

DENTAL IMAGING CENTER

[Clinic Address Line 1]
[City, State, Zip]
Phone: (000) 000-0000

INVOICE

#INV- _____
Date: _____

PATIENT INFORMATION

Name: _____
ID: _____
Referring Dr: _____

BILLING DETAILS

Insurance Provider: _____
Policy Number: _____
Due Date: _____

ADA Code	Service Description (X-Ray Type)	Qty	Unit Price	Total
D0210	Intraoral - Comprehensive Series (Full Mouth)		\$	\$
D0330	Panoramic Radiographic Image		\$	\$
D0274	Bitewings - Four Radiographic Images		\$	\$
D0367	Cone Beam CT (CBCT) - Full Maxilla/Mandible		\$	\$

ADA Code	Service Description (X-Ray Type)	Qty	Unit Price	Total
D0220	Intraoral - Periapical First Image		\$	\$

Subtotal: \$ _____
Insurance Coverage: (\$ _____)
Balance Due: \$ _____

Payment Terms: Please make checks payable to Dental Imaging Center. Net 30 days.

Notice: This document contains confidential health information protected by HIPAA. Please handle accordingly.