NON ACCIDENT

3. Diagnosis مشاكل هضمية وعدم القدرة على الأكل بسبب عدم وجود أضراس خلفية تحتاج إلى 11 تركيبة زركون

4. Treatment provided

☐ Consultation ☐ Scaling and Polishing ☐ Dental X ray

☐ I & D of Dental Abscess ☐ Gum treatment ☐ Crown

☐ Extraction – specify tooth ☐ Filling – specify tooth

☐ RCT – specify the tooth ☐ Application of sealant – specify tooth

☐ Others - specify 11 Fixed prosthesis 6543 | 345 / | 3456

I certify that I have satisfied myself by personal examination that all the foregoing statements are accurate and correct .

Name of attending physician and Qualification : Amira Signature : [signature] Date : 28-9-2019

DECLARATION : I hereby consent to and authorize the attending physician to provide AL- BUHAIRA NATIONAL INSURANCE COMPANY with complete information , including copies of my records, with reference to any sickness or accident , any treatment , examination , advice or hospitalization. Any photocopy of this authorization shall be taken as original copy .

د. أميرة 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

PR NO : .... Insurance I.D NO........

Patient's Name .... Total amount ....

Signature .... [signature] Date ....

Claims must be submitted alongwith supporting Documents in the first week of the month following the treatment month

g.i./medclfrm

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-005376

AED 8,883.00

RECEIPT VOUCHER

Date: 05-10-2019

Receive from Mr./Mrs./M/s. **1002921 - ALI SULTAN - 971503600400**

The sum of Dhs. **Eight Thousand Eight Hundred Eighty Three Only**

By Cash **0.00** / By Credit Card **8,883.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

Being **ADVANCE FO 12 VENEERS *325 + 14 ZIRCON *930 + VAT BALANCE 8883**

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

Discount

5/10/2019

Paid 50%

8883

مـركـــز أوركـــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

No: REC-005245

AED 150.00 **RECEIPT VOUCHER**

Date: 28-09-2019

Receive from Mr./Mrs./M/s. **1002921 - ALI SULTAN - 971503600400**

The sum of Dhs. **One Hundred Fifty Only**

By Cash **0.00** / By Credit Card **150.00 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

Being **ADVANCE FOR 1 COMPOSITE FILLING**

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

مـركـــز أوركـــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

AED 8,886.00 **RECEIPT VOUCHER (No.REC-005528)** **Date:14-10-2019**

Receive from Mr./Mrs./M/s. **1002921 - ALI SULTAN - 971503600400**

The sum of Dhs. **Eight Thousand Eight Hundred Eighty-Six Dirhams and Zero Fils Only**

By Cash **3.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **8,883.00**

Bank: Cheque No. Date: **14-10-2019**

Being **14 VENEERS *325 + ZIRCON CROWN 14 *930 + VAT REST BY 2 CHQ EACH 4440**

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 : **1002921 - ALI SULTAN - 971503600400**

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

ORCHID MEDICAL CENTER

MODE OF PAYMENT RECEIVED FOR LAB PROCEDURE Ali 1002921

NO: TEETH	RATE / TEETH	TOTAL AMT OF TREATMENT:	ADVANCE COLLECTED	CASH	CARD	CHEQUE	BALANCE
12 veneers 14 Zircon	⇒ 325 ⇒ 930	3900 ~~8883~~ ⇒ 13020	8886		✓		

BALANCE AMOUNT Total 16920

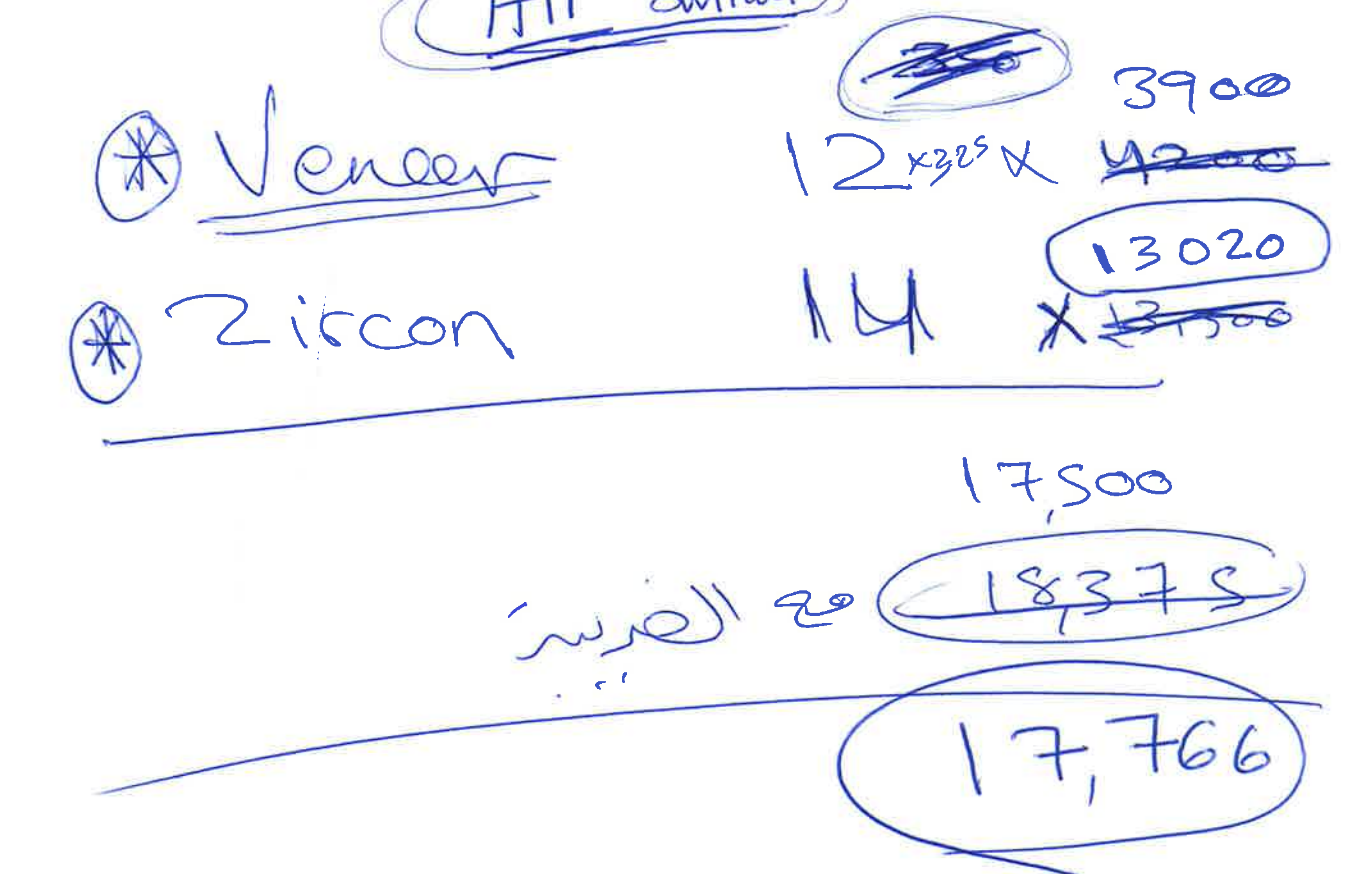
INSTALLMENT DETAILS

BANK NAME	DT: CHQ	CHQ #	INSTALLMENT AMT	CHQ REPLACEMENT DETAILS
Emirates Islamic	10-11-19	000011	4440	
~ ~	10-12-19	000012	4440	
		TOTAL	8880	

[signature] 14-10-19

CHQ COLLECTED FROM FRONT DESK:

NAME & SIGNATURE WITH DT : [signature] 14/10/2019



Veneer 12 x 325 = 3900

Zircon 14 x 930

13020

16920

VAT 846

17,766