DENTAL CARE CLINIC

123 Medical Plaza, Suite 400
City, State, ZIP
Phone: (555) 000-0000

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION:

Name: _____
ID: _____
Address: _____

PRACTITIONER:

Dr. _____
License #: _____

Tooth #	Surface	Procedure Description (CDT Code)	Fee
____	____	Filling - Composite Resin, 1 Surface (D2330/D2391)	$ ____
____	____	Filling - Composite Resin, 2 Surfaces (D2331/D2392)	$ ____
____	____	Filling - Composite Resin, 3 Surfaces (D2332/D2393)	$ ____

Tooth #	Surface	Procedure Description (CDT Code)	Fee
-	-	Local Anesthetic / Professional Services	$ ____

Subtotal: $ _____

Insurance Benefit Estimate: ($ _____)

Patient Responsibility: $ _____

Payment Terms: Payment is due at the time of service unless prior arrangements have been made.

Notes: _____