DENTAL CLINIC NAME

123 Medical Plaza, Suite 100
City, State, Zip Code
Phone: (555) 000-0000

INVOICE

Date: _____
Invoice #: _____

PATIENT:
Name: _____
Address: _____
ID/Chart #: _____
PROVIDER:
Dr. _____
License #: _____

Date	ADA Code	Description of Service	Tooth #	Fee

Subtotal: $_____
Insurance Coverage: ($_____)
Adjustments: $_____

Total Amount Due: $_____

Payment Terms: Payment is due at the time of service. We accept Cash, Check, and major Credit Cards.

Notes: _____