

DENTIST INVOICE

DATE: _____

Name: _____

Address: _____

City: _____ State _____ Zip _____

Phone: _____

SS# or EIN# _____

Fax invoice to Southern Crescent Personnel:

770-968-4606 | 770-692-0452

Services Performed:

Day	Date	Client Location	Time in	Time taken for Lunch Break	Time out	Total Hours
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
SUNDAY						

Signature: _____

Date: _____

Mail payment:	<input type="checkbox"/>
Hold Payment for Pickup:	<input type="checkbox"/>

*Refer a Friend and receive a Referral Bonus!!! (from \$50.00 to \$250.00 per person). Call for details.