مركز أوركيد الطبي
ORCHID MEDICAL CENTER

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

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

Date: 31/12/2019 File Number: .....1.203.690...

Patient Name: SANDRINE WANDJI TANKEU ..... :إسم المريض

Date Of Birth (تاريخ الميلاد) 23/07/1985 Gender (الجنس) : M / (F) Marital Status:(الحالة الاجتماعية) Married

Nationality (الجنسية) CAMEROONIAN Occupation (الوظيفة) : STUDENT

Address (العنوان) : DUBAI, Sports city, OP1 Phone No. (رقم الهاتف): 0529787206

E-MAIL: sandrynn_tank@yahoo.fr 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؟		
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	

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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 النتاجة 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: 30/12/2019

Patient Assesment Form استمارة تقييم المريض

Vital Signs المؤشرات الحيوية

Weight (الوزن): 80 Kg	Height (الطول): 170 cm	Blood Type (فصيلة الدم) : O+
Pulse (النبض): ppm	Blood Pressure (ضغط الدم) : /	Blood Sugar (سكر الدم) :

Chief Complaint سبب زيارة المريض للعيادة

Disease History :التاريخ المرضي

Allergies الحساسية — NA

Medications الأدوية — non

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

.....

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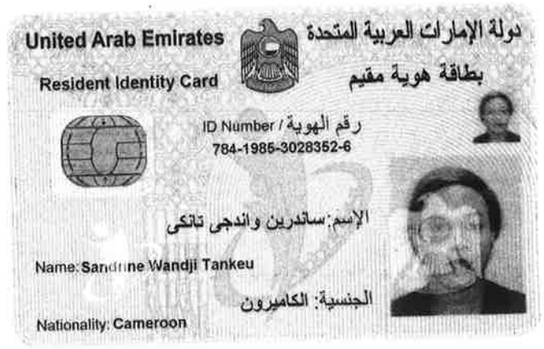
PATIENT NAME: **FILE NO#:**

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE


United Arab Emirates
دولة الإمارات العربية المتحدة
Resident Identity Card
بطاقة هوية مقيم
ID Number / رقم الهوية
784-1985-3028352-6
الإسم: ساندرين واندجى تانكى
Name: Sandrine Wandji Tankeu
الجنسية: الكاميرون
Nationality: Cameroon

ADNIC
شركة أبوظبي الوطنية للتأمين
ABU DHABI NATIONAL INSURANCE COMPANY

REIMBURSEMENT MEDICAL CLAIM FORM

Please read the instructions & guidelines on overleaf before filling the form

Voucher No.:

1. Patient's name: **2. Patient's Health Card no./Emirates ID no.:**

3. Group member's name:

4. Reason for not using listed Healthcare facilities: (kindly indicate)

☐ Emergency ☐ Elective ☐ Service not available ☐ On vacation/business trip outside the UAE

☐ Other(s) please specify .....

5. Medical information: (To be filled by treating doctor for all outpatient treatment. For cases like hospitalization procedures and surgeries, a detailed medical report is required)

Condition requiring treatment: Fractured tooth #30 with Tract Extending to Bifurcation **Visit date:**

Onset and duration of illness:

Treatment details: Extraction # 30, Complicated, Requiring sectioning of the tooth

I declare that I have attended to this patient and that the particulars given are to the best of my knowledge true and correct.

Name & signature of the doctor: ..... Date: ..... Stamp: .....

د. محمد عوده
Dr. Muhammed Odeh
ممارس عام - طبيب أسنان عام
G.P General Dentist
Orchid Medical Centre مركز أوركيد الطبي

6. Name & Address of the Hospital/Clinic	Bill No.	Treatment Date	Description of Services	Amount

Currency (If treatment availed outside the UAE) ..... TOTAL

7. Other information:

Is the above case work-related? ☐ No ☐ Yes (full details) .....

Is the claim covered by another insurance? ☐ No ☐ Yes (pls specify the amount reimbursed and by which insurance company)

8. Declaration:

I, the undersigned, hereby declare that the information above is true and complete and that reimbursement requested is for expenses paid by me for the treatment of my medical condition.

I agree to submit to ADNIC any mandatory/deemed necessary requested document to process my above claim. I hereby authorize ADNIC to approach any doctor/medical facility/any institution or any person who has any record/medical information about me or my family member, to provide ADNIC with complete information including copies of the records when requested.

Name Relationship to the card holder	Signature	Date	Contact no.	Email address

PREFERENCE – MODE OF SETTLEMENT

1. ☐ Cheque

2. ☐ Bank/Wire transfer

If Bank/Wire Transfer, please fill in the below authorization form.

AUTHORIZATION FORM FOR BANK/WIRE TRANSFER

Authorization

I, the undersigned, hereby authorize Abu Dhabi National Insurance Company (ADNIC) to wire transfer the amount of my claim under this form to the following bank account:

BANK NAME: .....

IBAN NUMBER: .....

EMAIL ID: .....

MOBILE NUMBER: .....

.....	.....	.....
Member Name & Medical insurance card number	Signature	Date

Disclaimer: All information provided is the responsibility of the member and is legally binding.

ADNIC OPS only

ADNIC staff name: Date:

Instructions

1. This form needs to be completed by the insured member (Card holder), only if the provider is not submitting the claim on his behalf.
2. Please read the form carefully and make sure to complete all pertinent information. ADNIC will not be able to process any incomplete Reimbursement Claim Form that lacks proper documentation.
3. Use a separate form for each Member.
4. All the documents including invoices and medical reports should be in either English or Arabic. Documents in other languages must be translated by an official public translator prior to submission.
5. The following documents to be attached to your duly filled Reimbursement Claim Form.
   - *Copy of Medical insurance card and Emirates ID.*
   - *Original itemized bill/invoices (dated) and receipts of payment.*
   - *Original prescription for medication given by the treating doctor (except for controlled drugs). Validity of the prescription is limited to 60 days and for controlled drugs limited to 3 days in line with Department of Health - Abu Dhabi.*
   - *Investigation requests/reports like laboratory tests, x-rays, etc.*

   Additional requirements to above:
   For Inpatient (Hospitalization Cases)
   - *Medical Report/Discharge Summary stamped & signed by the treating doctor.*

   For treatments availed Outside the UAE
   - *Proof of travel with date (E.g.: Copy of tickets/boarding pass/Exit & Entry page).*
   - *Elective treatment is subject to ADNIC prior approval at all times.*
6. Please retain copies of receipts and documents enclosed with your claim, as ADNIC will retain original documents.
7. All claims subject to reimbursement availed within or outside the UAE, should be submitted with 120 days of incurred treatment.
8. Please submit all the above required documents directly to:
   medicalclaims@adnic.ae

If you need assistance in filling this form, please call: 8008040

Instructions to complete the form

1. **Please write your name & Medical insurance card number** *as mentioned in the Card.*
2. **Medical Information** – *Request your treating doctor to fill up brief medical information about your condition and treatment.*
3. **Provider Name & Address** – *Kindly use more than one line if necessary to provide this information about each facility where you were treated.*
4. **Bill No.** – *Please write the serial number/reference number printed on the bill/receipt/invoice for each service separately.*
5. **Service Date** – *State date of treatment for each service against each bill.*
6. **Description of services** – *State type of service like consultation/Pharmacy/Investigations/Physiotherapy/Dental/ Hospitalization.*
7. **Amount** – *State the exact amount as appears on the invoices.*
8. **Total** – *Total amount of all the invoices submitted with this form for reimbursement from ADNIC.*
9. **Currency** – *Name of the currency in which actual payment was made.*
10. If treatment is due to a road traffic accident,, a police report is required to be submitted with this form.
11. **Declaration:** *Kindly write your name, signature, date, the contact number and relationship to the cardholder.*