

DENTAL SURGICAL SERVICES

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

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION:

Name: _____
ID: _____
Address: _____

SURGEON INFORMATION:

Dr. _____
License #: _____
NPI: _____

ADA Code	Tooth #	Description of Procedure	Fee
D7140	_____	Extraction, erupted tooth or exposed root	\$
D7210	_____	Surgical removal of erupted tooth	\$
D7240	_____	Removal of impacted tooth (Completely Bony)	\$

ADA Code	Tooth #	Description of Procedure	Fee
D9222	N/A	Deep sedation/general anesthesia (first 15m)	\$

Subtotal: \$ _____

Insurance Coverage Estimate: (\$ _____)

Total Balance Due: \$ _____

Notes: _____

Payment is due at the time of service. Please make checks payable to the clinic name listed above.