

<b>Patient Name</b> :	Ms.PRIYANKA .	<b>Bill Date</b> :	12-04-2024 12:15 PM
<b>Age / Gender</b> :	35Y(s) 6M(s) 24D(s)/Female	<b>Collected Date</b> :	12-04-2024 02:00 PM
<b>Lab Ref No/UHID</b> :	PS008321/P00000639570	<b>Received Date</b> :	12-04-2024 02:01 PM
<b>Lab No/Result No</b> :	2400143437/868184	<b>Report Date</b> :	12-04-2024 03:54 PM
<b>Referred By Dr.</b> :	HOSPITAL CASE	<b>Specimen</b> :	SERUM
		<b>Processing Loc</b> :	RHC Hinjawadi



**DEPARTMENT OF LABORATORY MEDICINE-BIOCHEMISTRY**

Investigation	Result	Units	Biological Reference Interval
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**FBS**

Glucose (Fasting). Method : GOD-POD	:94	mg/dL	Prediabetic : 100 - 125 Diabetic : >= 126 Normal : < 100.0
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REFERENCE : ADA 2015 GUIDELINES

**CREATININE**

Creatinine Method : Enzymatic	:0.6	mg/dL	0.5 - 1.2
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**BUN**

Urea Nitrogen(BUN) Method : Calculated	:7.94	mg/dL	6.0 - 20.0
Urea Method : Urease	:17	mg/dL	17.1-49.2

**CALCIUM**

Calcium Method : Arsenazo	:9.7	mg/dL	8.6 - 10.2
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**PHOSPHOROUS**

Phosphorus Method : Phospho Molybdate	:3.8	mg/dL	2.7-4.5
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**URIC ACID**

Uric Acid Method : Uricase	:7.1	mg/dL	2.6 - 6.0
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**LFT**

Total Bilirubin Method : Diazo	:0.5	mg/dL	0.3 - 1.2
Direct Bilirubin Method : Diazo	:0.1	mg/dL	0-0.4
Indirect Bilirubin Method : Diazo	:0.4	mg/dL	0.0 - 0.8
Alanine Transaminase (ALT) Method : Kinetic	:52.0	U/L	<35
Aspartate Transaminase (AST) Method : Kinetic	:45.0	U/L	10.0 - 40.0

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<b>Lab No/Result No</b>	: 2400143432/868184	<b>Report Date</b>	: 12-04-2024 04:30 PM
<b>Referred By Dr.</b>	: HOSPITAL CASE	<b>Specimen</b>	: SERUM
		<b>Processing Loc</b>	: RHC Hinjawadi



**DEPARTMENT OF LABORATORY MEDICINE-BIOCHEMISTRY**

Investigation	Result	Units	Biological Reference Interval
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**LFT**

Alkaline Phosphatase <i>Method : 4NPP/AMP BUFFER</i>	: 59.0	U/L	30.0 - 115.0
Total Protein <i>Method : Biuret</i>	: <b>8.4</b>	g/dl	6.0 - 8.0
Albumin <i>Method : BCG</i>	: 4.7	g/dl	3.5-4.8
Globulin <i>Method : Calculated</i>	: <b>3.7</b>	gm/dL	2.3-3.5
A/G Ratio <i>Method : Calculated</i>	: 1.27		

**T3-T4-TSH -**

Tri-Iodothyronine, (Total T3) <i>Method : Enhanced Chemiluminescence</i>	: 1.39	ng/ml	0.97-1.69
Thyroxine (T4), Total <i>Method : Enhanced Chemiluminescence</i>	: 9.96	ug/dl	5.53-11.01
Thyroid Stimulating Hormone (Ultra). <i>Method : Enhanced Chemiluminescence</i>	: 5.700	uIU/mL	0.58-6.88

1.The TSH levels are subject to diurnal/circadian variation. reaching to peak level between 2 to 4 am. and at a minimum between 6 to 10 pm. The variation is to the order of 50%, hence the time when sample is collected has influence on the levels of TSH. 2.Many substances produced in central nervous system, even in healthy euthyroid individuals, may enhance or suppress TSH production in addition to the feedback effect of thyroid hormone. 3.Furthermore, although TSH levels rise and fall in response to changes in the concentration of Free T4, individuals appear to have their own setpoints and factors such as race and age also contribute to variability in TSH levels. Alterations of normal pituitary response are also common in patients with a variety of illnesses which can affect the levels of TSH. 4.Interassay variations are possible on different Immunoassay platforms.

TSH - For pregnancy the reference range is as follows -

1st trimester : 0.6 - 3.4 uIU/mL  
 2nd trimester : 0.37 - 3.6 uIU/mL  
 3rd trimester : 0.38 - 4.04 uIU/mL

\*\*\* End Of The Report \*\*\*

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<b>Lab No/Result No</b>	: /868184	<b>Report Date</b>	: 12-04-2024 04:24 PM
<b>Referred By Dr.</b>	: HOSPITAL CASE	<b>Specimen</b>	: SERUM
		<b>Processing Loc</b>	: RHC Hinjawadi



**Verified By**  
Anand

*Pathak*

**Dr.POOJA PATHAK**  
Associate Consultant

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<b>Lab No/Result No</b> :	2400143438/868184	<b>Report Date</b> :	12-04-2024 03:22 PM
<b>Referred By Dr.</b> :	HOSPITAL CASE	<b>Specimen</b> :	EDTA WHOLE BLC
		<b>Processing Loc</b> :	RHC Hinjawadi



**DEPARTMENT OF LABORATORY MEDICINE-HAEMATOLOGY**

Investigation	Result	Units	Biological Reference Interval
<b>HAEMOGRAM/CBC/CYTO</b>			
<b>W.B.C.Count</b>	: 8860	/ul	4000-11000
<i>Method : Coulter Principle</i>			
Neutrophils	: 56.7	%	40-75
<i>Method : Derived from WBC Histogram</i>			
Lymphocytes	: 33.0	%	20-40
Monocytes	: 6.0	%	2-10
Eosinophils	: 3.7	%	1.0-6.0
Basophils	: 0.6	%	0.0-1.0
%Immature Granulocytes	: 0.0	%	0.00-0.10
Absolute Neutrophil Count	: 5.0	x10 <sup>3</sup> cells/ul	2-7
<i>Method : Calculated</i>			
Absolute Lymphocyte Count	: 2.9	x10 <sup>3</sup> cells/ul	1 - 3
<i>Method : Calculated</i>			
Absolute Monocyte Count	: 0.5	x10 <sup>3</sup> cells/ul	0.2-1.0
<i>Method : Calculated</i>			
Absolute Eosinophil Count	: 0.3	x10 <sup>3</sup> cells/ul	0.02-0.5
<i>Method : Calculated</i>			
Absolute Basophil Count	: 0.05	x10 <sup>3</sup> cells/ul	0.02-0.1
<i>Method : Calculated</i>			
R.B.C Count	: 4.66	million/ul	3.8 - 5.8
<i>Method : Coulter Principle</i>			
<b>Haemoglobin</b>	: <b>11.5</b>	g/dl	12 - 15.0
<i>Method : Cyanmethemoglobin Photometry</i>			
Haematocrit	: 38.9	%	36-46
<i>Method : Calculated</i>			
MCV	: 83.5	fl	83 - 99
<i>Method : Coulter Principle</i>			
MCH	: <b>24.7</b>	pg	27-32
<i>Method : Calculated</i>			
MCHC	: <b>29.6</b>	g/dl	31.5-34.5
<i>Method : Calculated</i>			
RDW	: <b>16.4</b>	%	11.6-14.0
<i>Method : Calculated From RBC Histogram</i>			
<b>Platelet Count</b>	: 447.0	x10 <sup>3</sup> /ul	150 - 450
<i>Method : Coulter Principle</i>			
MPV	: <b>12.3</b>	fl	7.8-11
<i>Method : Coulter Principle</i>			
RBC Morphology	: normocytic hypochromic		

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<b>Lab No/Result No</b>	: 2400143438/868184	<b>Report Date</b>	: 12-04-2024 03:42 PM
<b>Referred By Dr.</b>	: HOSPITAL CASE	<b>Specimen</b>	: EDTA WHOLE BLC
		<b>Processing Loc</b>	: RHC Hinjawadi



WBC Morphology : Within normal range

Platelet : Adequate

\*\*\* End Of The Report \*\*\*

**Verified By**  
Anand

**Dr.POOJA PATHAK**  
Associate Consultant

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**Lab Ref No/UHID** : PS008321/P00000639570  
**Lab No/Result No** : 2400143446-P/868184  
**Referred By Dr.** : HOSPITAL CASE

**Bill Date** : 12-04-2024 12:15 PM  
**Collected Date** : 12-04-2024 02:02 PM  
**Received Date** : 12-04-2024 02:01 PM  
**Report Date** : 12-04-2024 04:12 PM  
**Specimen** : SERUM  
**Processing Loc** : RHC Hinjawadi



**DEPARTMENT OF LABORATORY MEDICINE-BIOCHEMISTRY**

Investigation	Result	Units	Biological Reference Interval
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**PPBS**

Glucose (Post Prandial) : 125 mg/dL 60-140

Method : GOD-POD

\*\*\* End Of The Report \*\*\*

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**Received Date** : 12-04-2024 02:01 PM  
**Report Date** : 12-04-2024 05:08 PM  
**Specimen** : EDTA WHOLE BLC  
**Processing Loc** : RHC Hinjawadi



**DEPARTMENT OF LABORATORY MEDICINE-HAEMATOLOGY**

Investigation	Result	Units	Biological Reference Interval
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**ESR**

ESR At 1 Hour : 12 mm/hr 0 - 20

Method : Modified Westergren Method

**INTERPRETATION :**

ESR is a screening test to detect presence of systemic disease; however a normal result does not rule out a systemic disease.

ESR is also used to monitor course of disease or response to therapy if initially elevated.

\*\*\* End Of The Report \*\*\*

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**Report Date** : 12-04-2024 04:27 PM  
**Specimen** : SERUM  
**Processing Loc** : RHC Hinjawadi



**DEPARTMENT OF LABORATORY MEDICINE-BIOCHEMISTRY**

Investigation	Result	Units	Biological Reference Interval
<b>ELECTROLYTES (Na &amp; K)</b>			
Sodium <i>Method : Potentiometric</i>	: 140.0	mmol/L	136.0 - 145.0
Potassium <i>Method : Potentiometric</i>	: 4.6	mmol/L	3.5 - 5.1
Chloride <i>Method : Potentiometric</i>	: 98.0	mmol/L	98.0 - 107.0

\*\*\* End Of The Report \*\*\*

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<b>Lab Ref No/UHID</b> :	PS008321/P00000639570	<b>Received Date</b> :	12-04-2024 02:01 PM
<b>Lab No/Result No</b> :	2400143506/868184	<b>Report Date</b> :	12-04-2024 04:13 PM
<b>Referred By Dr.</b> :	HOSPITAL CASE	<b>Specimen</b> :	URINE
		<b>Processing Loc</b> :	RHC Hinjawadi



**DEPARTMENT OF LABORATORY MEDICINE-CLINICAL PATHOLOGY**

Investigation	Result	Units	Biological Reference Interval
<b>URINE ROUTINE</b>			
<b>PHYSICAL EXAMINATION</b>			
Colour	: Pale Yellow		
Appearance	: Slightly Turbid		
<b>CHEMICAL TEST</b>			
Ph	: 6.0		5.0-7.0
Specific Gravity	: 1.015		1.015-1.030
Albumin	: Absent		Abset
Urine Sugar	: Absent	mg/dL	
Ketone Bodies	: Absent		Absent
Bile Pigments	: Absent		Absent
<i>Method : Photometric Measurement</i>			
Urobilinogen	: Normal		Normal
Nitrites	: Absent		Absent
Leucocytes Esterase	: 1+		Absent
<b>MICROSCOPIC TEST</b>			
Pus Cells.	: 12-15	/hpf	0 - 5
Red Blood Cells.	: Absent	/hpf	0 - 2
Epithelial Cells.	: 6-8	/hpf	0-5
Bacteria	: Absent	/hpf	Absent
Cast	: Absent		Absent
Crystals	: Absent		Absent

\*\*\* End Of The Report \*\*\*

**Verified By**  
SACHIN

**Dr.POOJA PATHAK**  
Associate Consultant

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<b>Referred By Dr.</b> :	HOSPITAL CASE	<b>Specimen</b> :	SERUM
		<b>Processing Loc</b> :	RHC Hinjawadi



**DEPARTMENT OF LABORATORY MEDICINE-BIOCHEMISTRY**

Investigation	Result	Units	Biological Reference Interval
<b>LIPID PROFILE</b>			
Cholesterol	:203.0	mg/dL	130.0 - 220.0
<i>Method : Enzymatic</i>			
Triglycerides	:158	mg/dL	35.0 - 180.0
<i>Method : Enzymatic</i>			
HDL Cholesterol	:49	mg/dL	35-65
<i>Method : Enzymatic</i>			
LDL Cholesterol	:122.4	mg/dL	10.0 - 130.0
<i>Method : Calculated</i>			
VLDL Cholesterol	:31.6	mg/dL	5.0-36.0
<i>Method : Calculated</i>			
Cholestrol/HDL Ratio	:4.14	--	2.0-6.2
<i>Method : Calculated</i>			

\*\*\* End Of The Report \*\*\*

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**Received Date** : 12-04-2024 02:01 PM  
**Report Date** : 12-04-2024 05:08 PM  
**Specimen** : EDTA WHOLE BLC  
**Processing Loc** : RHC Hinjawadi



**DEPARTMENT OF LABORATORY MEDICINE-BLOOD BANK**

Investigation	Result	Units	Biological Reference Interval
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**BLOOD GROUP**

Blood Group : B RH POSITIVE

\*\*\* End Of The Report \*\*\*

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**Lab Ref No/UHID** : PS008321/P00000639570  
**Lab No/Result No** : 2400143439-G/868184  
**Referred By Dr.** : HOSPITAL CASE

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**Report Date** : 12-04-2024 04:15 PM  
**Specimen** : WHOLE BLOOD  
**Processing Loc** : RHC Hinjawadi



**DEPARTMENT OF LABORATORY MEDICINE-HAEMATOLOGY**

Investigation	Result	Units	Biological Reference Interval
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**GLYCOSYLATED HB% (HbA1C)**

Glycosylated Haemoglobin : 5.9 % 4-6.5  
(HbA1C)

Method : Turbidometric Inhibition  
Immunoassay

Prediabetic : 5.7 - 6.4 %  
Diabetic :  $\geq$  6.5 %  
Therapeutic Target :  $<$ 7.0 %

REFERENCE : ADA 2015 GUIDELINES

\*\*\* End Of The Report \*\*\*

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## RUBY HALL CLINIC PIMPLE SAUDAGAR

**Name:** PRIYANKA .

**Date:** 12-04-2024 **Time:** 11:10

**Age:** 35

**Gender:** F

**Height:** 159 cms

**Weight:** 77 Kg

**ID:** 12042024

**Clinical History:**

**Medications:**

### Test Details:

**Protocol:** Bruce

**Predicted Max HR:** 185

**Target HR:** 157

**Exercise Time:** 0:04:31

**Achieved Max HR:** 164 (89% of Predicted MHR)

**Max BP:** 150/80

**Max BP x HR:** 24600

**Max Mets:** 5.3


**Test Termination Criteria:**

### Protocol Details:

Stage Name	Stage Time	METS	Speed kmph	Grade %	Heart Rate bpm	BP mmHg	RPP	Max ST Level mm	Max ST Slope mV/s
Supine	00:36	1	0	0	107	120/80	12840	0.8 V2	-0.6 aVR
Standing	00:06	1	0	0	98	120/80	11760	0.9 I	-0.9 aVR
HyperVentilation	00:07	1	0	0	100	120/80	12000	-0.9 aVR	-0.6 aVR
PreTest	00:07	1	1.6	0	99	120/80	11880	1.1 V2	-0.9 aVR
Stage: 1	02:00	3.1	2.7	10	132	120/80	15840	1.1 V2	-1.1 aVR
Stage: 2	02:02	4.7	4	12	149	130/80	19370	-0.9 aVR	-1.9 aVR
Peak Exercise	00:29	5.3	5.5	14	164	150/80	24600	-1.6 III	-1.6 aVR
Recovery1	01:00	1	0	0	140	150/80	21000	-3.5 aVR	-2.9 aVR
Recovery2	01:00	1	0	0	119	150/80	17850	-2.5 aVR	-3.1 aVR
Recovery3	00:21	1	0	0	118	150/80	17700	0.5 V2	-1.2 aVR

### Interpretation

The Patient Exercised according to Bruce Protocol for 0:04:31 achieving a work level of 5.3 METS.  
 Resting Heart Rate, initially 107 bpm rose to a max. heart rate of 164bpm (89% of Predicted Maximum Heart Rate).  
 Resting Blood Pressure of 120/80 mmHg, rose to a maximum Blood Pressure of 150/80 mmHg  
 Poor Effort Tolerance  
 Normal HR & BP Response  
 No Angina or Arrhythmias  
 No Significant ST-T Changes Noted During Exercise  
 Negative Stress Test



**Ref. Doctor:** ----

**Doctor:** DR.KEDAR KULKARNI

**SCHILLER**

The Art of Diagnostics

( Summary Report edited by User )  
 Spandan CS 10 Version:3.2.0



<b>Name:</b> PRIYANKA . .	<b>Exam Date :</b> 12-Apr-2024 11:32
<b>Age :</b> 035 Years	<b>Accession:</b> 128472141743
<b>Gender:</b> F	<b>Exam:</b> ABDOMEN AND PELVIS
<b>PID:</b> P00000639570	<b>Physician:</b> HOSPITAL CASE^^^^
<b>OPD :</b>	

### ULTRASOUND OF ABDOMEN AND PELVIS

Liver is normal in size and shows increased echogenecity suggestive of grade I fatty changes. No focal lesion is seen. No intrahepatic biliary radicle dilatation seen. The portal vein and CBD appear normal.

**Gall bladder is well distended with normal wall thickness and shows echo reflective calculus measures 23 mm . No sludge is seen.**

Pancreas appears normal in size and echotexture. No focal lesion is seen.

Spleen appears normal in size and echotexture. No focal lesion is seen.

Right kidney measures 9.1 x 4.3 cms. Left kidney measures 10.5 x 5.3 cms. Both kidneys appear normal in size, shape & echotexture. They show good cortico-medullary differentiation. There is no hydronephrosis, hydroureter or calculus seen on either side.

The urinary bladder is well distended. Wall thickness is normal. No mass lesion or calculus is seen.

Uterus is normal in size and echotexture. Endometrium is central . No focal lesion is seen. Both ovaries are normal. No adnexal pathology is seen.

Visualised bowel loops are non-dilated and show normal peristalsis. There is no ascites or significant lymphadenopathy seen.

#### IMPRESSION :

**Grade I fatty liver.**

**Cholelithiasis.**

**Suggest : Clinical Correlation.**

DR. YATIN R. VISAVE  
CONSULTANT RADIOLOGIST  
MBBS, DMRD  
Regd. No. 090812

Date: 12-Apr-2024 14:29:54



Grant Medical Foundation  
**Ruby Hall Clinic**  
*Pimple Saudagar*

**Name:** PRIYANKA . .  
**Age :** 035 Years  
**Gender:** F  
**PID:** P00000639570  
**OPD :**

**Exam Date :** 12-Apr-2024 11:02  
**Accession:** 128471141743  
**Exam:** CHEST X RAY  
**Physician:** HOSPITAL CASE<sup>AAAA</sup>

Health Check

**Radiograph Chest PA View :**

Both lung fields normal.

Both costo-phrenic angles are clear.

Cardiac silhouette and aortic knuckle are normal.

Both hilar shadows and the diaphragmatic contours are normal.

Thoracic soft tissues and the rib cage normal.

**Impression :**

No significant abnormality noted.

**DR. YATIN R. VISAVE**  
**CONSULTANT RADIOLOGIST**  
**MBBS, DMRD**  
**Regd. No. 090812**

Date: 12-Apr-2024 14:25:44



Name: Priyanka Pandey

Date: 12 / 04 / 2024

Age: 35 Yrs

BMI: 30.7 Kg/m<sup>2</sup>

Gender: M / W

**Visited for health check**

**Present complaints:**

Generalized weakness

**Past History:**

Hypothyroidism :: 6 yrs on T. Thyronorm 75mcg O2

**Family History:**

Mother: HTN

**Clinical Exam:**

Pulse: 85/min, BP: 138/91 mm Hg, SPO<sub>2</sub>: 99 %, S/E: NAD.

**Post investigation review:**

**Rx.**

- Monitor BP at-home & consult if readings high
- Regular exercise / Reduce weight.

**Further Investigations:**

- vit B<sub>12</sub>
- vit D

**Reference:**

**DR. SATISH CHAUDHARI**  
MBBS; MD (Medicine)



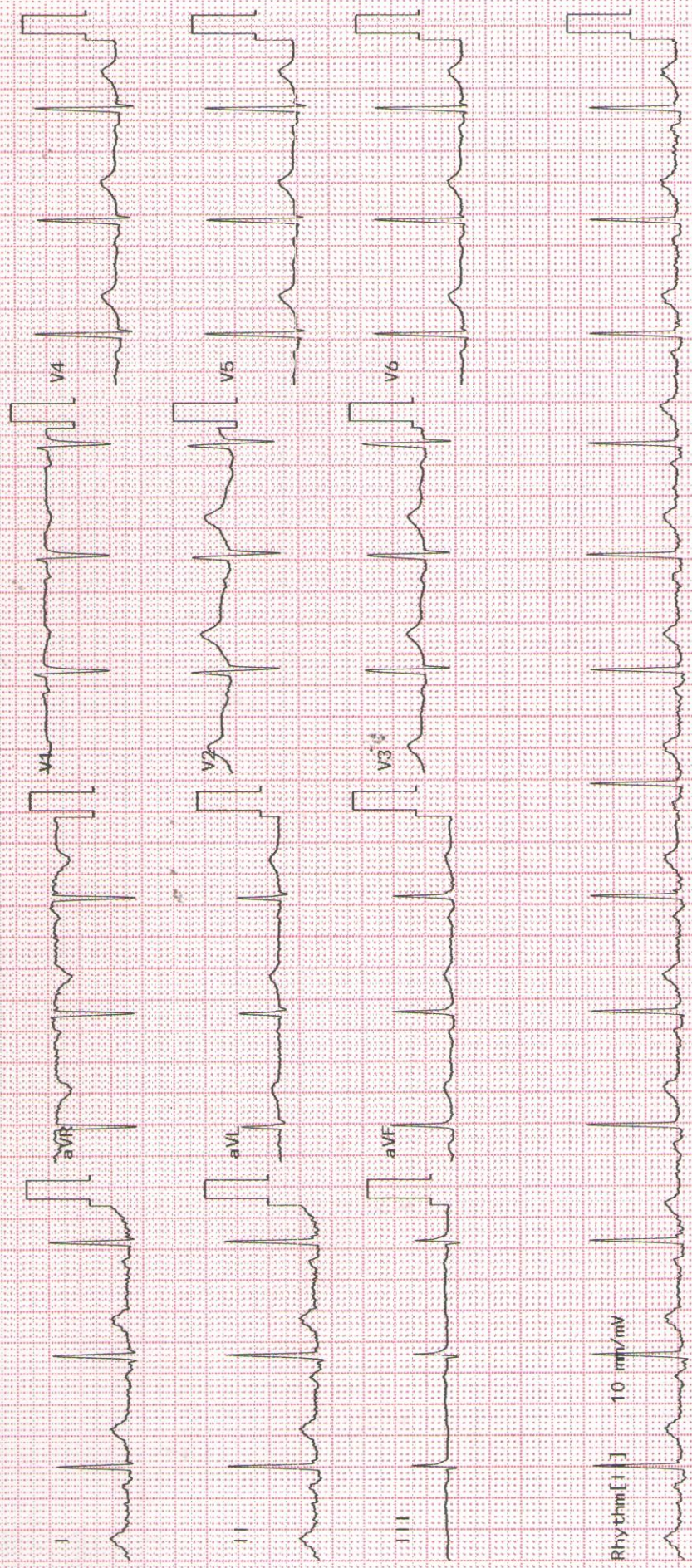
Name: priyanka  
 Sex: F cm kg Birth date: / / mm/ls  
 35 years 1100 Sinus rhythm  
 9110 \*\* normal ECG \*\*

Medication:  
 Symptoms:  
 History:

Vent. rate 82 bpm  
 PR int 146 ms  
 QRS dur 76 ms  
 QT/QTc(E) int 362/400 ms  
 P/ORS/T axis 38/ 42/ 29 °  
 RV5/SV1 amp 1.59/ 1.09 mV  
 RV5+SV1 amp 2.68 mV

Unconfirmed Report  
 Reviewed by:

10 mm/mV 25 mm/s Filter: H50 D 35 Hz 10 mm/mV 10 mm/mV





**OPHTHALMOLOGY**

NAME : Ms. Pranjanya,

AGE : 35 year.

R


L

- 1) Vision 

unaided	6/60	6/60
̄ glasses	6/6	6/6
- 2) Near Vision 

unaided	NIG.
̄ glasses	
- 3) Binocular Vision Normal.
- 4) Colour Vision Normal.
- 5) Tension 14 mmHg 12 mmHg
- 6) Anterior Segment WNL
- 7) Pupils WNL
- 8) Lens clear
- 9) Media & Fundus :
- 10) Remarks RE - 2.50 sph.  
LE - 2.00 sph.

Date : 12/04/24.

  
 (Signature)



Grant Medical Foundation

**Ruby Hall Clinic**

Pimple Saudagar

Name: Priyanka

Date: 12/04/2024

Age: 35 Yrs

Gender: M / F

Visited for regular dental check up

Present complaints:

Intra Oral Examination:

1. Stains: ++, Calculus: +
2. Caries: 8, 17
3. Missing: 8, 17
4. Root stumps:
5. Crown:
6. RC treated:
7. Orthodontic examination:

Mandibular distoma

Treatment Advised:

- ① RCT 8, 17
- ② 17
- ③ Ortho Rx.

Aniket

**DR. ANIKET MALABADI**

**BDS; MDS**

Ruby Hall Clinic,

Pimple Saudagar.

Mob: 9980283499

www.aniket32.com