PROFORMA INVOICE

[SUPPLIER NAME]
[Street Address]
[City, State, Zip]
[Phone/Email]

Date: [DD/MM/YYYY]
Invoice #: [PR-0000]
Valid Until: [Date]

Bill To:

[Dental Clinic Name]
[Attn: Dr. Name]
[Shipping Address]
[Phone Number]

Payment Terms:
[e.g., 50% Deposit / 50% Net 30]

Item Description	Model/SKU	Qty	Unit Price	Total
[Dental Unit / Chair]	[Model ID]	[0]	[0.00]	[0.00]
[Intraoral X-Ray System]	[Model ID]	[0]	[0.00]	[0.00]
[High-Speed Handpieces]	[Model ID]	[0]	[0.00]	[0.00]
[Autoclave Sterilizer]	[Model ID]	[0]	[0.00]	[0.00]

Subtotal: $0.00
Shipping/Freight: $0.00
Tax: $0.00

Grand Total: $0.00

Banking Details: [Bank Name] | **SWIFT:** [Code] | **Account:** [Number]

Warranty: [Standard 12-month warranty applies unless otherwise stated.]

Note: This is a Proforma Invoice, not a tax invoice. Goods will be dispatched upon receipt of payment.