Family Dental Wellness

123 Clinic Way, Suite 100
City, State, ZIP
Phone: (555) 012-3456

INVOICE

Invoice #: _____
Date: _____

BILL TO:

_____
_____
_____

PLAN DETAILS:

Plan Type: _____
Member ID: _____
Coverage Period: _____

Member Name	Service / Plan Item	Quantity	Unit Price	Total
_____	_____	____	$ _____	$ _____
_____	_____	____	$ _____	$ _____
_____	_____	____	$ _____	$ _____

Subtotal: $ _____
Wellness Discount: - $ _____

Total Due: $ _____

Notes: Please make checks payable to Family Dental Wellness. Payments are due within 30 days of the invoice date.