SURGERY & ANESTHESIA BILL

Invoice No: _____

Date: _____

Payment Due: _____

PATIENT INFORMATION

Patient Name:

Date of Birth:

Address:

Patient ID / Chart #:

Phone Number:

Insurance Provider:

SURGERY & ANESTHESIA RECORD

Surgeon:

Anesthesiologist:

Anesthesia Type:

☐ General

☐ IV Sedation

☐ Local

Date of Surgery:

Anesthesia Start Time:

Anesthesia End Time:

PROCEDURE & SERVICE FEES

TOOTH / QUAD	CDT CODE	DESCRIPTION OF SERVICE / PROCEDURE	FEE ($)

TOOTH / QUAD	CDT CODE	DESCRIPTION OF SERVICE / PROCEDURE	FEE ($)

Gross Total:	
Insurance Estimated Coverage:	
Discounts / Adjustments:	
Amount Paid:	
Total Balance Due:	

Authorized Professional Signature

Date: _____ Credentials: _____

Patient / Guarantor Signature

Date: _____