

PEDIATRIC DENTAL SURGERY

INVOICE

PROVIDER INFORMATION

Dr. _____
Clinic Address Line 1
City, State, Zip
Phone: (____) ____ - ____

PATIENT / GUARDIAN

Patient Name: _____
Guardian Name: _____
Date of Service: ____ / ____ /20____
Insurance ID: _____

| ADA Code | Description of Procedure | Tooth/Area | Amount |
|----------|--------------------------|------------|---------|
| _____ | _____ | _____ | \$ 0.00 |
| _____ | _____ | _____ | \$ 0.00 |
| _____ | _____ | _____ | \$ 0.00 |
| _____ | Anesthesia / Sedation | N/A | \$ 0.00 |

Subtotal: \$ 0.00
Insurance Adjustment: (\$ 0.00)
Amount Due: \$ 0.00

NOTES & POST-OP INSTRUCTIONS

Payment is due within 30 days. Please make checks payable to the clinic name listed above.

Thank you for choosing our practice for your child's dental health.