DENTAL IMAGING CENTER

[Clinic Address]
[Phone Number]
[Tax ID]

Invoice #: _____

Date: _____

PATIENT INFORMATION:

[Patient Name]
[Patient ID]
[Insurance Provider]

REFERRING DOCTOR:

[Doctor Name]
[Clinic Name]

ADA Code	Description of Service	Tooth/Area	Fee
D0210	Intraoral - Comprehensive Series (FMX)	Full Mouth	$ 0.00
D0330	Panoramic Radiographic Image	Maxilla/Mandible	$ 0.00
D0367	Cone Beam CT (CBCT) - Limited Field	[Area]	$ 0.00
D0274	Bitewings - Four Radiographic Images	Posterior	$ 0.00

Subtotal: $ _____

Insurance Coverage: $ _____

Total Amount Due: $ _____

Terms: Payment due upon receipt of imaging services.

Methods: Credit Card, Debit, or Insurance Claim Transfer.