[DENTAL PRACTICE NAME]

[Street Address]
[City, State, Zip]
[Phone Number]
[License/NPI Number]

INVOICE

Invoice #: [0000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

PATIENT INFORMATION

[Patient Full Name]
[Patient Address]
[City, State, Zip]
ID: [Patient ID/Chart #]

INSURANCE INFO (IF APPLICABLE)

[Insurance Provider]
Group #: [Group Number]
Member ID: [Member ID]

Date	ADA Code	Description of Service	Tooth #	Amount
[Date]	[DXXXX]	[Service Description]	[#]	$0.00
[Date]	[DXXXX]	[Service Description]	[#]	$0.00

Subtotal: $0.00
Insurance Coverage: ($0.00)
Adjustments: $0.00

Balance Due: $0.00

Notes/Payment Instructions:
Please make checks payable to [Practice Name]. Payments are due within [X] days of the invoice date. Professional fees are due at the time of service unless prior arrangements have been made.