PHARMACY NAME

123 Medical Boulevard
City, State, Zip
Phone: (555) 000-0000

SALES INVOICE

Invoice #: _____
Date: _____

Bill To:

Name: _____
Address: _____
ID/Insurance: _____

Prescriber Info:

Doctor: _____
License #: _____
Rx Number: _____

NDC / Item Code	Description / Medication	Qty	Unit Price	Total

Subtotal: $_____
Tax: $_____
Insurance Paid: ($_____)

Balance Due: $_____

Pharmacist Signature: _____

Note: Please check medication and dosage before leaving the counter.