RECEIPT

Receipt No.	
Date	

PATIENT INFORMATION

Patient Name

Patient ID

Contact No.

Doctor / Specialist

NO.	DESCRIPTION OF MEDICAL SERVICE / CONSULTATION	AMOUNT
1		
2		
3		
4		

PAYMENT METHOD

☐ Cash
☐ Card
☐ Bank Transfer
☐ Insurance

Subtotal	
Tax / VAT	
Discount	
Total Paid	

Patient Signature

Authorized Signature / Stamp