

OFFICIAL RECEIPT

Receipt No: _____

Date: _____

PATIENT INFORMATION

Patient Name: _____ Patient ID: _____

Date of Birth: _____ Contact No: _____

Address: _____

Insurance Provider: _____ Policy Number: _____

HEALTHCARE SERVICES RENDERED

DATE	CODE	DESCRIPTION OF SERVICE / PROCEDURE	QTY	AMOUNT

Method of Payment

- Cash
- Credit / Debit Card
- Personal Check
- Insurance Copay
- Bank Transfer

Transaction Ref: _____

Subtotal: _____

Tax / VAT: _____

Discount / Co-Pay: _____

Total Paid: _____

Outstanding Balance: _____

PATIENT SIGNATURE

AUTHORIZED REPRESENTATIVE
