

KHYBER COLLEGE OF DENTISTRY  
& DENTAL HOSPITAL,  
PESHAWAR.

Receipt No. 50

Humaira Bidi

C-HBS - HCV - HIV

Incharge Section

KHYBER COLLEGE OF DENTISTRY  
ORAL & DENTAL HOSPITAL,  
PESHAWAR.

Book No. 614

Receipt No. 20

Date 14/12/23

Received from Humaira Bidi

Amount of Rs. 0000

on account of BSR

Rs. 8000

Incharge Section

**WAJID**

Jail Plaza Near MCB Bank

99134  
9949358  
5/11/2023 15:45:41  
Mob#:

Price	Total
4.00	40.00
22.80	228.00
260.58	260.58
18.21	182.10
206.68	206.68

il: 917.36  
d: 37.69  
al: 880.00

دوائی تین دن کے اندر

فرج آگم۔ انسولین، اینڈرا

ed by Abuzar Consultancy.

**WAJID**

Jail Plaza Nawan Kali Bara Road Near MCB Bank

Peshawar  
LIC NO# M3299134  
0915231110 0316-9949358

No. 84971 16/11/2023 17:31:20  
Name: Mob#:

R#	Item Name	Qty	Price	Total
	Nitto Tape	1	83.33	83.33
	Nichipore			
	1 Cc Shifa	2	30.00	60.00
	Syring			
	2sum 1gm Inj	2	415.00	830.00
	New			
	5cc Shifa	1	275.00	275.00
	Iv Canula 22g			

Total items: 4 Gross Total: 1,248.33  
You Saved: 8.00

WAJID Net Total. 1,240.00

دوائی تین دن کے اندر دیکھ کر دے اور سید لازی ہے  
فرج آگم۔ انسولین، اینڈرا اور گائیس کی دوائی نہیں ہے۔

(Computer Software developed by Abuzar Consultancy.  
Ph 042-37426911-15)

**WAJID**

Jail Plaza Nawan Kali Bara Road Near MCB Bank

Peshawar  
LIC NO# M3299134  
0915231110 0316-9949358

No. 85520 17/11/2023 18:31:05  
Name: Mob#:

R#	Item Name	Qty	Price	Total
F 5	Augmentin	2	260.58	521.16
	625mg Tab			
	2sum 1gm Inj	4	415.00	1660.00
	New			
	5cc Shifa	5	20.00	100.00
	Syring			

Total items: 3 Gross Total: 2,281.16  
You Saved: 31.37

WAJID Net Total. 2,250.00

دوائی تین دن کے اندر دیکھ کر دے اور سید لازی ہے  
فرج آگم۔ انسولین، اینڈرا اور گائیس کی دوائی نہیں ہے۔

(Computer Software developed by Abuzar Consultancy  
Ph 042-37426911-15)



# ACCIDENT & EMERGENCY DEPARTMENT

Khyber Teaching Hospital  
Medical Teaching Institution Peshawar, KPK.

Invoice #: K03235688390

No: K03ACE00924259

Clinic: CASUALTY

Name: Humaira Bibi

Patient Type: ACUTE EMERGENCY

Gender: Female

Date: 15-NOV-23 09:06:25

Age: 40 Year(s)

Operator: SAJID KHAN

Complaints:

Ref: ENT  
~~Ext~~ Concentric  
 own upper  
 lip

RX S inj. broad in that

Findings:

Ac  
 - CBC  
 - WBC 141  
 - HCO

→ Td: Flexin 5mg  
 2-5 - 1+1

Td: Nurofen  
 2-5 - 1+1

Investigations:

X-Ray @ Shoulder  
 upper limb

→ Td: Olanzapine  
 5mg

Diagnosis:

Refer to consultant  
 OPD

Complete bed rest  
 Signature: Sajid Khan

Next Visit:

Consultant Name:

Phone: (091)9224400

website: www.kth.gov.pk



KHYBER COLLEGE OF DENTISTRY, PESHAWAR  
Out-Patients Department

Rs. 10/-



S. No. (2)

- LOC -ve
- Vomiting -ve
- Nasal discharge -ve

Patient ID: 208785  
 Patient Name: HAMAIRA BIBI  
 Sex: Female Age: 40  
 Date & Time: 15-NOV-23 10:11:19

Refer to Si

adv OPG

O/E

- TMS Palpable

- Bk mouth opening normal

- laceration on left side of upper lip

- grade II mobile H

Adv
- HBS
- HCW
HU

3, 2, 1 / 1, 2, 3

Advised for splinting  
Dr. Hussam

Hussam  
15/Nov/23

Splinting done 15th/Nov/2023

Follow up 29th Nov/23



PATHOLOGY DEPARTMENT  
KHYBER COLLEGE OF DENTISTRY, PESHAWAR  
BLOOD SCREENING REPORT

Name: Humaira Poibi Age/Sex: F Lab. No: 113

INVESTIGATION REQUIRED	PATIENT RESULT
HBS (Ag) by ICT (Hepatitis B Surface Antigen)	Non-Reactive
HCV (Ab) by ICT (Hepatitis C Virus Antibodies)	Non-Reactive
HIV (Ab) by ICT (Human-Immune-Deficiency-Virus)	Non-Reactive

Immunochromatographic Technique (ICT) Screening Test.

Incase of any doubt (Positive or Weakly Positive) confirmation by Elisa /  
Confirmatory test is required

Remarks: \_\_\_\_\_

Date: 15 / 11 / 2023

Clinical Pathologist

GS & PD NN 3246 BLOOD SCREEN REPORT IN DENTAL HOSPITAL FOLDER 07.09.2022



حکومت پاکستان

قومی شناختی کارڈ

17304-4273271.2

نام : میراج علی

جنس : عورت

دوسرا کارڈ نمبر : 258756

شہرستانی شناختی کارڈ نمبر

09/03/1982 : تاریخ پیدائش

عذرا ایمن بی

پتو : گلبرگ 2، اسلام آباد

سنگھار





صافحہ نمبر : 17301-1273271-2

موضوع : اسی سطور میں اصل رٹا لکھ کر بھیج دینا

منسلک شدہ دستخط طلب نو تقریر نمبر 139 اپنا وار کونٹ

بجیل و سٹیج اپنا وار

تاریخ : 05/05/2026

خط و کتابت کے لیے برقراری کیے جانے والی ہیں



13582610379





Note: All answers must be in the physician's handwriting.

**Patient Information**

Name of Patient	<u>HUMAIRA JAHANGIR</u>	Date of Birth	<u>02/03/1982</u>
Patient's Address	<u>Old Bara road, Peshawar</u>		

**Employer Information**

Name of Employer	
------------------	--

**1. History**

(a) Date doctor first consulted due to disability	<u>15/11/2023</u>
(b) Date symptoms first appeared or accident happened	<u>15/11/2023</u>
(c) Date patient ceased work because of disability	<u>Yes</u>
(d) Has patient ever had same or similar condition?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, state when and describe
(e) Is condition due to injury or sickness arising out of patient's employment?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, state when and describe
(f) Name the first doctor with full address, consulted by the claimant for the above disability/accident?	
Name of Doctor	<u>Dr. SYED USMAN ZAHEER</u> Mobile No <u>0345-9487470</u>
Address	<u>House No. 51, The Mall road, Bannu Cantt.</u>

**2. Diagnosis**

(a) Date symptoms first appeared or accident happened	<u>15/11/2023</u>
(a) Diagnosis (including any complications)	<u>Lacerated lips and luxated front upper teeth.</u>
(c) Subjective symptoms	<u>Mobile teeth, Lacerated lips.</u>
(d) Objective findings (including current X-rays, ECG's, Laboratory data any clinical findings):	
(1) Clinical Findings	<u>Luxated 21/12,</u>
(2) Diagnosis Studies and results:	<u>-</u>

**3. Progress**

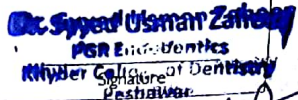
(a) Patient is	<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Bed Confined	<input checked="" type="checkbox"/> House Confined	<input type="checkbox"/> Hospital Confined
(b) Patient has	<input type="checkbox"/> Recovered	<input checked="" type="checkbox"/> Improved	<input type="checkbox"/> Stabilized	<input type="checkbox"/> Retrogressed

**4. Prognosis**

(a) Is the disability presumed to be reversible	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
(a) Is patient now capable of performing duties of	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
(c) What duties of his or her job is patient incapable of performing?	<u>Writing and holding any thing.</u>		
(d) Do you expect a fundamental or marked change in future?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
If yes, patient should recover sufficiently to perform duties on or about	<u>_____</u>		
If No, Please explain	<u>Patient will be recovered in one month time.</u>		
(e) Specify the date by which you presume that the patient will be able to resume his duties/work			
<input type="checkbox"/> Totally	<input type="checkbox"/> Partially	<input type="checkbox"/> Temporarily	<input checked="" type="checkbox"/> Permanently

**Remarks**

**Declaration:** I hereby declared that the above statements are true and complete to the best of my knowledge.

Attending Physician's Name	<u>Dr. SYED USMAN ZAHEER</u>	Telephone No	<u>0345-9487470</u>
Address	<u>House No. 51, The Mall road,</u>		
Specialty	<u>Bannu Cantt.</u>		
	<u>Endodontics / Operative Dentistry</u>		
	Date	<u>27/11/2023</u>	

**PAK-QATAR FAMILY TAKAFUL LIMITED**

102-105, Business Arcade, Block-6, P.E.C.H.S, Shakra-e-Faisal, Karachi 75400, Phone: (92-21) 34311747-56 (Ext-162)  
 Fax: (9221) 34386451, UAN: 021-111-TAKAFUL (825238), Email: life.claims@pakqatar.com.pk, www.pakqatar.com.pk

www.pakqatar.com.pk

111-TAKAFUL (825-238)

# Hayatabad Medical Complex

Hayatabad, Peshawar, Pakistan. Phone: 091-9217140-46, Fax: --

Email: pathoff@hmckp.gov.pk, Website: www.hmckp.gov.pk



## INVOICE\_RECEIPT\_SMALL

Order No: 232098217      Inv Date : 24-NOV-23 09:03 AM  
Inv No : K01234983856      Access code :  
MRNO : 00001909540      Patient Type : REGULAR  
Name : Humaira Jahangir  
Clinic :  
Doctor : N/A

Sr	Item Description	Qty	Rate	Amount
1	CT All Joint 3 D(Shoulder, Elbow, Wrist, Hip, Knees, Ankle)	1	3,600	3,600

Total Amount      3,600.00  
Charge to Hospital (Free)      1,800.00  
Special Discount      1,800.00

*Scan performed*  
*RAD*

24-11-2023 09:03 AM - - HMC-RAD-002

S08REP00309

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Hayatabad Medical Complex Peshawar.

Doc Code

HMC-OPD-Ins-01

OUTPATIENT DEPARTMENT (OPD)

Version No.

MEDICAL TEACHING INSTITUTION

Serial No.

274738

Appointment Time : 11:18

DENTAL - OPD

Token# 001

Name : Humaira Jahangir

35 Year(s)

Sex : Female

Father \ Husband Name : NASIR KHAN

Invoice # : K01224923839

MRNO : K0100001909540

Serial # : 1239115

Amount Paid : 50.00

Print Date : 20 NOV 23 11:21:00

Complaints:

Rx

Findings:

LH of RTA.

Lc oc → pain on biting/chewing

Lc tenderness on Lt IOR.

Intra-oral:

- disturbed occlusion

- Lt splinted

- tenderness in Lt 2M Buttness

Investigations:

Adv: 3DCT jaw  
E all views

Person free

Diagnosis:

50%

HOSPITAL DIRECTOR  
MTI HMC PESHAWAR

Next Visit:

Consultant Name:

Signature:

Phone: 9217140 - 46

Website: www.hmckp.gov.pk



**KHYBER COLLEGE OF DENTISTRY, PESHAWAR**  
**Out-Patients Department**

**Rs. 10/-**



S. No. \_\_\_\_\_

Patient ID: 210367  
Patient Name: **MHUMAIRA BB**  
Sex: Female Age: 40  
Date & Time: 24-NOV-23 11:11:40

→ Post of Case of RTA. 10 days back.  
→ Repaired den in upper **(L)** Lip.

O/E.

- Wound healing **(N)**
- No pus discharge
- Stitches  $\bar{e}$  s $\bar{i}$ k in placed in upper **(L)** Lip.

Refer to ward for stitch removal.

**AF** 24-11-2023



# KHYBER COLLEGE OF DENTISTRY, PESHAWAR

## Out-Patients Department

113

**Rs. 10/-**



S. No. 21

- LOC -ve
- Vomiting +ve
- Nasal discharge -ve

Patient ID: 208785  
 Patient Name: HAMAIRA BIBI  
 Sex: Female Age: 40  
 Date & Time: 15-NOV-23 10:11:19

Refer to Si

Adv OPG  
 Adv  
 - FBs  
 - HCW  
 HU

O/E - TMT Palpable

- Bk/k mouth opening normal
- laceration on left side of upper lip
- grade II mobile HL

Advised to splint by Dr. Hussam

? Hussam  
15/Nov/23

3, 2, 1 / 1, 2, 3

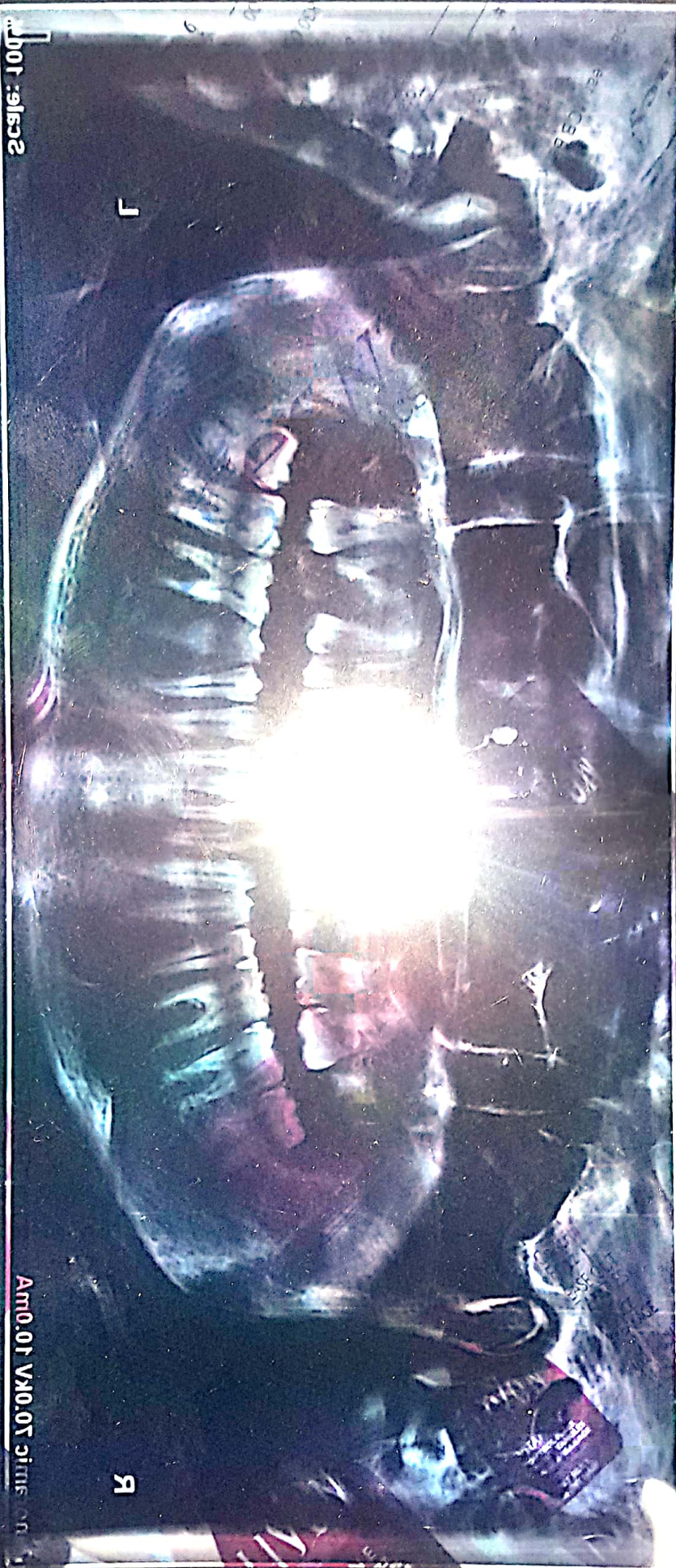
Splinting done 15<sup>th</sup> / Nov / 2023.

Follow up 29<sup>th</sup> / Nov / 2023



mm: 50

Scale: 100%



Am 0.01 V 10.05 01

L

R

153











# Employer's Statement – DS1 (Disability Claim Form)

Note: Please don't leave any blank, unanswered question, date and/or signature, wherever applicable

### Section I. Policy holder's information

Name of Policy Holder <b>Humaira Jehangir</b>	
Takaful Policy No.	Takaful Policy Commencement Date.
Designation <b>AS</b>	Phone No / Mobile No <b>03109532873</b>
E-mail address <b>-</b>	
Employee's Name <b>Humaira Jehangir</b>	CNIC <b>17301-1273211-2</b>
Employee's Address <b>Shahzadabad, Nauway Kalay, UC Dish-takshara</b>	
Employee's Date of Birth <b>02/03/1982</b>	Age <b>41 years</b> S. No. on list

### Section II (to be completed in Full by the Employer)

Employee's Date of Appointment	Employee's Effective Date of Takaful	Last Day Worked <b>15-11-2023</b>	Returned to Worked <b>20-11-2023</b>
Reason for Stopping Work <b>She came with an incident during field visit and due to this she injured resulted in mouth jaws injury as well as in left hand elbow cracked.</b>			
Gross Earning from Salary/Wages <b>Rs. 34,626</b> Per Month	Amount of Takaful cover <b>Rs.</b>	What is the present employment status of the employee <input type="checkbox"/> On Duty <input type="checkbox"/> Terminated <input checked="" type="checkbox"/> On Sick Leave <input type="checkbox"/> Temporary Laid off	
Amount of Claim <b>25,000/-</b>	Title of Cheque		
Claimant Name		Telephone No	
Date of Statement			
Employer Signature		Company Stamp	

### Section III (to be completed in Full by the Patient/Employee)

Type of disability claim? <input type="checkbox"/> Natural (Sickness) <input checked="" type="checkbox"/> Accidental	Please describe how and where the disability/accident occurred <b>I was visiting cttws in field during MCB updation as I visited one cttw and going to other one, I came across an incident as a motorcycle has hit me in mehmanabad area. I dropped very hard on road and her left hand has badly injured resulted in cracked ankle of left hand.</b>		
Date of Accident or the date I first Noticed the symptoms of this was: <b>15-11-2023</b>	(a) Is your accident or illness related to your occupation? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No if "Yes", Please explain <b>I am working as a area supervisor and we work in field for visiting cttws and checking their work.</b>		
I (was/have) unable to work because of this disability starting on <b>15-11-2023</b>	I (returned/was able to return/will be able to return to work on a full time basis on <b>28-11-2023</b>		
On What date did employer discontinue your monthly salary/wages	Treated by <input checked="" type="checkbox"/> Hospital <input type="checkbox"/> Doctor	Name <b>Jehyber Teaching hospital</b> Address <b>University Road</b>	
Date I was first treated for this accident or illness <b>15-11-2023</b>	Treated by <input type="checkbox"/> Hospital <input type="checkbox"/> Doctor	Name Address	
Have you ever had the same or Similar condition in the past? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", when	Name Address		

I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company of employer have information available regarding the benefit or the diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me to give Pak-Qatar Family Takaful Limited, or its representatives and all such information. I AGREE that a photographic copy of this Authorization will be valid as the original. this authorization will remain valid for the term of coverage of the policy

Date of Statement: **30-11-2023** Signature of Employee: *[Signature]* Telephone No.