مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

File No: ..... Date: / /

Date: ... / ... / ..... File Number: 1003585

Patient Name: Ghizlane Benkirane إسم المريض :

Date Of Birth (تاريخ الميلاد) : 24 / 11 / 1981 Gender (الجنس) : M / (F) Marital Status:(الحالة الاجتماعية) .....Married....

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

Address (العنوان) :..... Phone No. (رقم الهاتف): 0529111401

E-MAIL: ....Ghizlane.benkirane@yahoo.com How did you know about us: .....Instagram.....

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 (سرطان الدم) انيميا (فقر الدم)، لوكيميا	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

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 الالم 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: ... 17/12/2019

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
	4/11/2020: sagging face Plan: threads + Botox previous procedure: face filler Botox		cons	

د. وسام مروان الطباع
Dr. Wessam Marwan Al Tabbaa
اختصاصي جلدية
Dermatology Specialist
ترخيص رقم: 26
مركز اوركيد الطبي

REDAD DATA

cAEAIOEBAA83ODQxO

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	Ghizlane,,,,Benkirane	**IDN:**	784198165097654	**Mother Name:**	
Name (Ar)	غزلان,,,,بنكير ان	**Card Number:**	089525418	**Mother Name (Ar):**	
Title:		**Nationality:**	MAR	**Family ID:**	
Title(Ar):		**Nationality (Ar):**	المغرب		
Issue Date:	13/06/2018	**Sex:**	F	**Sponsor Type:**	09
Expiry Date:	11/06/2021	**Date of Birth:**	24/11/1981	**Sponsor Name:**	حياه العالميه - المركز المالى
Marital Status:	02	**Husband IDN:**		**Sponsor Number:**	00
Residency Type:	03	**Residency Number:**	20120153160302	**Residency Expiry:**	11/06/2021
ID Type:	IL	**Occupation:**	98	**Occupation Field:**	00

Photo

Signature Image

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

No: REC-006599

AED 6,956.25

RECEIPT VOUCHER

Date: 19-12-2019

Receive from Mr./Mrs./M/s. **1003585 - CHIZLANE 000 - 971529111401**

The sum of Dhs. **Six Thousand Nine Hundred Fifty Six and Two Five Fils Only**

By Cash **0.00** / By Credit Card **6,956.25 (Bank Charges: 0.00)** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date:

eing **ADVANCE FOR 3 D VENEERS 12 + 8 ZIRCON CROWN + 1 COMPOSITE + VAT BALANCE 6956.25**

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

13250

DENTAL CLAIM FORM

Cigna

HOW WE USE YOUR INFORMATION

We will collect, use, store, and disclose your personal information, including sensitive information (in particular, information relating to your medical history and any medical treatment you may have or have had), in accordance with relevant data protection legislation. We collect and will use your personal information, including sensitive information, for the purpose of carrying out our obligations under this plan. We may share your information, including sensitive information, with other Cigna companies and authorised healthcare providers, where necessary to carry out our obligations under this plan. This statement also applies to personal information of any beneficiaries detailed on this application form. You have the right to request a copy of your personal information held by us, and beneficiaries under your policy have the right to request a copy of personal information we hold about them. We may charge a fee to provide this information.

PATIENT'S DETAILS

To be completed by the beneficiary or his/her legal representative

1 Patient name	Ghizlane Benkirane		
2 Policy ID		**3** Patient's date of birth	
4 Full mailing address of patient			
5 State nature of illness			
Email address		Tel no	Fax no
6 Do you have any other health or travel insurance policy for which you may receive full or partial reimbursement for these expenses?		Yes ◯	No ◯
If you have answered yes in section 6, please give details below:			
Full name		Policy number	
Address of insurance company			

PAYMENT DETAILS

To be completed by the beneficiary or his/her legal representative

7 List of expenses for which reimbursement is claimed and amount — **8** State to whom you wish settlement paid and currency

Treatment	Date	Amount	Payment to	Currency
X-Ray	19-12-2019	1000		
RCT	19-12-2019	1000		
4 Zircon Crown	19-12-2019	3250x4		
		13000		

9 Select payment method		**Cheque** ◯	**Bank wire transfer** ◯
10 Should payment be sent to your bank account, please complete the following:			
Bank account no.		Bank name	
Sort Code		Name of account holder	
Swift Code*		IBAN*	
Bank branch address:			

11 I authorise the release of any medical information necessary to process this claim. To the best of my knowledge all the details given are true.

I warrant and represent that I have each covered person's consent to disclose the personal information, including the sensitive personal information (e.g. medical information) contained in this form to you. I confirm that each covered person is aware of their duty to take reasonable care to answer questions accurately, honestly, completely and to the best of their knowledge.

(Please note that if you are declaring the above on another person's behalf, it is your obligation to keep evidence of the consent you are providing hereto of your covered family members' actual declarations and consents.)

Signature of insured person (or Legal Representative):	
Date	

*by providing this information, payment will be transferred more efficiently by the receiving bank

THIS SECTION TO BE COMPLETED BY THE DENTIST

CODE	TREATMENT	NO OF UNITS	DATE OF TREATMENT	CHARGE TO PATIENT
	PREVENTATIVE TREATMENT			
	EXAMINATIONS			
A01	Normal			
A11	Extensive			
A21	Full case assessment			
	X-RAYS			
B01	Bitewing		19.12.19	1000
B02	Intra oral			
B03	O.P.G.			
	SCALING AND POLISHING			
E01	One visit			
D01	Fissure sealants			
D11	Topical fluoride application			
M0U	Occlusal splint			
	MINOR TREATMENT			
	FILLINGS			
G01	Amalgam - one surface			
G02	Amalgam - two surfaces			
G03	Amalgam - three+ surfaces			
G21	Composite - one surface			
G22	Composite - two surfaces			
G31	Additional charge use of pin			
	ROOT CANAL TREATMENT			
H01	Upper and lower anterior (1 root)	12	19.12.19	1000
H02	Upper premolar (2 roots)			
H03	Lower premolar (1 root)			
H04	Molars (3+ roots)			
	EXTRACTIONS			
L01	Single			
L02	Per additional tooth			
N11	Post-operative care			

CODE	TREATMENT	NO OF UNITS	DATE OF TREATMENT	CHARGE TO PATIENT
	MAJOR TREATMENT			
	PERIDONTAL TREATMENT (NON-SURGICAL)			
E21	Prolonged (curettage/root planing)			
F51	Splinting			
	PERIDONTAL TREATMENT (SURGICAL)			
F01	Gingivectomy			
F11	Mucoperio, flap bone surgery			
	DENTURES - METAL/ACRYLIC			
R63	Additional tooth			
R61	Addition of clasp			
K71	Denture repair			
	CROWNS/BRIDGES			
J01	Veneers (per tooth)			
K32	Adhesive bridges			
K41	Conventional bridgework			
K12	Standard post and core			4 Zircon Crown.
K11	Gold post and core			
K07	Bonded precious crown			
K05	Bonded non-precious crown			
K08	Full cast crown			
K06	Porcelain crown			
	INLAYS			
K02	Precious			
K01	Non-precious			
K03	Porcelain			

TOTAL 15000

I confirm that the treatment has been/will be carried out and I hereby declare that all treatment as stated is being submitted for approval/has been completed.

Dentist's signature:

Date:

Dentist's stamp:

د. امينة 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

Please return your fully completed form along with the original receipt/invoices to:

Treatment incurred outside the USA send to:

Cigna Global Health Options
1 Knowe Road
Greenock
PA15 4RJ
Scotland

Tel: +44 (0) 1475 788182
Fax: +44 (0) 1475 492113
Email: cignaglobal_customer.care@cigna.com

Treatment incurred inside the USA send to:

Cigna International
PO Box 15964
Wilmington, Delaware 19850
United States of America

Tel: +44 (0) 1475 788182
Fax: 855 358 6457
Email: cignaglobal_customer.care@cigna.com

FRAUD NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing deliberately false information, commits a fraudulent insurance act, which is a crime.

We will not deal with any claims which we believe to be fraudulent. Committing fraud may result in your policy being terminated, or we will investigate any claims which we believe to be fraudulent.

Your relevant Cigna contracting entity from those listed below will be detailed in you Policy Rules and Certificate of Insurance.

a) Cigna Life Insurance Company of Europe S.A-N.V.; or
b) Cigna Global Insurance Company Limited; or
c) Cigna Worldwide General Insurance Company Limited; or
d) Cigna Europe Insurance Company S.A-N.V.

ORCHID MEDICAL CENTER

TAX INVOICE

PATIENT FILE #:	**1003585**	**VISIT DATE:**	**19-12-2019**
PATIENT NAME:	**GHIZLANE BENKIRANE**	**INSURANCE:**	**CASH**
DOCTOR:	**AMIRA**	**INVOICE DATE:**	**19-12-2019**
VAT REG #:	**100479302000003**		

SL.NO	CODE	SERVICE	UNIT PRICE	QUANTITY	GROSS	DISCOU	VAT%	VAT AMOUNT	NET
1	X14	X-RAY	1000	1	1000	0	0	0	1000
2	R01	RCT	1000	1	1000	0	0	0	1000
3	C114	ZIRCON	3250	4	13000	0	0	0	13000
		GROSS TOTAL (AED)							15000
		DISCOUNT (IN AED)							0
		NET TOTAL							15000
		NET + VAT TOTAL							15000
		PAID (IN AED)							15000
		BALANCE (IN AED)							0
		ADVANCE BALANCE							0

ORCHID MEDICAL CENTER

PATIENT NAME: GHIZLANE BENKIRANE

PATIENT SIGNATURE:

CIGNA International Medical & Dental Claim Form

Please mail or fax completed Claim Form with itemized bills and receipts. Please tape small receipts on 8.5 x 11 paper. Please do not staple receipts to Claim Form.

CIGNA International
P O Box 15050
Wilmington, DE 19850-5050

Phone: (800) 441.2668 (outside the U.S.A., via ATT + access)
(302) 797.3100 (outside the U.S.A., collect calls accepted)
Facsimile: (302) 797.3150 (inside the U.S.A.)
(800) 243.6998 (outside the U.S.A., via ATT + access)
E-mail: cieb@cigna.com Website: http:///www.cigna.com/expatriates

Please print or type on this Claim Form. Please complete Sections A and B and Signature lines. Complete Section C if other coverage is in effect or the claim is accident or work related. Complete a Separate Claim Form for each Family Member.

SECTION A. EMPLOYEE AND PATIENT INFORMATION

Type of Claim ❑ Medical/Vision ❑ Dental ❑ Prescription Drugs (Please tape receipts on 8.5 x 11 paper) Date of service, earliest date if multiple _____ (month) (day) (year)

Country where services were rendered_____ Diagnosis/Reason for treatment _____ (Please note diagnosis/reason for each service received)

Employer _____ CIGNA Employee ID Number | | | | | | | | | | |

Employee's Name _____ Patient's Name Gamal Raafat

Employee's Date of Birth _____ (month) (day) (year) Patient's Date of Birth _____ (month) (day) (year)

Mailing Address _____

City _____ State/Province _____ Country _____

Postal/Zip Code _____

Please provide telephone and facsimile numbers, with country and city codes.
Home #_____ Work #_____ Fax #_____
E-mail Address_____

SECTION B. PAYMENT INFORMATION. Please complete either Option #1 or Option #2 and indicate preferred currency for payment. If you wish to receive funds via wire transfer, please contact us for additional instructions (note: your financial institution may assess fees for processing the wire). If you would like to enroll for Electronic Funds Transfer (EFT) please contact us for an application. If already enrolled with EFT, we will automatically send payment via EFT unless noted otherwise below.

Please indicate currency preference_____
If currency is not specified, payment will be made in U.S. dollars.

❑ *OPTION #1* *Payment to EMPLOYEE. Please indicate where you wish the payment to be sent*	❑ *OPTION #2* *Payment to PROVIDER of Service, e.g. hospital, physician.*
❑ Address as listed above ❑ EFT (requires prior EFT enrollment)	Provider name _____
❑ Direct mail check deposit to your bank account:	Provider Address _____
Bank account #_____	City _____ State/Province _____
Bank name _____	Country _____
Name on account _____	Postal/Zip code _____
Bank Branch Address _____	Telephone Number _____

PAYMENT AUTHORIZATION: I authorize payment as indicated in Section B of this Claim Form.
EMPLOYEE'S SIGNATURE:_____ DATE:_____

PATIENT'S SIGNATURE AND RELEASE: (Parent or Guardian, if claim is for a minor). I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine benefits payable.
PATIENT'S SIGNATURE:_____ ***DATE:***_____

SECTION C. OTHER COVERAGE INFORMATION. Complete only if other coverage is in effect or if the claim is accident or work related.

Do you have any other insurance? ❑ Yes ❑ No. If yes, please provide source of insurance.

1. Please indicate source _____

2. Is this claim accident or work related?

   ❑ Accident related (continue to no. 3)

   ❑ Work related (continue to no. 3)

   ❑ No, not accident or work related (go to signature section)

3. Please provide a brief description of how the accident or work injury occurred.

   - Root Canal Infection #6

   - Composite filling #7

4. If claim is due to an accident, are you seeking reimbursement from another source? ❑ Yes ❑ No.

   If yes, please indicate source _____

Please be sure to sign the Claim Form and attach all itemized bills and receipts.

Please tape small receipts on 8.5 x 11 paper. Please do not staple receipts to Claim Form.

Please include diagnosis or reason for treatment information for each service received.

DISCLOSURE

Information we collect about you will not be given to anyone without your consent, except when it is necessary for conducting our business. The only individuals who have access to the information are CIGNA employees who service your policy or claims, and those who have insurance related, regulatory or legal need for the information. In other situations, we will ask for your written authorization to disclose information about you.

FRAUD NOTICE:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subject such person to criminal and civil penalties.

12/17/01

د. هيثم عبد اللطيف
Dr. Hythem Abdellatif
DHA: 0058894
مركز برايت وايت لطب الاسنان ش.ذ.م.م
BRIGHT WHITE DENTAL CENTER L.L.C

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 13,912.50 **RECEIPT VOUCHER (No.REC-006845)** **Date:02-01-2020**

Receive from Mr./Mrs./M/s. **1003585 - CHIZLANE 000 - 971529111401**

The sum of Dhs. **Thirteen Thousand Nine Hundred Twelve Dirhams and Fifty Fils Only**

By Cash **0.00** / By Credit Card **6,956.25** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **6,956.25**

Bank: Cheque No. Date: **02-01-2020**

Being **12 VENEERS 3 D *425 + 8 ZIRCON CROWN *1000 + 1 COMPOSITE FILLING + 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 : **1003585 - CHIZLANE 000 - 971529111401**

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

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

2019/12/31

اسم المريض: غزلان بتكير ان

رقم الملف: ١٠٠٣٥٨٥

ضمان تركيب فينيير.

ضمان خمس سنوات من المختبر فيما يتعلق بفنيير الاسنان, الضمان يشمل اي مشكلة ناتجة عن عيوب التصنيع او التركيب بالاضافة الى ضمان خمس سنوات من مركز اوركيد الطبي, مع مسؤولية المريض على العناية بالصحة الفموية والفحص الدوري والصحة العامة للاسنان.

الضمان لايشمل اي تكسير او ضرر ناتج عن اي حوادث او عوارض خارجية.

يبدأ الضمان من تاريخ هذه الرسالة.

ضمان من المختبر

2024/12/30-2019/12/31

ضمان من مركز اوركيد الطبي

2029/12/30-2024/12/31

شكرا لاختياركم مركز اوركيد الطبي....

مركز اوركيد الطبي

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ORCHID MEDICAL CENTER

TAX INVOICE

4-1-2020

PATIENT FILE #: 1003585
PATIENT NAME: GHIZLANE BENKIRANE
DOCTOR: AMIRA
VAT REG #: 100479302000003

VISIT DATE: ~~19-12-2019~~
INSURANCE: CASH
INVOICE DATE: 19-12-2019

SL.NO	CODE	SERVICE	UNIT PRICE	QUANTITY	GROSS	DISCOU	VAT%	VAT AMOUNT	NET
1	C001	SCALING AND POLISHING	500	1	500	0	0	0	500
2	C004	COMPOSITE FILLING	500	5	2500	0	0	0	2500
3	Z006	ZIRCON	3250	3	9750	0	0	0	9750
4	E152	EXTRACTION	1000	2	2000	0	0	0	2000
		GROSS TOTAL (AED)							14750
		DISCOUNT (IN AED)							0
		NET TOTAL							14750
		NET + VAT TOTAL							14750
		PAID (IN AED)							14750
		BALANCE (IN AED)							0
		ADVANCE BALANCE							0

ORCHID MEDICAL CENTER

04/01/2020

PATIENT NAME: GHIZLANE BENKIRANE

PATIENT SIGNATURE:

Note:-
@Only For Insurance Purpose