DENTAL TREATMENT FORM

Ref No.

Dear Doctor you are kindly requested to complete this Consultation Form and fax it to NAS Claims Center at 02-6766227.
For prescriptions, kindly use Prescription/ Advice Form.

PATIENT INFORMATION

NAME:	KRIS FERNANDEZ DAVID	**GIVEN NAME:**	KRIS FERNANDEZ DAVID
DATE OF BIRTH :	08-Jul-1993	**GENDER:**	Female
CARD NBR:	F28J-EFE2-C2CF-GCDE	**PAYER**	NAS - SRN WN

CASE INFORMATION

DIAGNOSIS

K08.132 - Complete loss of teeth due to caries, class II

AETIOLOGY

(Please indicate the exact cause in case of injuries)

PROCEDURE / MANAGEMENT PLANNED

(AMOXICILLIN : 500 MG) CAPSULES AMOXICILLIN [500 MG], (DICLOFENAC POTASSIUM : 50 MG FILM COATED TABLETS ORAL, D0150 - comprehensive oral evaluation - new or established patient

TREATING DENTAL SPECIALIST Abdulrahman

HOSPITAL / CLINIC CITICARE MEDICAL CENTER LLC

CONSULTATION DETAILS **NEW** ☐ **FOLLOW-UP** ☐ **CONSUTATION FEES**

Dr. Abdulrahman Al Tekreeti
General Dentist
DHA No: 84724128-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

DATE: 16-Feb-2025

DOCTOR'S SIGNATURE AND STAMP

I hear allow NAS authorized personnel to obtain any requisite medical details from my current and previous physicians and case diles.

BENEFICIARYS' SIGNATURE