Prescribed by State Board of Accounts Form No. GH-12 (1963)

Ins._____ Kind_____

IN OR OUT PATIENT RECORD

Acct. No._____

Name_____ Address_____ Tele. No._____

_____ Employer_____ Doctor_____

_____ Nationality_____ Age_____ Married_____ Single_____

Friend or Relative_____ Address_____ Tele. No._____

Baby's Birth Date_____ 19____ Male_____ Female_____ Discharge Date_____ 19____ Hospital No._____ _____

Send Bill To_____ Address_____ Tele. No._____

Rate	Date	Room Ward
Adm.		A.M. P.M.
Dischg.		A.M. P.M.

Date 19____	Routine Service	Oper. or Del. Room	Anesthesia	Diagnostic Radiology	Laboratory	Basal Metabolism		Med. & Surg. Sup.	Pharmacy					Total Charges	CREDITS			Balance
															Rec. No.	Explanation	Amount	
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