

Orthodontic **Treatment**  
 and Retention treatment  
 (Teeth straightening)

**MOST RECENT INVOICE NO.**

**Patient's name**

**Dentist's stamp**

**CPR no.**

**Start date**

**End date**

Orthodontic treatment		Currency
Removable device	Upper jaw Lower jaw	
Small fixed device (max. 6 teeth)	Upper jaw Lower jaw	
Complete fixed device	Upper jaw Lower jaw	
Skeletal anchorage (screws or bone anchors)	Qty. _____	
<b>Retention treatment</b>		
Fixed retention device	Upper jaw Lower jaw	
Removable retention device	Upper jaw Lower jaw	
<b>Additional services</b>		
Supplementary profile x-ray image	Qty. _____	
Supplementary panoramic x-ray image	Qty. _____	
Supplementary frontal x-ray image	Qty. _____	
<b>Total fee</b>		

**Receipt issued for the amount**

**Date**