|  |  |
| --- | --- |
| **Clinic Name** | **LOGO** |
| Address : |
|  |
| Phone No.: |
| Email ID: |
| GSTIN: |
| State: |
|  |
| **Tax Invoice** |
|  |
| **Bill To:** | **Patient Name** |
| Name: | Age: |
| Address: | Blood Group: |
|  |  |
| Contact No.: | **Invoice No.:** |  |
| GSTIN No.: | **Date:** | DD/MM/YYYY |
| State: |  |
|  |
| **#** | **Service name** | **HSN** | **QTY** | **Unit** | **Price/ Unit** | **Disc** | **GST** | **Amount** |
|  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |
|  |
|  |  | **Sub Total:** |  |
| Discount: |  |
| **Amount in words:** | SGST |  |
| CGST |  |
| **Total** |  |
| Received |  |
|  | Balance |  |
| Company seal and Sign | Payment Mode: |  |
|  |
|  |
|  |
|  |