RECEIPT

Receipt No: _____

Date: _____

PATIENT INFORMATION

Patient Name:

Date of Birth:

Subscriber ID:

Insurance Provider:

SERVICES RENDERED

ADA Code	Description of Service	Tooth / Qty	Fee
D0120	Periodic Oral Evaluation - Established Patient		
D1110	Prophylaxis - Adult (Cleaning)		
D0274	Bitewings - Four Radiographic Images		
D1208	Topical Application of Fluoride - Excluding Varnish		

Total Fee Charged: _____

Insurance Paid: _____

Patient Write-off: _____

Patient Paid: _____

Balance Due: _____

Authorized Representative Signature

Patient / Responsible Party Signature

This is an official receipt for dental services rendered. Please retain this copy for your insurance and tax records.