



BILLING STATEMENT

STATEMENT DATE:

STATEMENT #:

ACCOUNT #:

DUE DATE:

PATIENT / RESPONSIBLE PARTY

INSURANCE PROVIDER (IF APPLICABLE)

DATE	TOOTH	ADA CODE	DESCRIPTION OF COSMETIC SERVICE	FEE	ADJUSTMENT / INS
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OFFICE NOTES & PAYMENT INSTRUCTIONS

TOTAL CHARGES

INSURANCE PENDING

PATIENT PAYMENTS

TOTAL AMOUNT DUE

