DENTAL CLINIC NAME

123 Medical Plaza, Suite 100
City, State, Zip Code
(555) 012-3456

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name: _____
ID: _____
Phone: _____

PROVIDER INFORMATION

Dentist: _____
License #: _____

Tooth #	Description of Service	ADA Code	Amount
____	Simple Tooth Extraction	D7140	$_____
____	Surgical Extraction / Erupted Tooth	D7210	$_____
____	Local Anesthesia / Sedation	D9223	$_____
____	Post-Operative X-Ray	D0220	$_____

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

Payment is due at the time of service. Thank you for choosing our clinic.

Authorized Signature: _____