**MEDICAL INVOICE**

Patient Name: Age: Gender:

Address:

|  |  |
| --- | --- |
| **Service** | **Price** |
| $name | $price |
|  |  |
|  |  |
|  |  |
|  |  |

**Total:**

|  |
| --- |
| HoChiMinh City, 30th May 2025  **Receptionist Sign**  $Receptionist Name |