

Clinic Invoice

Clinic Name _____

Address _____

Phone _____

Email _____

Patient Name _____

Patient ID _____

Date of Birth _____

Phone _____

Invoice # _____

Date of Invoice _____

Due Date _____

Description of Service	Date	Code	Quantity	Amount
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Subtotal _____

Tax _____

Total _____

Amount Paid _____

Balance Due _____
