

EMERGENCY INVOICE

Invoice No: _____
Date: _____
Payment Due: _____

PATIENT & INSURANCE INFORMATION

Patient Name:
Date of Birth:
Phone:
Account/Chart #:
Insurance Provider:
Policy / Group ID:

EMERGENCY SERVICES RENDERED

ADA Code	Tooth #	Description of Treatment	Qty	Unit Cost	Total

Subtotal	
Emergency After-Hours Fee	
Insurance Pending Payment	
Patient Responsibility	

Treating Dentist Signature

Patient / Guarantor Signature

Emergency Care Billing Policy: Payment is due at the time emergency services are rendered unless prior financial arrangements have been documented. If insurance has been verified, the patient is responsible for any deductible, co-payment, or non-covered emergency procedures not fully reimbursed by the provider.