DENTAL INVOICE

Invoice No: _____
Date: _____
Payment Due: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
Phone: _____
Patient ID / Ref: _____

INSURANCE INFORMATION

Provider: _____
Policy Number: _____
Group Number: _____
Pre-Auth Code: _____

PROVIDER INFORMATION

Dentist Name: _____
License / NPI No: _____

Tooth #	Surf.	ADA Code	Description of Service	Qty	Unit Fee	Total Fee

Gross Subtotal:

Insurance Paid:

Discount/Adj:

Total Due (Patient):

Dentist / Authorized Signature

Patient / Responsible Party Signature

Payment Methods Accepted

Thank you for choosing our practice for your dental care.