STATEMENT OF ACCOUNT

David L. Fried, D.M.D.
329 Main St.
Suite 212
Yalesville, CT 06492
(203)265-7118

CHART NO.	PAGE NO.
004938	1
BILLING DATE	**DUE DATE**
10/23/2012	11/07/2012

GUARANTOR NAME AND MAILING ADDRESS

Kimberly LaPierre / Blake LaPierre
8 Pequot Rd
Wallingford, CT 06492

CREDIT CARD #_____ EXP._____

NAME_____
(As it appears on card)

SIGNATURE_____

TYPE OF CARD_____

SECURITY CODE_____

AMOUNT ENCLOSED
$

TO ENSURE PROPER CREDIT, PLEASE DETACH AND RETURN THIS PORTION OF THE STATEMENT WITH YOUR PAYMENT

PLEASE RETAIN THIS PORTION OF THE STATEMENT FOR YOUR RECORDS

DATE	DESCRIPTION	PATIENT'S NAME	CHARGES	CREDITS
07/01/2012	Balance Forward		0.00	
07/10/2012	FLUORIDEX	Blake	16.00	
07/10/2012	Bitewings-four films	Blake	73.00	
07/10/2012	Periodic oral evaluation	Blake	47.00	
07/10/2012	Prophylaxis-adult	Blake	108.00	
07/10/2012	AMX Payment -Thank You	Blake		-28.00
* 07/06/2012	Periodic oral evaluation	Kimberly	47.00	
* 07/06/2012	Prophylaxis-adult	Kimberly	108.00	
07/23/2012	Delta Write-Off	Kimberly		-10.00
07/23/2012	Dental Ins Pmt-(07/06/2012)-Delta Dental Plan	Kimberly		-101.50

Hi Blake,

Your insurance with Metlife was terminated on 6/30/12. Please call our office with your new insurance information so we can re-submit your claim. If you do not have new insurance, the number below is your current balance. Please call our office if you have any questions. Thank you!

* Indicates that Dental Insurance has been billed.

CURRENT BALANCE	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	TOTAL BALANCE	DENTAL INS. EST.
0.00	0.00	0.00	259.50	259.50	0.00

PLEASE PAY THIS AMOUNT → 259.50

DLSTM 2