

# DENTAL COST ESTIMATE

For completion by your dental practitioner.  
Please note, this document is not for use as an invoice or Claim Form.

## DETAILS OF RECIPIENT OF TREATMENT

Eurotrainee institution

Policy number (N/A when claiming for the 1st time)

Mr.  Mrs.  Ms.  Miss  Other

First name

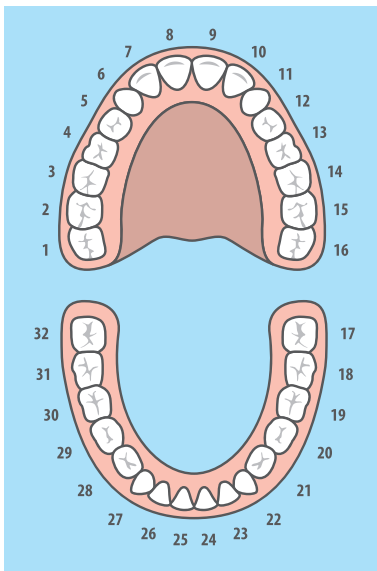
Surname

Full address

Date of birth   /   /

## DENTITION DIAGRAM

Blacken out missing teeth and indicate with arrows the teeth to be attended to for this estimate.



Dental treatment	Tooth number	Estimated fees
• Filling		
• Extraction		
• Root canal treatment		
<b>Fixed prosthesis</b>		
• Gold crown, resin jacket		
• Resin bridge tooth element		
• Gold inlay, cast dummy		
• Pivot crown		
• Veneer or Richmond crown or metal ceramic crown		
• Metal ceramic bridge device		
• Gold and porcelain bridge tooth element		
• Spring attachment		
• Hinge		
<b>Removable prosthesis</b>		
<b>Upper jaw</b>		
Number of teeth to be replaced		
Clasp		
Attachment		
Suction system		
Base: resin <input type="checkbox"/> chrome-cobalt <input type="checkbox"/> gold <input type="checkbox"/>		
Repair to the resin base		
Addition of tooth or clasp on resin base		
Rebasing		
Remounting		
<b>Lower jaw</b>		
Number of teeth to be replaced		
Clasp		
Attachment		
Suction system		
Base: resin <input type="checkbox"/> chrome-cobalt <input type="checkbox"/> gold <input type="checkbox"/>		
Repair to the resin base		
Addition of tooth or clasp on resin base		
Rebasing		
Remounting		

Dental treatment	Tooth number	Estimated fees
<b>Temporary dentures</b>		
• Crown		
• Tooth to be replaced (bridge pontic or tooth on removable denture)		
• Clasp		

Periodontic treatment (indicate site on diagram)	Details incl. quadrant	Tooth number	Estimated fees
• Non-surgical treatment			
• Surgical treatment			
• Other			
<b>Implants</b>	<b>No. of implants</b>		
• Sub-periosteal implant			
• Endo-osseous implant			
<b>Special treatment</b>	<b>Details</b>		
• Occlusal cap-splint			
• Other			
<b>Total estimated fees</b>			


## DENTAL PRACTITIONER DETAILS

Dentist name

Practice name and address




Telephone number  COUNTRY CODE  AREA CODE

Practitioner's stamp

 Practitioner's signature \_\_\_\_\_

Date  /  /

## Please complete, sign and return this form by:

-  Email to: IGOclaims@allianzworldwidecare.com
-  Fax to: + 32 2 210 6597
-  Post to: Allianz Care, Place du Samedi 1, 1000 Brussels, Belgium

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