INVOICE

[Practice Name]
[Address Line 1]
[City, State, Zip]
[Phone/Email]

Invoice #: _____
Date: _____

PATIENT INFORMATION:

[Patient Name]
[Patient ID / Chart #]
[Address]
[Phone]

INSURANCE / PROVIDER:

Carrier: _____
Group #: _____
Provider: _____
NPI: _____

Date of Service	ADA Code	Description / Quadrant (UR, UL, LR, LL)	Tooth Range	Fee
	D4341	Periodontal Scaling & Root Planing (4+ teeth)		$
	D4342	Periodontal Scaling & Root Planing (1-3 teeth)		$
	D4381	Localized Delivery of Antimicrobial Agents		$
	D4910	Periodontal Maintenance		$
		Other:		$

Subtotal: $ _____
Insurance Est. Coverage: $ (_____)
Adjustments: $ _____

Balance Due: $ _____

Notes: Follow-up evaluation is typically required 4-6 weeks post-procedure.

Payment Terms: Due upon receipt. Please make checks payable to [Practice Name].