

EMERGENCY DENTAL CARE

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

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION:

Name: _____
ID: _____
Address: _____
Phone: _____

INSURANCE / PAYMENT:

Provider: _____
Policy #: _____
Auth #: _____

ADA Code	Description of Service	Tooth #	Amount

ADA Code	Description of Service	Tooth #	Amount
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Subtotal: \$ _____

Insurance Paid: \$ _____

Total Due: \$ _____

Diagnosis/Notes: _____

Provider Signature: _____ Date: _____

Thank you for choosing our emergency services.