

Address: _____

Phone: _____

Email: _____

RECEIPT

Receipt No: _____

Date: _____

Payment Mode: _____

Patient Details

Patient Name: _____

Patient ID: _____

Contact No: _____

Dentist Details

Dentist Name: _____

License No: _____

Department: _____

NO.	TREATMENT / PROCEDURE DESCRIPTION	TOOTH NO.	AMOUNT
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____

Subtotal: _____

Discount: _____

Tax/VAT: _____

Total: _____

Amount Paid: _____

Balance Due: _____

PATIENT SIGNATURE

AUTHORIZED SIGNATURE / STAMP

Thank you for choosing our dental care services. Wishing you a healthy smile!