

Medical Payment Receipt



Name of Medical	
Practitioner Name	
License Number	
Address	
City/State/ZIP	

Receipt Number	
Date	

Patient Information	
Name	
Street Address	
City/State/ZIP	

Code	Description of Services/Medicine/Products	Qty	Rate	Line Total (\$)

Payment Method	
Card/Check No.	

Subtotal	
Tax Rate	
Total:	