

# DENTAL & VISION BUDGET

Fiscal Year: \_\_\_\_\_

Family Name: \_\_\_\_\_

SERVICE / ITEM	EST. DATE	BUDGETED	ACTUAL
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## DENTAL CARE

Routine Cleaning (6-month)		\$	\$
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X-Rays & Exams		\$	\$
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Fillings / Major Work		\$	\$
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Orthodontics		\$	\$
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## VISION CARE

Annual Eye Exam		\$	\$
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Prescription Frames/Lenses		\$	\$
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Contact Lenses & Supplies		\$	\$
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<b>SERVICE / ITEM</b>	<b>EST. DATE</b>	<b>BUDGETED</b>	<b>ACTUAL</b>
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Other (LASIK/Medication)		\$	\$
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**INSURANCE & SAVINGS**

Monthly Premiums (Total)	Monthly	\$	\$
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HSA/FSA Contributions	Monthly	\$	\$
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**Estimated Annual Total: \$\_\_\_\_\_ Actual Annual Total: \$\_\_\_\_\_**

**Notes & Reminders:**