**Dental Laboratory Invoice Template**

Name of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male / Female

Date of First Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Days of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



NOTES

|  |  |  |  |
| --- | --- | --- | --- |
| Dental Treatment | Teeth Examined | Material Cost | Fee |
| Consultation |  |  |  |
| Intra-oral X-Ray |  |  |  |
| Panoramic X-Ray |  |  |  |
| Cranial X-Ray |  |  |  |
| Filling |  |  |  |
| Inlay |  |  |  |
| Metal Crown |  |  |  |
| Post Crown |  |  |  |
| Jacket Crown |  |  |  |
| Bridge Work |  |  |  |
| Plate / Partial / Complete Denture |  |  |  |
| Extraction |  |  |  |
| Apicoectomy |  |  |  |
| Others |  |  |  |
| Total |  |  |  |

Name of the Dental Technician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Total Billed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dental Laboratory Name | Street Address 1, Street Address 2, PIN 23423 | PH: (333)-9999-888**

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