

[CLINIC NAME] ORTHODONTICS

[Street Address]
[City, State, Zip]
[Phone Number]

INVOICE

Date: [Date]
Invoice #: [00000]

PATIENT INFORMATION

[Patient Name]
[Patient Address]
[Patient ID / DOB]

PAYMENT STATUS

[Pending / Paid / Partial]

Service Description	ADA Code	Amount
Initial Orthodontic Consultation & Clinical Exam	D0150	\$0.00
Panoramic Radiographic Image	D0330	\$0.00
Cephalometric Radiographic Image	D0340	\$0.00

Service Description	ADA Code	Amount
Diagnostic Casts / Digital Scans	D0470	\$0.00

Subtotal: \$0.00
Insurance Credits: (\$0.00)
Total Due: \$0.00

Notes: [Insert treatment plan summary or next appointment details here]

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