|  |  |
| --- | --- |
| **Clinic/Hospital Name:** | **LOGO** |
| Address:  |
|   |
| ZIP Code: |
| Phone No.: |
| GSTIN No.: |
| DL. No.: |
|   |
| **Tax Invoice**  |
|   |
| Reg. No.: | Receipt No.: |  |
| **Patient Name:** | Date: |  |
| Gender/Age: | Lab No:  |   |
| Phone No.: | Address: |
| Payer: |   |
| Pres. Doctor: |   |
| Referred By: |   |
|   |
| **#** | **Particular** | **HSN/SAC** | **QTY** | **Unit** | **Price/Unit** | **Discount** | **Amount** |
| 1 | Service 01 | 1234 | 1 | Days | 200.00 | 50 | 150 |
| 2 | Service 02 | 1235 | 1 | Days | 250.00 | 20 | 230 |
| 3 | Service 03 | 1236 | 1 | Days | 340.00 | 30 | 310 |
| 4 | Service 04 | 1237 | 1 | Days | 300.00 | 20 | 280 |
| 5 | Service 05 | 1237 | 1 | Days | 300.00 | 20 | 280 |
| 6 | Service 06 | 1237 | 1 | Days | 300.00 | 20 | 280 |
| 7 | Service 07 | 1237 | 1 | Days | 300.00 | 20 | 280 |
| **Total** |  |  |  | **180** | **1810** |
|   |
|  |   | **Sub Total:** | **1810** |
| Total Discount: | 180 |
| **Amount in words:** | SGST: | 20 |
| CGST: | 20 |
| **Total:** | **1670** |
| Received | 500 |
|  | Balance | 1170.00 |
| Company seal and Sign |   |
|   |
| **Payment Mode:** |   |
|   |
|
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