



مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

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

File No: 1002926

Date: / /

Date: 21/9/2019 File Number: 1002926  
Patient Name: Hoda Ragab Ahmed  
Date Of Birth: 18/1/1976 Gender: M / F Marital Status: (الحالة الاجتماعية) .....  
Nationality: (الجنسية) : Egypt (الوطنية) : A.T.Tache Adina S.F. Financial (Gen. cons) Egypt  
Address: D.N. Tower, Afghanska, 5015, 1888 Phone No. (رقم الهاتف) : 504740720  
E-MAIL: .....@.banet How did you know about us: In Internet

التاريخ الطبي Medical History		
الحالة الطبية Medical Condition	Yes/No نعم / لا	If 'YES' give details إذا كانت الإجابة نعم انظر بالتفصيل
Recent or current drugs/Medical Treatment هل تتعاطى أي أدوية أو تتلقى أي علاجات حديثة؟	لا	
Corticosteroids/Immunosuppressant هل تتعاطى أي مخدرات أو مثبطات للمناعة؟	لا	
Allergies هل لديك أي حساسية؟	لا	
Surgical Operations, Serious illness هل أجريت أي عمليات جراحية أو تعاني من أي أمراض؟	لا	
Cardiac surgery, Rheumatic fever, Endocarditis, Artificial heart valve, Congenital heart disease جراحة قلب، حمى روماتويد، التهاب شغاف القلب، صمام قلب صناعي، أمراض القلب	لا	
High Blood Pressure, Bleeding disorders, Anticoagulants هل لديك ارتفاع في ضغط الدم، مشاكل في النزيف أو تتعاطى أي مميعات الدم؟	لا	
Anemia, Leukemia (سرطان الدم) أنيميا (نقر الدم)، لوكميا (سرطان الدم)	لا	
Chest disease, Asthma, Bronchitis, TB, Other أمراض صدرية، أزمة قلبية، التهاب في الشعبات، السل، أمراض أخرى	لا	
Renal, Urinary, Sexually transmitted disease هل تعاني من أي أمراض في الكلى أو أمراض بولية أو تناسلية؟	لا	
Pregnancy, Contraceptive pill, Menstrual problems هل أنت حامل؟ هل تتعاطين أي مانع للحمل؟ هل تعانين من مشاكل في الدورة الشهرية؟	لا	
Hepatitis, Jaundice, Other liver diseases التهاب الكبد الوبائي، الصفراء، أي أمراض كبدية أخرى	لا	
Peptic ulcer, Crohn's ulcerative colitis, Other قرحة معوية، داء كرون، أي أمراض معوية أخرى؟	لا	
Epilepsy, or any other neurological disease هل تعاني من الصرع أو أي أمراض في الجهاز العصبي؟	لا	
Thyroid Diseases, Diabetes هل تعاني من مرض السكري أو أمراض الغدة الدرقية؟	لا	
Other conditions MSV, HIV...etc هل تعاني من أي أمراض أخرى؟ فيروس الإيدز، فيروس الحلا البسيط etc	لا	



### 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 services, 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 minor):

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

### نموذج إقرار طبي

- أوافق و أسمح للطبيب بملاح حالتي المرضية التي تم شرحها لي من قبل الطبيب المختص و الخوّل.
- أفهم أن بعض الإجراءات الطبية والتشخيصية الإضافية قد تكون ضرورية من أجل تزويدي بالمعالج الأمثل و الخدمة الأفضل.
- أفهم أنه من الممكن أن يكشف الطبيب خلال العلاج أموراً مختلفة عن ما فكرت في الفحص الأولي و التي قد تتطلب إجراءات إضافية أو مختلفة عن تلك المخطط لها.
- أفوض الطبيب المعالج باتخاذ كل الإجراءات الطبية و العلاجات اللازمة و المطلوبة بحكم خبرته المهنية و الطبية.
- أقر أنه لم يتم تقديم أي ضمانات أو تأمين نتائج العلاجات و الإجراءات الطبية أو التجميلية المقدمة لي، كما أفهم الإخطار و المضاعفات الناتجة عن عدم استكمال علاج حالتي المرضية.
- أفهم تماما كافة الإخطار و المضاعفات التي قد تكون مصحبة للفحوصات و الإجراءات العلاجية و الجراحية.
- و ادرك ان بعض الإجراءات التشخيصية و العلاجية و الجراحية قد تؤدي الي مضاعفات كالتهاب أو التورم أو النزيف أو الالم أو الحساسية
- أفهم أن هناك رسوم بالحد الأدنى يجب علي بعضها مقابل الخدمة العلاجية و أن جميع الرسوم المطلوبة يجب أن تسدد بالكامل قبل الانتهاء من العلاج.
- أقر أن كافة المعلومات الطبية و التاريخ الطبي الذي قدمت لي قسمي الملف صحفية و أفهم ان أي معلومات تتعلق بحالتي الصحية ستبقى سرية تماما ولا يمكن الاطلاع عليها دون موافقتي
- أقر ان 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

أنا على دراية تامة أن أي مدفوعات للمركز هي غير قابلة للاسترداد

توقيع المريض / ولي الأمر لمن هم دون السن القانونية):

صحة... ابتسامة... جمال

التاريخ: ... / ... / .....

## استمارة تقييم المريض Patient Assessment Form

### المؤشرات الحيوية Vital Signs

Weight (الوزن):	Kg	Height (الطول):	cm	Blood Type (نوعية الدم):
Pulse (النبض):	ppm	Blood Pressure (ضغط الدم):	/	Blood Sugar (سكر الدم):

### سبب زيارة المريض للعيادة Chief Complaint

Disease History (التاريخ المرضي):	
Allergies (الحساسية):	
Medications (الأدوية):	
Pregnancy (الحمل):	
Previous Surgeries, Hospitalization (عمليات سابقة، إيداع للمستشفى):	
Smoking (التدخين):	Y / N
Alcohol (الكحول):	Y / N
Drugs (تدخين العقاقير):	Y / N

### الملاحظات العامة و السريرية General & Clinical Findings

#### الفحص Examination

#### الصور الشعاعية Radiography

#### التشخيص Diagnosis



PATIENT NAME: *Floda Rayab*

FILE NO#:

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
21/9/2019	Laser consultation P: AVÈN trixèra MOI u-shield Hair face body + (Deba)			<i>Beel</i>
19/10/19	hair-face body plus (Deba)			<i>Beel</i>
2-11-2019	scabbing → pdish		150	<i>O. Ay</i>
16/11/19	hair-face body plus (Deba)			<i>Beel</i>
21/11/19	hair-face body plus (Deba)			<i>Beel</i>
25/11/20	hair-face body plus (Deba)			<i>Beel</i>

د. وسام مروان الطباع  
 Dr. Wesam Marwan Al Tabbaa  
 اختصاصي جلدية  
 Dermatology Specialist  
 MOH License No: V826  
 Orchid Medical Centre

د. أميرة حسن  
 Dr. Amira Hassan  
 ممارس عام - طبيب الأسنان عام  
 G.P General Dentist  
 MOH License No.: D57288  
 Orchid Medical Centre



precisely Kindly Answer the following questions يرجى الاجابة على الأسئلة التالية بدقة

How do you better describe your skin Type	ما هي الوصف الأنسب لنوع بشرتك ؟
<input type="checkbox"/> Always Burned , little tanned	<input type="checkbox"/> دائمة الاحتراق , قليلة الاسمرار
<input type="checkbox"/> Always Burned, Never Tanned	<input type="checkbox"/> دائمة الاحتراق , عديمة الاسمرار <b>والخطي اسمرار</b>
<input type="checkbox"/> Little Burned, Always Tanned	<input type="checkbox"/> قليلة الاحتراق , دائمة الاسمرار
<input type="checkbox"/> Rarely Burned, Always Tanned	<input type="checkbox"/> نادرة الاحتراق , دائمة الاسمرار
Have you Ever had Scars or keloids? Yes / No	هل ظهرت لديك سابقا علامات ندوب أو جدره ؟ نعم / لا <input checked="" type="checkbox"/> لا
Have you ever had Herpes simplex, blisters or ulcers on site? Yes/ No	هل ظهر لديك حلا البسيط أو بثور أو تقرحات في منطقة العلاج ؟ نعم / لا <input type="checkbox"/> لا
Have you Taken Akutan or Isotritonine in the last 6 months? Yes/ No	هل تناولت عقار الاكيتان/ الايسوتريتونين خلال الست اشهر الماضية؟ نعم / لا <input checked="" type="checkbox"/> لا
Have you used Retin A.Glycolic acid or Hydroquenon on Site? Yes/ No	هل استخدمت ريتين أي أو منتجات حمض الجليكوليك أو الهيدروكينون في منطقة العلاج ؟ نعم / لا <input type="checkbox"/> لا
Have you plucked or waxed hair on site in the last 6 months? Yes/ No	هل قمت بنتف أو كي أو إزالة الشعر بالشمع في منة العلاج خلال ال ٦ اسابيع الماضية؟ نعم / لا <input checked="" type="checkbox"/> لا
Did you get exposed to sun or got tanned lately? .....	هل كنت اخر مرة تعرضت فيها لاشعة الشمس لمدة طويلة أو قمت بجلسة تسمير؟ نعم / لا <input checked="" type="checkbox"/> لا
Do/ Did you use any tanning products? Yes / No	هل استخدمت مستحضرات تسمير البشرة؟ نعم / لا <input checked="" type="checkbox"/> لا
Do you Have any tattoos on site? Yes / No	هل لديك أي وشم / تاتو في منطقة العلاج؟ نعم / لا <input checked="" type="checkbox"/> لا
Have you been diagnosed with any hormonal abnormalities? Yes / No	هل تم تشخيصك سابقا بأي اختلالات أو مشاكل هرمونية؟ نعم / لا <input checked="" type="checkbox"/> لا
What products you are using for your skin recently? .....	ماهي المنتجات التي تستخدمها / تستخدمها ليشربك حاليا؟ .....
Have you Done Any Laser Hair Removal Before? Yes / No	هل اجريت اي عملية إزالة شعر سابقا؟ نعم / لا <input checked="" type="checkbox"/> نعم
For Ladies: Are You Pregnant ? Yes / No	السيدات فقط : هل أنت حامل؟ نعم / لا <input checked="" type="checkbox"/> لا
Have you done any permanent make up? Yes / No	هل قمت سابقا بإجراء مكياج دائم للوجه؟ نعم / لا <input checked="" type="checkbox"/> لا

I ..... hereby consent that I came to Orchid Medical Center/ Sharjah to remove unwanted hair by laser. I understand that laser produces a beam of light that generates an energy of a certain wavelength which is absorbed in the pigments of hair follicles to impair its' ability to grow hair. I understand that the results of the treatment varies from one person to another by the variation of medical history and the skin type, hair type , patients commitment to precautions before and after sessions and the va-riation of individual responses to treatment. and I consent that I know all the alternative hair removal methods and I choose removing my unwanted hair by laser.

I consent that I got the following precautions:  
-It's not allowed to get tanned or use tanning solutions for 4-6 weeks before and after treatment.  
- Waxing and Plucking must be avoided at least 6 weeks prior to sessions.  
- Tattoos and permanent make up on treatment site will be affected by laser.  
- Full Medical History must be given including previous treatments, allergies and skin type.  
- people who took akutan during the last 6 months or any drugs that inhibits patients from sun exposure can not remove their hair by laser.  
I understand that i might see some change from first session, nevertheless the treatment will take many sessions to get the result.

Side Effect  
side effects may include burning like redness, and it's possible to see some swelling or cracks, these side effects will fade away few hours to few days after treatment. hypo/hyperpigmentation is not common and it rarely last. it's advisable to avoid sun exposure, and to use sun protections.  
I consent that I had the chance to enquire and ask any questions I have to the therapist and I have read and understood the content of this form (or it was read to me) and I am more than 18 years old or I have the approval of my sponsor.

Name and Signature .....

Date  
... / ... / .....

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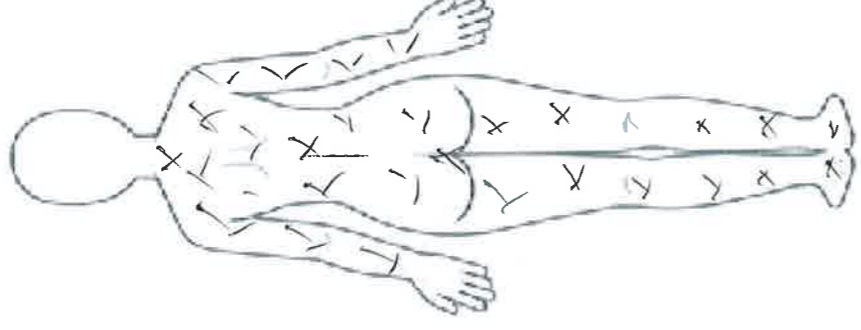
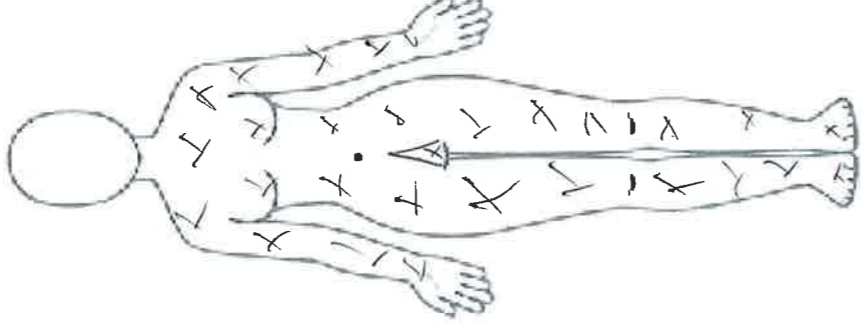
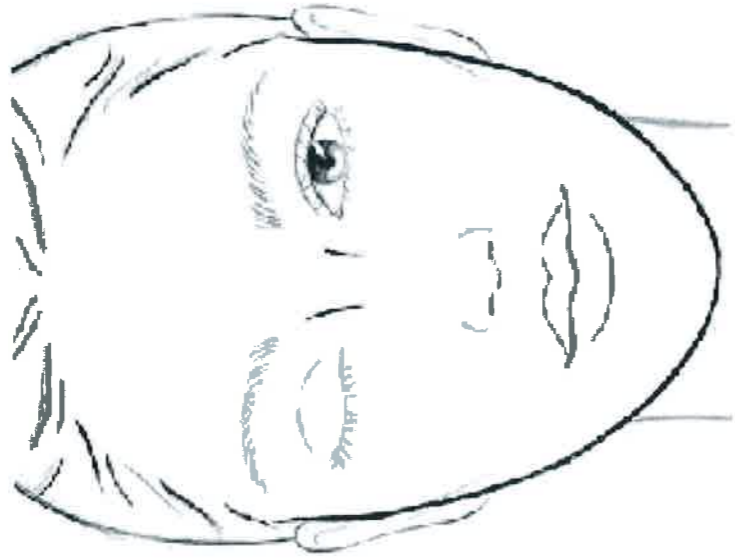
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سم و التوقيع  
.....  
..... / ... / .....

تاريخ  
..... / ... / .....

اسم المريض: Hoda Raga  
 Patient's Name: .....  
 رقم الملف: .....  
 File Number: .....  
 تقييم و الموافقة اكتملت؟ Yes / No  
 Pretreatment photography taken? Yes / No  
1002926



	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6
Treatment Date	21/9/19	19/10/19	16/11/19	21/12/19	25/01/20	
Treatment Area	Full body +	Same	Same	Same	Same	
Hair Type	M/S/D	M/S/H	Soft/Light Soft	Thin	Thin/Soft	
Mode	ND YAG	NDYAG	NDYAG	NDYAG	NDYAG	
Fluence	16/15, 15/18 m					
Pulse Type		16/14				
CNT Pulse		14/16	16/13-14	16/13-4ms	16/15-13ms	
Passes	1					
Starting Time	3:45 pm	12:30 pm	11:45 AM	7 pm	8:15 pm	8:15 am
Finish Time	5 pm	1:15 pm	1 pm	8:15 pm	11 AM	12:10 pm
Post Treatment	Hindoid Ray	FUCICORT		HIRUDOID	advised mebo / shower legs / Not deodorant / No hair	

Therapist Name and Signature .....

REDAD DATA

cAEAlOEBAa83ODQxO\*

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	Hoda,Ragab,Ahmed,,Morsy	IDN:	784197653650545	Mother Name:	
Name (Ar)	هدى رجب احمد مرسى	Card Number:	095680623	Mother Name (Ar):	
Title:		Nationality:	EGY	Family ID:	
Title(Ar):		Nationality (Ar):	مصر		
Issue Date:	23/07/2019	Sex:	F	Sponsor Type:	15
Expiry Date:	20/07/2021	Date of Birth:	12/08/1976	Sponsor Name:	
Marital Status:	02	Husband IDN:		Sponsor Number:	00
Residency Type:	04	Residency Number:	31201920002417	Residency Expiry:	20/07/2021
ID Type:	IL	Occupation:	98	Occupation Field:	00



Photo

Signature Image

هدى رجب احمد

<http://orchidsvr/EMID/default.aspx>

9/21/2019





مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

AED 1,102.50

RECEIPT VOUCHER (No. REC-005160)

Date: 21-09-2019

Receive from Mr./Mrs./M/s. 1002926 - HUDA 00. - 971504740720

The sum of Dhs. **One Thousand One Hundred Two Dirhams and Fifty Fils Only**

By Cash **1,102.50** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank:

Date: 21-09-2019

Cheque No.

Being **FULL BODY PLUS + 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 : 1002926 - HUDA 00. - 971504740720

**Tel : + 9716 555 8337, Fax : + 9716 528 8130, e - mail : [info@omc1.ae](mailto:info@omc1.ae)  
[www.omc1.ae](http://www.omc1.ae)**



مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

AED 1,102.50

RECEIPT VOUCHER (No. REC-005573)

Date:19-10-2019

Receive from Mr./Mrs./M/s. 1002926 - HUDA 00. - 971504740720

The sum of Dhs. **One Thousand One Hundred Two Dirhams and Fifty Filis Only**

By Cash **1,102.50** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No.

Date: 19-10-2019

Being **FULL BODY + 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 : 1002926 - HUDA 00. - 971504740720

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



مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

AED 157.50

RECEIPT VOUCHER (No.REC-005792)

Date:02-11-2019

Receive from Mr./Mrs./M/s. 1002926 - HUDA 00. - 971504740720

The sum of Dhs. **One Hundred Fifty-Seven Dirhams and Fifty Fils Only**

By Cash **157.50** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No.

Date: 02-11-2019

Being **SCALING AND POLISHING + 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 : 1002926 - HUDA 00. - 971504740720

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



مركز أوركيذ الطبي  
ORCHID MEDICAL CENTER

AED 1,102.50

RECEIPT VOUCHER (No.REC-005988)

Date:16-11-2019

Receive from Mr./Mrs./M/s. 1002926 - HUDA 00. - 971504740720

The sum of Dhs. **One Thousand One Hundred Two Dirhams and Fifty Fils Only**By Cash **0.00** / By Credit Card **1,102.50** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank:

Date: 16-11-2019

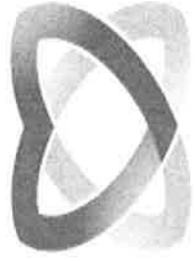
Cheque No.

Being **FULL BODY PLUS + 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 : 1002926 - HUDA 00. - 971504740720

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



مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

AED 1,102.50

RECEIPT VOUCHER (No.REC-006646)

Date:21-12-2019

Receive from Mr./Mrs./M/s. 1002926 - HUDA 00. - 971504740720

The sum of Dhs. **One Thousand One Hundred Two Dirhams and Fifty Fils Only**

By Cash **1,102.50** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No.

Date: 21-12-2019

Being **FULL BODY PLUS + 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 : 1002926 - HUDA 00. - 971504740720

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



مركز أوركيد الطبي  
ORCHID MEDICAL CENTER

AED 1,102.50

RECEIPT VOUCHER (No.REC-007230)

Date:25-01-2020

Receive from Mr./Mrs./M/s. 1002926 - HUDA 00. - 971504740720

The sum of Dhs. **One Thousand One Hundred Two Dirhams and Fifty Fils Only**

By Cash 0.00 / By Credit Card 1,102.50 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 25-01-2020

Being 1 session full body + 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 : **1002926 - HUDA 00. - 971504740720**

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