



REIMBURSEMENT FORM

24 hour Tel: 04-2708800, Fax: 04 2708592

Please Complete Clearly (All Fields Mandatory) FORM No:

ADMINISTRATIVE

Healthcare Provider: <u>Dentistree Dental Clinic</u>		Patient's Name: <u>Althea Lorraine AZARCON Surja</u>	
Date of Service: <u>dd/mm/yyyy</u> <u>06.01.2025</u>	Patient's Tel: <u>0561871062</u>	DOB <u>dd/mm/yyyy</u> <u>03/02/2010</u>	Sex: <input checked="" type="checkbox"/> F <input type="checkbox"/> M
Emirates ID No: <u>784-2010-4280790-0</u>		Email address: (Mandatory)	
Insurance Company:			
Account Name:		UAE IBAN Number:	
UAE Bank Name:		UAE Swift Code:	

SUBJECTIVE (To be completed by Physician)

Symptom(s) As Described by Patient (CHIEF COMPLAINT)

Date of Present Symptom Onset: 06 / 01 / 2025
dd mm yyyy

What date did the Patient first feel same / similar symptom(s): / /
dd mm yyyy

Is the Patient under any type of treatment / Meds: YES NO
If yes, indicate what assessment and since when:

OBJECTIVE / ASSESSMENT (To be completed by Physician) Vital Signs T: P: R: B/P:

Past Medical & Surgical History:

Clinical Details & Description of Present Case:

Cause: Physical Illness Accident Maternity Preventive Psychiatric Dental Work Related
 Acute Chronic Confirmed Suspected Other

Assessment / Diagnosis: <small>INDICATE DIAGNOSIS NOT SYMPTOM</small>	Diagnosis Code
1. <u>class III malocclusion</u>	
2.	
3.	

Is Assessment / Diagnosis related to another Assessment? YES NO If yes, specify: (i.e. Retinopathy related to Diabetes)

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

<input type="checkbox"/> Consultation	Cost	<input type="checkbox"/> Physiotherapy	Cost
<input type="checkbox"/> Pharmacy	Cost	<input type="checkbox"/> Laboratory / Radiology / Other	Cost
		<u>Comprehensive orthodontic treatment</u>	<u>ADD 300</u>

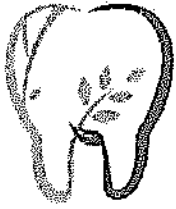
TOTAL CHARGES

Was In-patient Required? Length of Stay _____ Indicate Provider _____ Cost _____

• Discharge Summary: Itemized Invoices, Reports & Receipts Attached?

Treating Physician Name: <u>Dr. Pratik Premjani</u>	I, hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical condition & history to NEXICARE for the purpose of determining insurance benefits.
Name & Address of Facility: <u>Dr. Pratik Premjani Dental Clinic</u>	
Tel / Fax: <u>0561871062</u>	
Email: <u>DentistreeDentalClinic@gmail.com</u>	
Signature: <u>[Signature]</u>	Patient's Signature (Parent if minor) _____ Date _____





DENTISTREE DENTAL CLINIC

TAX INVOICE

Reg TRN No : 100529934000003
Facility Name : DentisTree Dental Clinic
Address : P.O.Box 23581, Ground floor, Shop 3, Wasl Port Views 8, Al Mina Road, Jumeirah 1, Dubai
042529935 / 045641764

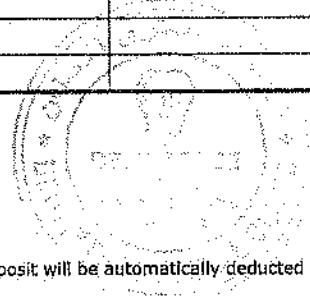
Invoice No : INV-1C009337 Invoice Date : 06-01-2025
Doctor : Pratik Premjani Department : Dental
Patient Name : Althea Lorraine Azarcon Sunga MRN # : 3412
Age / Gender : 14Y - 11M - 13D / Female Type : Cash
Visit Date : 06-01-2025 Inv. Time : 17:37:02

Sl No	Service Code	Treatment / Procedure	Tooth No	Unit Price	Qty	Gross	Discount	VAT %	VAT Amount	Net
1	65	ORTHODONTIC MONTHLY VISIT		600.00	1	600.00	300.00	0	0.0000	300.00
Gross Amount (In AED)										600.00
Discount (In AED)										300.00
Net Amount (In AED)										300.00
Tax on 5%(In AED)										0.00
Total Amount(In AED)										300.00
Paid (In AED) (Credit Card)										300.00
Balance (In AED)										0.00
Advance Balance (In AED)										0.00

Prepared By Joy

Patient Signature

Kindly note that this automated and uniquely dated Invoice is payable on this visit before leaving the Center deposit will be automatically deducted upon settlement.





DENTISTREE DENTAL CLINIC

300.00

RECEIPT VOUCHER (No. REC-1009310)

Date: 06-01-2025

Receive from Mr./Mrs./M/s. 3412 - Althea Lorraine Azarcon Sunga

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

By Cash 0.00 / By Credit Card 300.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No:

Date: 06-01-2025

Being

Made by Joy

