[Clinic Name]

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

INVOICE

Date: [Date]
Invoice #: [0000]
Patient ID: [ID]

BILL TO:

[Patient Name]
[Patient Address]
[Patient Phone]

INSURANCE INFO:

[Provider Name]
[Policy Number]
[Group ID]

Tooth #	ADA Code	Description of Service (Crown Type)	Fee
[ ]	[D2740]	Restorative Crown - Porcelain/Ceramic substrate	$ 0.00
[ ]	[D2750]	Restorative Crown - Porcelain fused to high noble metal	$ 0.00
[ ]	[D2950]	Core Buildup, including any pins when required	$ 0.00

Tooth #	ADA Code	Description of Service (Crown Type)	Fee
-	-	[Additional Lab Fees/Services]	$ 0.00

Subtotal: $ 0.00

Insurance Estimated Coverage: ($ 0.00)

Total Patient Responsibility: $ 0.00

Notes/Aftercare: [Insert notes regarding permanent crown placement or temporary instructions.]

Payment is due within [Number] days. Thank you for choosing [Clinic Name] for your dental care.