Hospital Invoice

(Hospital Name / Logo)
(Address, Contact details)

Invoice No: _____
Date: __ /__ /____
Patient ID: _____
Admission Date: __ /__ /____
Discharge Date: __ /__ /____
Patient Name: _____
Age/Gender: _____ / _____
Doctor: _____
Room/Ward: _____

Invoice Items

S.No.	Description	Quantity	Rate	Amount
1				
2				
3				
4				

Payment Method: _____
Remarks:

Subtotal	_____
Taxes	_____
Discount	_____
Total	**_____**

_____

_____
Patient/Guardian Signature

Authorized Signature

Thank you for choosing our services.