

# Orthodontic Service Invoice

[Clinic Name]

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[Clinic Address / Phone]

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INVOICE NUMBER

#

DATE

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## PATIENT INFORMATION

Name:

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ID/Record #:

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Contact:

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## PAYMENT STATUS

Insurance Provider:

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Authorization #:

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Service Description (Adjustment/Maintenance)	Qty	Unit Price	Total
Archwire Adjustment / Activation			\$
Ligature/Elastic Replacement			\$
Bracket Re-bonding / Repair			\$
X-Ray / Imaging (Progress)			\$

Subtotal: \$

Insurance Coverage: (\$ )

Amount Due: \$

Next Appointment: \_\_\_\_\_

**Notes:** All payments are due upon receipt of service. Please retain this invoice for insurance claims.