Medical Store Invoice Form

Medical Store Details

Name of Store: ________________________________

Store Address: ________________________________

Contact Number: ________________________________

Email Address: ________________________________

GST/Tax ID: ________________________________

Invoice Details

Invoice Number: ________________________________

Date of Invoice: ________________________________

Customer Details

Full Name: ________________________________

Address: ________________________________

Contact Number: ________________________________

Prescription Attached: [ ] Yes [ ] No

Items Purchased

S. No.	Medicine Name	Batch No.	Quantity	Unit Price	Total Price
1					
2					
3					
4					

Payment Information

Total Amount: ________________________________

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Payment Method: [ ] Cash [ ] Card [ ] UPI

Paid Amount: ______________________________

Balance Amount: ______________________________

Authorized Signature

Signature: ______________________________

Date: ______________________________

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