DENTAL SERVICES RECEIPT

Dental Office Name: _____
Street Address: _____
City, State, Zip: _____
Phone: _____
Email: _____
Website: _____

Date: _____ Receipt #: _____

Patient Information

Name: _____ Street Address: _____
City, State, Zip: _____ Phone: _____

Description of Services

Services Rendered: _____
_____
_____

Service Date: _____
Payment: _____ Dollars ($_____)

☐ Insurance Copayment
☐ Self-Pay Amount

Subtotal: _____
Tax Rate: _____
Total Tax: _____
Amount Due: _____

Summary of Charge

The aforementioned Client paid the total amount of _____ Dollars ($_____) in the form of (check one)
☐ Cash
☐ Credit (No. _____)
☐ Check (No. _____)
☐ Other: _____.

Authorized Signature _____