

# INVOICE

Invoice #: \_\_\_\_\_

Date: \_\_\_\_\_

## Dental Assistant Information

Name: \_\_\_\_\_

License #: \_\_\_\_\_

Email/Phone: \_\_\_\_\_

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## Bill To:

Dental Office Name: \_\_\_\_\_

Address: \_\_\_\_\_

Attn: \_\_\_\_\_

## Payment Instructions:

Payable To: \_\_\_\_\_

Method:  Check  Zelle  ACH

DATE	CLOCK IN	CLOCK OUT	BREAK (MIN)	TOTAL HOURS	HOURLY RATE	TOTAL

Subtotal: \$ \_\_\_\_\_

Expenses/Travel: \$ \_\_\_\_\_

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**TOTAL DUE: \$** \_\_\_\_\_

**Authorizations:**

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Dental Assistant Signature

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Office Manager/Doctor Signature

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Terms: Payment due within \_\_\_\_\_ days of receipt.