

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 _____

TOTAL ANNUAL COST
PER FAMILY

EXPENSES:

| | | |
|--------------------------|--|----------|
| <input type="checkbox"/> | Prescription Medications | \$ |
| <input type="checkbox"/> | Health Insurance Premiums Paid Out of Pocket (NOT pretax through employer).. | \$ |
| <input type="checkbox"/> | Dental Insurance Premiums Paid Out of Pocket (NOT pretax through employer).. | \$ |
| <input type="checkbox"/> | Vision Insurance Premiums Paid Out of Pocket (NOT pretax through employer).. | \$ |
| <input type="checkbox"/> | Long Term Care Premiums Paid Taxpayer (include proof of premiums paid)..... | \$..... |
| <input type="checkbox"/> | Long Term Care Premiums Paid Spouse (include proof of premiums paid) | \$..... |
| <input type="checkbox"/> | Fees for Doctors, Dentists, etc..... | \$ |
| <input type="checkbox"/> | Fees for Qualifying Alternative Medical Care (Chiropractic, Acupuncture, etc.).... | \$ |
| <input type="checkbox"/> | Fees for Hospitals, Clinics, etc..... | \$ |
| <input type="checkbox"/> | Lab & X-ray Fees | \$ |
| <input type="checkbox"/> | Eye Glasses & Contact lenses | \$ |
| <input type="checkbox"/> | Medical Equipment & Supplies | \$ |
| <input type="checkbox"/> | Medical Miles Driven Round Trip | |
| <input type="checkbox"/> | Other Medical Transportation Costs Not Included Above i.e. Ambulance Fees | \$ |
| <input type="checkbox"/> | 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 | |
| <input type="checkbox"/> | Other Medical, Dental, and Vision Expenses..... | \$ |
| <input type="checkbox"/> | | \$ |
| <input type="checkbox"/> | | \$ |
| <input type="checkbox"/> | | \$ |
| <input type="checkbox"/> | | \$ |
| <input type="checkbox"/> | | \$ |
| <input type="checkbox"/> | | \$ |
| <input type="checkbox"/> | | \$ |

QUESTIONS: