



INDEPENDENT NATIONAL ELECTORAL COMMISSION
DEPARTMENT OF HEALTH AND FAMILY WELFARE
GOVT. HOSPITAL, CHITTOOR

Form No. _____
Date: _____
Place: _____
To: _____
From: _____
Subject: _____

1. Name of the patient: _____
2. Age: _____
3. Sex: _____
4. Address: _____
5. Occupation: _____
6. Date of admission: _____
7. Date of discharge: _____
8. Name of the doctor: _____

Sl. No.	Particulars	Amount	Total
1	Medicine	100	
2	Diagnosis	50	
3	Investigation	200	
4	Operation	1000	
5	Post-operative care	500	
6	Room rent	100	
7	Food	100	
8	Laundry	50	
9	Transportation	100	
10	Other charges	100	
11	Total	2200	
12	Amount paid	1000	
13	Balance due	1200	

Signature of the patient: _____
Signature of the doctor: _____
Signature of the cashier: _____

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