[Dental Clinic Name]

[Address Line 1]
[City, State, Zip]
[Phone Number]

INVOICE

Date: __________
Invoice #: __________

PATIENT INFO:

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

PROVIDER INFO:

Dr. [Dentist Name]
License #: [Number]
NPI: [Number]

ADA Code	Description of Service	Tooth/Quad	Fee
D1110	Prophylaxis - Adult	Full	$ 0.00
D0120	Periodic Oral Evaluation	N/A	$ 0.00

ADA Code	Description of Service	Tooth/Quad	Fee
D0274	Bitewings - Four Radiographic Images	N/A	$ 0.00
D1208	Topical Application of Fluoride	Full	$ 0.00

Subtotal: $ 0.00
Insurance Paid: $ 0.00
Total Due: $ 0.00

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

Notes: Next cleaning recommended in 6 months.