Clinic Name:		
Address:		
Phone No.:		
Email ID:		
GSTIN:		
State:		
Estimate For:	**File Number:**	
Name:	**Date:**	
Age/Sex:		

	ESTIMATE SLIP FOR TREATMENT OFFERED	**Teeth No:**	**Cost**
A	1. CONSULTATION 2. 3. IOPA XRAYS:IMPRESSION FOR ANALYSIS : UPPER LOWER		
B	1. SCALING & POLISHING REGULAR DEEP SUB-GINGIVAL 2. CURETTAGE		
C	1. RESTORATIONS : SILVER AMALGAM COMPOSITE GIC 2. TEMPORARY RESTORATION : WITH MTA 3. INLAY/ONLAY : CERAMIC COMPOSITE METAL 4. PIT AND FISSURE SEALING		
D	1. TEETH WHITENING / BLEACHING IN-OFFICE : HOME : 2. VENEERS / LAMINATES : COMPOSITE: CERAMIC:		
E	SPLINTS : SOFT SPLINT: 1mm 1.5mm 2mm HARD SPLINT VERTICAL BITE RAISE - COMPOSITE COMPOSITE WIRE SPLINTING		
F	1. ROOT CANAL THERAPY ; RE - TREATMENT ANTERIORS POSTERIORS 2. POST AND CORE : METAL FRC POST CAST		
G	CROWNS & BRIDGES 1. METAL GOLD: CHROMIUM - COBALT: 2. CERAMIC FUSED TO METAL (WITH 5 TO 15 YEARS WARRANTY) GOLD: CHROMIUM-COBALT: 3. METAL-FREE CERAMIC (WITH 5 TO 15 YEARS WARRANTY) 4. COMBINATIONS (1+2)		
H	1. COMPLETE DENTURES BPS (Ivoclar Vivadent, Schaan, Liechtenstein) RICHMOND SUPPORTED RE-LINING OF EXISTING LOOSE FITTING DENTURES 2. REMOVABLE PARTIAL DENTURE REGULAR CAST PARTIAL PRECISION ATTACHMENT (RHEIN 83, ITALY):		
I	IMPLANTS AND SUPPORTED PROSTHESIS		

J	EXTRACTION		
K	SURGERY IMPACTION FLAP SURGERY ALVEOLOPLASTY ORTHO SURGERY APICOECTOMY GINGIVOPLASTY BIOPSY WITH CONSCIOUS SEDATION		
	Total		

Estimate Amount in Words:		Sub Total:
		Discount:
		Discount Amount:
		Final Amount
Terms and Conditions:		
		Seal & Signature

NOTE: The costs mentioned are subject to change in case of change in treatment plan during the course of treatment.

THIS ESTIMATE IS VALID FOR THE MONTH