038431

Dr. LEILA H. MEDICAL CENTER W.L.L.

مركز د. ليلى حامد الطبي ذ.م.م.

Dental Sheet

DATE: march.4.2024 التاريخ

FILE NO: 038431 رقم الملف NATIONALITY: Indonesia الجنسية C.S. married الحالة الاجتماعية

NAME OF PATIENT: Ayoneda Siti Sarah Bt mukodo اسم المريض AGE: 51 السن SEX: Female الجنس:

I.D. NO. 2733 600 2290 رقم بطاقة MOB.: 55844 323 جوال TEL.: تليفون:

ADDRESS m. khalifa عنوان COMPANY: الشركة INSURANCE: تأمين:

DOCTOR Dr: Habiba

CHIEF COMPLAINT:

PAST MEDICAL HISTORY:

H/O DRUG ALLERGY NO ☐ YES ☐

* Dx Caries-C; Pulpitis-P; Crown- OCR; Bridge- OB; Missing- M; R. Dec. Teeth-RD; Retreated-RCD; Impacted-I; Root Stump-RS

																	Rx
Dx																	
			A	B	C	D	E		F	G	H	I	J				
1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16	
32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17	
			T	S	R	Q	P		O	N	M	L	K				

State of Qatar
Residency Permit

دولة قطر
رخصة إقامة

ID. No: **27336002290** الرقم:

D.O.B. **04/08/1973** تاريخ الميلاد:

Expiry: **21/02/2025** الصلاحية:

الجنسية: اندونيسيا

Nationality: **INDONESIA**

Occupation: محاسبة المهنة:

الاسم: ايويندا سيتي ساره بت موكودو

Name: **AYOENDA SITI SARAH BT MUKODO**

Passport Number: **X1299504** رقم جواز السفر:

Passport Expiry: **17/03/2027** تاريخ انتهاء الجواز:

Serial No: 11141511287EA127 الرقم المسلسل:

Residency Type: عمل نوع الرخصة:

Employer: الالتزام لجلب الايدي العاملة المستقدم:

مدير عام الجنسية و المنافذ وشؤون الوافدين
General Director of Nationality, Borders & Expatriates Affairs

توقيع حامل البطاقة
Holder's Signature

Dr. LEILA H. MEDICAL CENTRE W.L.L

مركـــز د. ليلـى حـامـد الطبي ذ.م.م

Consent Form (Dental Treatment)

PATIENT NAME	QID NUMBER	FILE NUMBER
Ayoneda Gitti		038431

Consent Form:

A legal document signed or marked by a patient or legal authorized representative voluntarily, without coercion or undue influence, prior to any medical

Treatment/procedure. This form states that the patient agrees to undergo the recommended treatment/procedure and is aware of any possible risks that might occur

1. DRUGS AND MEDICATIONS

I have been advised by the attending dentist & understand that antibiotics & analgesics & other medications can cause allergic reactions causing redness & swelling of the tissues , pain, itching, vomiting & / or anaphylactic shock (severe allergic reaction). I understand it is my responsibility to inform the doctor in case I am allergic to specific medication & also any medication I am currently taking

2. XRAYS

I agree that it is my responsibility to inform the attending dentist if I AM PREGNANT

3. LOCAL ANESTHESIA

I have been advised by the attending dentist & understand that there are some risks involved in the administration of local anesthesia. Most risks are related to the position of the nerves under the tissues at the site of injection although the risks seldom occur they might include loss of feeling in my teeth, lips, tongue & surrounding tissue (Paresthesia) that can last for an indefinite period of time, days or months & may resolve spontaneously. In addition, administration of local anesthesia into the body may result in a rare allergic reaction.

4. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dental to make any/all changes and addition as necessary.

5. REMOVAL OF TEETH

I authorize the Dentist to remove the following teeth and any others necessary for reasons. I understand removing teeth does not always have complications if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if compilations arise during or following treatment, the cost of which is my responsibility.

6. DIRECT RESTORATION/ FULLVENEERS /PARTIAL VENEERS/DIRECT VENEERS ON ESTHETICS

I realize that veneer treatment is typically used for teeth that are discolored, either because of root canal treatment, stains from tetracycline or other drugs, excessive fluoride. Veneer can be used for aesthetic purposes to repair teeth that are misaligned uneven or irregularly shaped or to close the space between teeth that have gaps between them. I understand that holding my mouth for longer time leave my jaw feeling stiff and sore and may make it difficult to open wide for several days. As there is removal of some portion of teeth (enamel) and some portion of teeth is exposed (dentin) they will be sensitivity and following treatments for sensitivity should be performed. I understand that veneers are usually non repairable should they chip/crack. The need for a full coverage crown may warrant. When veneers are done on demand on esthetics each patients tooth varies on its style shape and overall prognosis

7. CROWN, BRIDGES AND CAP

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth, I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation.

8. ROOT CANAL TREATMENT

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment and resection

9. ORTHODONTIC TREATMENT/ GENERAL DENTIST / IMPLANT.

I authorize the all Dentist doctors to do my treatment and pledge that I will follow the treatment and instructions for this or any other procedures as written in the form.

I UNDERSTAND THAT DENTISTRY IS NOT AN EXACT SCIENCE AND THAT THEREFORE REPUTABLE PRACTITIONERS CANNOT FULLY GUARANTEE RESULTS. I ACKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE MADEBY ANYONE REGARDING THE DENTAL TREATMENT WHICH I HAVE AUTHORIZED AND REQUESTED. I HAVE HAD THE OPPORTUNITY TO READ THIS FORM AND ASK QUESTIONS. MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I CONSENT TO PROPOSED TREATMENT

Patient's Signature	Doctor's Signature: Dr. Habiba Rahim
Date: 4/3/2024	Date:

تليفـون : ٤٤٨١٧٦٥١ / ٤٤٨١٧٦٥٢ - فـاكـس ٤٤٨١٢٧٩٦ - شارع الســلام - معيــذر الشمالي فيـلا رقم ٨٠/٨٢