

# Medical Receipt Form

(For patient and provider records)

**Receipt No.:**

\_\_\_\_\_

**Date of Payment:**

\_\_\_\_\_

**Patient Name:**

\_\_\_\_\_

**Patient ID:**

\_\_\_\_\_

**Date of Birth:**

\_\_\_\_\_

**Provider Name:**

\_\_\_\_\_

**Provider ID:**

\_\_\_\_\_

**Clinic/Facility Name:**

\_\_\_\_\_

**Service(s) Provided:**

\_\_\_\_\_

**Total Amount (\$):**

\_\_\_\_\_

**Payment Method:**

\_\_\_\_\_

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Provider Signature

Thank you for your payment. Please retain this receipt for your records.