MEDICAL EXPENSES

In order for us to maximize your deductions, please complete this worksheet

Client Name _____ Tax Year _____

Note: These expenses must be paid by the taxpayer and for the taxpayer's self, spouse or dependent. Do not deduct expenses which are reimbursed by insurance or other sources.

Medical Miles _____

Medications and Drugs

Prescribed Controlled Substances		Other	
Insulin		**TOTAL MEDICATION & DRUGS**	

Doctors, Dentists, Psychiatrists, Chiropractors C/S Practitioners, Acupuncture, Others

Dr.		Dr.	
Dr.		Dr.	
Dr.		Dr.	
Dr.		Dr.	
Dr.		Dr.	
Dr.		Dr.	
Dr.		Dr.	
Dr.		Dr.	
Dr.		**TOTAL DOCTORS & DENTISTS**	

Hospitals

		TOTAL HOSPITAL EXPENSES	

Insurance

Health Insurance		Contact Insurance	
Hospital Insurance		School Insurance	
Group Insurance		Supplemental Medicare	
Long Term Care Insurance		Other (Do not include income protection plans)	
		TOTAL INSURANCE PREMIUMS	

Other Medical & Dental Expenses

Anesthesia		X-rays	
Oxygen		Clinics	
Laboratories		Sanitariums	
Nurses		Nurses Aides	
Ambulance		Psychologists	
Psychiatric Care		Physical Therapy	
Mental Therapy		Eyeglasses	
Optometrists		Contact Lenses	
Hearing Aids		Hearing Aid Batteries	
Prescribed Pools & Spas		Surgical Equipment	
Hospital Equipment		Hospital Supplies	
Orthopedic Shoes		Canes / Walkers	
Crunches		Braces	
Elastic Hose		Massage Unties	
Heating Pads		Prescribed Health Institutes, Gyms, Swim Clubs	
Humidifiers		Special Schools for the Handicapped	
Asthmatic Air Conditioner			
Wheel Chair		*Capital Improvements (Amount not adding to FMV)*	
Wigs		Elevator	
Prescribed Expenses Equipment		Wheel Chair Ramps	
Parking & Tolls		Water Fluoridations Systems	
Travel & Transportation Lodging ($50 max)		Other Improvements	

TOTAL OTHER MEDICAL & DENTAL EXPENSES