ORAL SURGERY ASSOCIATES

123 Medical Plaza, Suite 400
Healthcare City, ST 12345
Phone: (555) 010-8899

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
Address: _____
Phone: _____

INSURANCE PROVIDER

Carrier: _____
Policy #: _____
Group #: _____

Date of Service	ADA Code	Description of Procedure	Tooth #	Amount

Gross Charges: $ _____
Insurance Adjustment: - $ _____
Patient Paid to Date: - $ _____

Total Balance Due: $ _____

Notes: Payment is due within 30 days. Please include the invoice number on your check.

Thank you for choosing Oral Surgery Associates for your care.