[Clinic Name] Pediatric Care

[Address Line 1]
[Phone Number]
[Email/Website]

INVOICE

Date: [Date]
Invoice #: [0000]

PATIENT INFORMATION

[Patient Name]
DOB: [MM/DD/YYYY]
Guardian: [Parent/Guardian Name]

BILLING ADDRESS

[Street Address]
[City, State, Zip]
[Insurance Provider / Policy #]

Date of Service	Description / CPT Code	Amount
[Date]	[Service Description - e.g., Well Child Visit]	$0.00
[Date]	[Service Description - e.g., Immunization]	$0.00
[Date]	[Service Description - e.g., Lab Work]	$0.00

Subtotal: $0.00
Insurance Coverage: ($0.00)
Total Due: $0.00

Please make checks payable to **[Clinic Name]**.

Thank you for choosing our clinic for your child's healthcare needs.