DENTIST INVOICE

INVOICE: _____
DATE: _____

BUSINESS NAME: _____
ADDRESS: _____
CITY, STATE, ZIP CODE: _____
TELEPHONE _____
FAX _____
WEB ADDRESS _____

CLIENT NAME: _____
ADDRESS: _____
CITY, STATE, ZIP CODE: _____
TELEPHONE _____
FAX _____
WEB ADDRESS _____

SHIP TO:

NAME: _____
ADDRESS: _____
CITY, STATE, ZIP CODE: _____
TELEPHONE _____

DENTIST/TECH	PROCEDURE	DATE	APPT TIME	APPT END	MISC

ITEM(S)	ITEM(S) PRICE	LABOR	TOTAL

Make all checks payable to _____

THANK YOU FOR YOUR BUSINESS!