Pediatric Medical Receipt

Provider Name: _____
Provider Address: _____
Contact: _____
Receipt No: _____
Date: _____
Time: _____

Patient Information
Name: _____
Age: _____
Parent/Guardian: _____

Services/Items

Description	Qty	Unit Price	Total

Subtotal: _____

Tax: _____

Total: _____

Amount Paid: _____

Balance Due: _____

_____
Authorized Signature

_____
Date