

BIOCHEMISTRY LABS INC.

123 Science Park Drive
Diagnostic Wing, Suite 400
Contact: (555) 010-8899

INVOICE

Invoice #: _____
Date: _____

PATIENT DETAILS

Name: _____
Patient ID: _____
DOB: _____
Gender: _____

ORDERING PHYSICIAN

Dr. _____
Clinic: _____
Ref #: _____

Test Code	Description	Unit Cost

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Subtotal: \$ 0.00

Lab Facility Fee: \$ 0.00

TOTAL DUE: \$ 0.00

All results are strictly confidential. Please consult your physician for clinical correlation.
Payment is due within 30 days of receipt.