

Dental Treatment Invoice

Invoice No.:

Date:

Patient Name:

Patient ID:

Dentist Name:

Treatment Description	Quantity	Unit Price	Total
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Grand Total			<input type="text"/>

Payment Method:

Notes: