HOSPITAL NAME HERE

Street Address:
City, State, ZIP:
Phone:
Email:

Receipt #: ______________________ Admission Date: ____________________ Counter #: _______________

Patient Details

Name:		**Age:**	
Sex:		**Address**	
Phone:		**Email:**	

Ward No:		**Doctor:**	
Patient Type:		**File No.**	
Insurance No.		**Ins. Claim No.**	
Rate Code:		**Conf. No.**	

#	Particulars	Rate	Discount	Total
			Sub Total:	
			Med. Claim:	
			Advance:	
			Balance:	

________________________________ Manager Signature

____________________________________ Patient Signature