Tax Year _____

Form A - Medical Expenses

(*ONLY IF YOUR EXPENSES EXCEED 7.5% OF YOUR INCOME)

MEDICAL EXPENSES	**TOTAL**	
Prescription medication	$_____	
Insurance Premiums	$_____	Health Ins $_____ Dental Ins $_____
SSA Medicare (from 1099)	$_____	Taxpayer $_____ Spouse $_____
Long-Term Care Taxpayer	$_____	Ins Co Name _____
		Policy # _____
Long-Term Care Spouse	$_____	Ins Co Name _____
		Policy # _____
Fees for Doctors, Dentist etc	$_____	
Fees for hospitals, clinics etc.	$_____	
Lab and X-Ray fees	$_____	
Eyeglasses and contact lenses	$_____	
Equipment and supplies	$_____	
Medical Transportation	$_____	**Miles driven for medical #_____**
Lodging for medical care	$_____	
Other medical and dental	$_____	
Parking	$_____	
_____	$_____	
_____	$_____	
_____	$_____	
_____	$_____	