DENTAL INVOICE

[Clinic Name]
[Clinic Address]
[Phone Number]

INVOICE #
DATE

PATIENT INFORMATION

Name:

ID/DOB:

Address:

SURGEON DETAILS

Dentist Name:

License No:

Tooth #	Description of Procedure (Extraction/Impaction Type)	Quantity	Unit Price	Total
	Wisdom Tooth Removal - Upper Left			
	Wisdom Tooth Removal - Upper Right			
	Wisdom Tooth Removal - Lower Left			
	Wisdom Tooth Removal - Lower Right			
-	Local/General Anesthesia			

Tooth #	Description of Procedure (Extraction/Impaction Type)	Quantity	Unit Price	Total
-	Post-Op Medication / Imaging (X-Ray)			

Subtotal:

Insurance Coverage:

Balance Due:

Notes: _____

Payment Terms: Payment is due upon completion of the procedure. Thank you for choosing our clinic.

_____
Patient Signature

_____
Authorized Signature