

**To be filled by the patients:-**

Name (write in **BOLD** letters): \_\_\_\_\_

Mobile No. (Write one CLEARLY): \_\_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Desired Solution or Checkups: \_\_\_\_\_

☒ Truthfully disclose medical and dental allergy history each and every time you visit, even after 24-48 hours.

**Preventive Dental (PCDP) Care Package:** Additional for Elite Dental Club

**1st:** Visit [www.drdhruv.com/preventive-system](http://www.drdhruv.com/preventive-system) for signing up membership with your dentist.  
For booking appointments or WhatsApp +91-8884757388

**2nd:** Visit link/QR for post-care and locations. Only 10-minute consultation.

R<sub>X</sub>



**Next Visit**

|    |   |    |   |      |
|----|---|----|---|------|
| DD | / | MM | / | YYYY |
|----|---|----|---|------|

**Feedback by Doctor:-**



**Feedback rating by patient (Any comments to improve or help):-**



**Oral consent.**

Post-care for 2 months. This is a D warranty prescription offers one year of coverage at 20-40% less than the original cost. Extendable with preventive care package of two years maximum with treating doctors. 'For you' ND·love brand; to be shown as receipt and carried for x-ray scanner centers. **We request you to save your prescription and bring your file every visit.**

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