**MEDICAL INVOICE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient | Date of birth | Gender | Weight | Height | Date |
|   |   |   |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Medical services performed | Rate | Total |
|  | ­  |  |  |
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|  |  |

**Make all checks payable to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PATIENT’S NAME

Street Address

Address 2

City, State

Zip Code

Telephone

DOCTOR/MEDICAL PRACTICE

Street Address

Address 2

City, State

Zip Code

Telephone

Fax

Invoice #