

INVOICE

Dental Practice Name
Street Address, City
Phone: (555) 000-0000

Invoice #: _____
Date: _____

PATIENT INFORMATION:

Name: _____
ID: _____
Address: _____

TREATMENT DETAILS:

Dentist: _____
Tooth Number(s): _____
Insurance: _____

ADA Code	Description of Service	Fee
D3310/20/30	Endodontic Therapy (Root Canal)	\$
D0220	Intraoral Radiograph (Periapical)	\$
D9215	Local Anesthesia	\$
D2950	Core Buildup / Temporary Filling	\$
	Other: _____	\$

Subtotal: \$ _____

Insurance Paid: - \$ _____

Adjustments: - \$ _____

Total Due: \$ _____

Payment Terms: Due upon receipt. Please make checks payable to the Dental Practice Name.

Thank you for choosing our practice for your endodontic care.