MAXILLOFACIAL SURGERY

[Practice Name]
[Clinic Address]
[City, State, Zip]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____

PATIENT INFO:

[Patient Name]
[Address]
[Phone/Email]

BILLING INFO:

[Insurance Provider]
[Policy/Group Number]
[Authorization ID]

CPT/CDT Code	Procedure Description	Date of Service	Fee

Subtotal: $_____

Insurance Coverage: $_____

Total Amount Due: $_____

Payment Terms: Due upon receipt. Please make checks payable to "[Practice Name]".

Surgeon Signature: _____