

DENTAL CLINIC NAME

123 Dental St, Suite 100
City, State, Zip
Phone: (555) 000-0000

INVOICE

Date: _____
Invoice #: _____

PATIENT INFO:

Name: _____
Address: _____
Phone: _____

PRACTITIONER:

Dr. _____

Service Description	Units	Unit Price	Total
In-Office Professional Teeth Whitening	_____	\$	\$
Custom Take-Home Whitening Trays	_____	\$	\$
Whitening Gel Refill Kit	_____	\$	\$
Pre-Whitening Polishing / Consultation	_____	\$	\$
Subtotal: \$ _____			
Tax: \$ _____			
TOTAL: \$ _____			

Notes: Avoid staining foods/drinks (coffee, wine, tobacco) for 48 hours following treatment.

Payment is due upon completion of service. Thank you for choosing our clinic for your smile enhancement.