**MEDICAL INVOICE**

Patient Code: {{patientId}}

Patient Name: {{patientName}} Age: {{age}} Gender: {{gender}}

Address: {{address}}

|  |  |
| --- | --- |
| **Service** | **Price** |
| {{serviceName}} | {{price}} |
|  |  |
|  |  |
|  |  |
|  |  |

**Total:** {{totalPrice}}

|  |
| --- |
| HoChiMinh City, {{date}}  **Receptionist Sign**  {{receptionistName}} |