PRESCRIBED BY STATE BD. OF ACCTS.

FORM NO. GH-13 (REV. 1963)

INS._____ KIND_____

IN OR OUT PATIENT RECORD

ACCT. NO._____

DOCTOR

NAME | RELIGION | AGE

EMPLOYER

ADDRESS TELE. NO.

ADDRESS

MALE ☐ COLOR ☐ MARRIED
FEMALE ☐ NATIONALITY ☐ SINGLE

BABY'S BIRTH DATE

FRIEND OR RELATIVE

A.M. MALE
P.M. FEMALE

ADDRESS TELE. NO.

DISCHG. DATE

SEND BILL TO

HOSP. NO.

ADDRESS TELE. NO.

RATE	DATE	RM. OR WARD
ADM.		A.M. / P.M.
DISCHG.		A.M. / P.M.

DATE 19__	ROUT. SER.	OPER. OR DEL. ROOM	ANES. THETIC	DIAGN. RADI. OLOGY	LAB.	BASAL METAB. OLISM		MED & SURG. SUPP.	PHARM			TOTAL CHARGES	CREDITS REC. NO.	CREDITS EXPLANATION	CREDITS AMOUNT	BALANCE
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																
11																
12																

NAME_____ ACCT. NO._____

DATE 19__	ROUT. SER.	OPER. OR DEL. ROOM	ANES-THETIC	DIAGN. RADI-OLOGY	LAB.	BASAL METAB OLISM		MED. & SURG. SUPP.	PHARM.			TOTAL CHARGES	CREDITS			BALANCE
													REC. NO.	EXPLANATION	AMOUNT	
13																
14																
15																
16																
17																
18																
19																
20																
21																
22																
23																
24																
25																
26																
27																
28																
29																
30																
31																

REMARKS: