DENTAL SUPPLY INVOICE

[Clinic Name]
[Street Address]
[City, State, Zip]
[Phone Number]

Invoice #: _____
Date: _____
Due Date: _____

Supplier / Vendor:
[Name]
[Address]
[Contact Info]
Ship To:
[Internal Dept / Doctor Name]
[Room/Floor]

Item Description	SKU / Catalog #	Qty	Unit Price	Total

Subtotal: $0.00
Tax: $0.00
Shipping: $0.00

Total: $0.00

Payment Terms: [Net 30/On Receipt/Credit Card]
Notes: [e.g. Sterile packaging checked, Lot numbers recorded]