

General Practitioner Receipt

Date _____

Receipt No. _____

Patient Name _____

Address _____

Date of Birth _____

Details of Service

Description of Service	Date	Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
		Total _____

Paid By _____

Payment Method _____

Doctor's Signature

Doctor's Name _____

Provider Number _____

Practice Address _____