

EQUINE SURGERY INVOICE

Clinic Name
Street Address
City, State, Zip
License No: _____

Invoice #: _____
Date: _____
Case Ref: _____

CLIENT INFORMATION

Name: _____
Phone: _____
Address: _____

PATIENT (EQUINE) INFORMATION

Horse Name: _____
Breed/Age: _____
ID/Chip #: _____

Service / Supply Description	Qty/Units	Unit Price	Total
Surgical Suite Fee - General Anesthesia			
Lead Surgeon Services			
Post-Operative Medications (Antibiotics/NSAIDs)			
Imaging (Radiography/Ultrasound)			
Stabling/Recovery (Per Diem)			

Service / Supply Description	Qty/Units	Unit Price	Total

Subtotal: \$ _____

Tax: \$ _____

Grand Total: \$ _____

Clinical Notes / Discharge Summary:

Payment Terms: Payment due upon discharge. Please make checks payable to Clinic Name.