Outpatient Service Receipt

[Hospital/Clinic Name Here]

Date: _____
Receipt No: _____

Patient Name: _____ **Patient ID:** _____

Date of Birth: _____ **Phone:** _____

Address: _____

Service Description	Code	Qty	Unit Price	Amount

Subtotal:

Tax:

Total Amount:

Payment Method:

Paid Amount:

Due Amount:

_____
Patient/Guardian

_____
Authorized By