DENTAL CLINIC RECEIPT

Clinic Name: _____

Address: _____

Contact Number: _____

Receipt No.: _____

Date: _____

Patient Name: _____

Contact: _____

Service / Treatment	Quantity	Unit Price	Amount

Subtotal: _____

Discount: _____

Total Amount: _____

Amount Paid: _____

Balance: _____

Payment Method: _____

Remarks: _____

_____

Patientâ€™s Signature

_____

Authorized Signature