PRESCRIPTION /ADVICE FORM

Ref No

(IMPORTANT: Please copy from the Consultation Form)

PATIENT NAME sai krishna

DIAGNOSIS sai krishna

NATURE OF TREATMENT : (Please use separate sheet for each group)

☐ Pharmacy ☐ Diagnostic ☐ Physiotherapy ☐ Others

Doctorâ€™s Signature and Stamp

Section B -Medical Section

(to be fully completed by treating dentist - involved tooth numbers must be marked on chart also)

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the above-mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy or any other person who has provided medical services to me to furnish any and all information with regard to any medical history, medical condition, or medical services and copies of all medical and Clinic records.

Patient's Signature

2024-05-02

Date

Pharmaceuticals (to be filled by treating doctor only)