

# Outpatient Clinic Receipt

Receipt No. \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient ID \_\_\_\_\_

Doctor \_\_\_\_\_

Address \_\_\_\_\_

Contact No. \_\_\_\_\_

Description	Qty	Unit Price	Amount
Total			

Payment Method \_\_\_\_\_

Received From \_\_\_\_\_

Remarks \_\_\_\_\_

Patient Signature

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_