Medical Bill Receipt

Date: _____
Receipt #: _____

Medical Institution:
Name: _____
Address: _____
City/State/Zip Code: _____
Phone Number: _____
Practitioner Name: _____
License #: _____

Patient Information:
Name: _____
Date of Birth: _____
Address: _____
City/State/Zip Code: _____
Phone Number: _____
Insurance Information: _____

Description of Services Provided:

Date	Procedure/Service/Medicine	Quantity	Cost	Total

Subtotal: $_____
Taxes (_____%): $_____

Total Amount Due: $_____

Payment made by: _____

Check/Card Number: _____

Payment Date: _____

Special Instructions (if applicable):

_____
_____
_____

Authorized Signature: _____

Name: _____