All India Institute of Medical Sciences, Bhubaneswar
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HOSPITAL ESTIMATE FORM

Name of Patient : Age/Sex : _____ Years
(Male/Female) :
Father/Husband's Name : Vill :
PO : District: State:
Phone Number: Email:
OPD/IPD Registration Number(CR No) : Dated :
Provisional Diagnosis:

Ser No	Expenditure Heads	Approximate Cost
1.	Medicines and consumables	
2.	Planned Surgery/intervention	
3.	Diagnostic modalities (CT Scan/MRI/ endoscopy etc.)	
4.	Implants/prosthesis etc.	
5.	Any other	
Total Rs (Rupees _____ _____only)		

Signature of the Patient: _____

Signature of the Physician:
Signature
Name:
Designation:
Department: Medical Superintendent
Medical Registration Number: