TRILOK DENTAL SOLUTIONS

DENTAL HEALTH CARE MEMBERSHIP ENROLLMENT FORM

A. MEMBER DETAILS **S.No._____**

1. Full Name: _____DOB/Age:_____
2. Gender: ☐ Male ☐ Female ☐ Other
3. Mobile Number: _____
4. Email ID: _____
5. Address: _____

B. MEMBERSHIP PLAN SELECTED

Membership Start Date: _____ Expiry Date: _____

☐ Individual Plan – ₹1499 / Year ☐ Premium Plan – ₹6999 / Year

☐ Family Plan – ₹3999 / Year (Up to 4 Members)

C. FAMILY MEMBER DETAILS *(For Family)*

S.No.	Name	Age	Relationship
1			
2			
3			
4			
5			

D. MEDICAL & DENTAL HISTORY

1. Do you have any medical condition? ☐ Yes ☐ No
   If yes, specify: _____

S.No.	Name	Age	Condition
1			
2			
3			
4			
5			

2. Are you currently under any medication? ☐ Yes ☐ No
   If yes, specify: _____

S.No.	Name	Age	Medication
1			
2			
3			

4			
5			

3. Any known drug allergy? ☐ Yes `☐ No
   If yes, specify: _____

S.No.	Name	Age	Allergy
1			
2			
3			
4			
5			

F. TERMS & DECLARATION

☐I hereby apply for the Dental Health Care Membership Program and confirm that all details provided are true and correct. I understand that:

- Membership is valid for **12 months** from the start date.
- Membership is **non-transferable & non-refundable**.
- Discounts cannot be clubbed with other offers.
- Lab charges and outsourced procedures are not included.
- In case the patient does not follow instructions/advice given by the dentist, the clinic shall not be responsible for treatment outcome.

☐I agree to abide by the clinic's rules, regulations, and treatment protocols.

Member Signature: _____ Date: _____

Clinic Representative Name & Signature: _____

Stamp:

E. PAYMENT DETAILS

Mode of Payment: ☐ Cash ☐ UPI
Amount Paid (₹): _____
Date: _____ `
Clinic Representative Name & Signature: _____

Stamp: