[CLINIC NAME]

[Address Line 1]
[Address Line 2]
Phone: [Phone Number]

RECEIPT

Date: _____
Invoice #: _____

PATIENT INFORMATION:

Name: _____
ID/DOB: _____
Phone: _____

DENTIST:

Dr. _____
License #: _____

Service Description	Tooth/Area	ADA Code	Amount
Comprehensive Oral Evaluation	-	D0150	$
Prophylaxis (Cleaning) - Adult	-	D1110	$
Bitewing X-rays (Four Images)	-	D0274	$
Fluoride Varnish	-	D1206	$
[Other]: _____	-		$

Subtotal: $_____

Insurance Paid: ($_____)

Total Amount Paid: $_____

Payment Method: [ ] Cash [ ] Card [ ] Insurance [ ] Other

Thank you for choosing [Clinic Name] for your dental care.