Gagliano Associates LLC est. 1987
"Pay only what you legally owe and not a penny more"
Income Tax Preparation Specialists

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Medical, Dental, and Vision Expenses Worksheet

Fill out this form if you wish to itemize medical expenses on Schedule A. For medical expenses, you can deduct expenses that are greater than 7.5% of your Adjusted Gross Income. For example, if your Adjusted Gross Income is $100,000, then only medical expenses above $7,500 will be deductible. If you are unsure whether you can itemize your medical expenses, then feel free to fill out this form and we will determine if you can itemize. The more thorough you are in listing ALL applicable expenses, the better the deduction you may qualify for. Make sure you keep receipts to substantiate these expenses for your own records. Do not submit actual receipts to our office.

Client Name(s)_____

Tax Year _____

EXPENSES: *(Include all costs for taxpayer, spouse, and dependents on tax return)*	**TOTAL ANNUAL COST PER FAMILY**
☐ Prescription Medications	$ .....
☐ Health Insurance Premiums Paid Out of Pocket (NOT pretax through employer)	$ .....
☐ Dental Insurance Premiums Paid Out of Pocket (NOT pretax through employer)	$ .....
☐ Vision Insurance Premiums Paid Out of Pocket (NOT pretax through employer)	$ .....
☐ Long Term Care Premiums Paid Taxpayer (include proof of premiums paid)	$.....
☐ Long Term Care Premiums Paid Spouse (include proof of premiums paid)	$.....
☐ Fees for Doctors, Dentists, Copays, etc.	$ .....
☐ Fees for Qualifying Alternative Medical Care (Chiropractic, Acupuncture, etc.)	$ .....
☐ Fees for Hospitals, Clinics, etc.	$ .....
☐ Lab & X-ray Fees	$ .....
☐ Eye Glasses & Contact lenses	$ .....
☐ Medical Equipment & Supplies	$ .....
☐ Medical Miles Driven Round Trip	.....miles
☐ Other Medical Transportation Costs Not Included Above i.e. Ambulance Fees	$ .....
☐ Medical Lodging (up to $50 per night per person)	$ .....
o Number of Nights in Lodging: _____ nights	
o Number of Qualified People Staying in Lodging: _____ people	
☐ Other Medical, Dental, and Vision Expenses	$ .....
☐ Amount of medical expenses listed above which were reimbursed by HSA/FSA	$ .....
☐	$ .....
☐	$ .....
☐	$ .....
☐	$ .....
☐	$ .....

QUESTIONS: