

Hospital Receipt

| | |
|-------|----------------|
| <hr/> | <hr/> |
| Date | Receipt Number |

Name of Medical Institution

Practitioner Name

Address

License Number

City, State, ZIP Code

Patient Information

Name

City, State, ZIP Code

Address

| Code | Description of Services/Medicine/Products | Quantity | Rate | Total |
|------|---|----------|----------|----------|
| | | | \$ _____ | \$ _____ |
| | | | \$ _____ | \$ _____ |
| | | | \$ _____ | \$ _____ |
| | | | \$ _____ | \$ _____ |
| | | | \$ _____ | \$ _____ |
| | | | \$ _____ | \$ _____ |

| | |
|--------------|----------|
| Subtotal: | \$ _____ |
| Tax rate: | % _____ |
| Total: | \$ _____ |
| Amount paid: | \$ _____ |

Payment method: _____.

Card/Check number: _____.

Printed Name

Authorized Signature