

# Medical Bill

**Patient Details:**

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Bill Summary:**

Description	Amount (INR)
Consultation Fee	500 INR
Medication Charges	800 INR
Lab Tests	700 INR
Other Charges	200 INR
Total Amount	2200 INR

**Doctor's Signature:** \_\_\_\_\_