INVOICE

Optical Clinic Name
Street Address, City
Phone: (000) 000-0000

Date: _____
Invoice #: _____

PATIENT INFO:

Name: _____
Address: _____
ID/D.O.B: _____

PRESCRIBER:

Dr. _____
License #: _____

PRESCRIPTION DETAILS

EYE	SPH	CYL	AXIS	ADD	PD
O.D. (Right)					
O.S. (Left)					

ORDER SUMMARY

Description	Quantity	Unit Price	Total
Frame: _____			
Lens Type: _____			
Coatings/Treatments: _____			
Professional Fees / Eye Exam			

Subtotal: $_____

Insurance Coverage: -$_____

Tax: $_____

GRAND TOTAL: $_____

Notes: _____

Signature: _____ Date: _____