

**Administrative Section**

Policy number 16/XC/30059/0/39/E/0 Membership number
Patient name SAID ESSAM SAID FTOUH Provider name CITICARE MEDICAL CENTER LLC
Date of treatment 05-Aug-2025 Patient Gender ☒ Male ☐ Female

Medical Section

Type of visit ☐ Outpatient ☐ Inpatient If ☐ Emergency ☐ Maternity ☐ Dental ☐ Optical

If Pregnant: L.M.P. Date Nature of conception ☐ Natural ☐ Assisted

Chief complaint

follow up patient

came with complain of something inside the ear.

we have done procedure without anesthesia.

done irrigation with normal saline water and removed wax.

History of present illness

Date	Doctor	Location	Quality	Severity	Duration	Timing	Context	Modifying Factor	Symptoms
No Previous Complaints Found									

Clinical findings/other conditions**Past medical history**

Details of trauma - if applicable (where, when & how) ☐ Work Related ☐ RTA Related ☐ Sports Related

If yes ☐ Professional ☐ Non-Professional

Diagnosis

T16.9XXA - Foreign body in ear, unspecified ear, initial encounter

Treatment plan, recommended medications, investigations, and/or procedures

Treatments: 69200, Removal foreign body from external auditory canal without general anesthesia, 65220, Removal of foreign body external eye corneal without slit lamp, 9.01, FOLLOW UP GP

Prescription:**Patient declaration**

I hereby confirm that I am the patient/AXA card holder, Patient's parent or guardian (if under 16 years of age) and I wish to claim and declare that all the details/ information given above are to the best of my knowledge true and correct. I hereby consent to and fully authorize the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to AXA Insurance (Gulf) B.S.C © representative or any of AXA company affiliates. I subrogate all my rights in relation to this claim and I fully authorize and give access to AXA Insurance (Gulf) B.S.C © representative or any of AXA company affiliates to audit, review and copy all my medical records details including any historical medical records regardless the previous payer/insurer. I agree that a copy of this consent shall have the validity of the original.



Signature

Date:05-Aug-2025

Medical practitioner declaration

I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.

Name

Signature

Date:05-Aug-2025

Dr .Frahan Ilyas Malik
Physician-General Practitioner
DHA-06441782-001
CITICARE MEDICAL CENTER
DUBAI U.A.E

Stamp

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