DONALD SCHMITT,
300 EL CERRO BLVD.
SUITE E
DANVILLE, CA 94526-1745

6636

**RETURN SERVICE REQUESTED**

002957
0101

(925)837-8218

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

| CARD NUMBER | SIGNATURE CODE (CVV) |
|---|---|
| SIGNATURE | EXP. DATE |

| STATEMENT DATE | ACCT. # |
|---|---|
| 02/27/2023 | |
| | AMOUNT PAID |
| | $ |

NIKOLAI SCHLEGEL
6 ELIZABETH LANE
DANVILLE, CA 94526-1547

DONALD SCHMITT,
300 EL CERRO BLVD.
SUITE E
DANVILLE, CA 94526-1745

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

## STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

607515(PC1)

| DATE | DESCRIPTION | PATIENT | CHARGES | CREDITS |
|---|---|---|---|---|
| 01/26/2023 | Balance Forward | | 48.90 | |
| * 02/16/2023 | Additional PAX(4Xrecall) | Mikhaila | 16.00 | |
| * 02/16/2023 | Additional PAX(4Xrecall) | Mikhaila | 16.00 | |
| * 02/16/2023 | Periodic oral evaluation | Mikhaila | 70.00 | |
| * 02/16/2023 | Bitewings-two films | Mikhaila | 93.00 | |
| * 02/16/2023 | Prophylaxis-child | Mikhaila | 123.00 | |

*Dental Insurance has been billed.
Over 30 days. Please contact your insurance company if necessary.

000004335-A

PARENTS OR GUARDIANS ARE RESPONSIBLE FOR ANY BALANCE OR CO-PAYMENTS NOT MET BY THEIR INSURANCE

15

| CURRENT BALANCE | OVER 30 DAYS | OVER 60 DAYS | OVER 90 DAYS | TOTAL BALANCE |
|---|---|---|---|---|
| 318.00 | 48.90 | 0.00 | 0.00 | 366.90 |

**MAKE CHECKS PAYABLE TO:**
DONALD SCHMITT,
**PAGE NUMBER: 1**
**133850.18284**
**v2.0.000**

6636*6636ALL*SK60WCIXV000351

## IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE.

### ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY STATE ZIP

TELEPHONE
( )

MARITAL STATUS
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER'S NAME PHONE

EMPLOYER'S ADDRESS

CITY STATE ZIP

### ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

PRIMARY INSURANCE COMPANY'S ADDRESS PHONE

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

SECONDARY INSURANCE COMPANY'S ADDRESS PHONE

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

000004335-B

DONALD SCHMITT,
300 EL CERRO BLVD.
SUITE E
DANVILLE, CA 94526-1745

6636

**RETURN SERVICE REQUESTED**

002750
0101

(925)837-8218

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CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

| CARD NUMBER | SIGNATURE CODE (CVV) |
|---|---|
| SIGNATURE | EXP. DATE |

| STATEMENT DATE | ACCT. # |
|---|---|
| 01/27/2023 | |
| | AMOUNT PAID $ |

NIKOLAI SCHLEGEL
6 ELIZABETH LANE
DANVILLE, CA 94526-1547

DONALD SCHMITT,
300 EL CERRO BLVD.
SUITE E
DANVILLE, CA 94526-1745

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

## STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

607515(PC1)

| DATE | DESCRIPTION | PATIENT | CHARGES | CREDITS |
|---|---|---|---|---|
| 12/20/2022 | Balance Forward | | 25.50 | |
| * 01/05/2023 | Additional PAX w/Apro/4bwx | Vincent | 45.00 | |
| * 01/05/2023 | Additional PAX w/Apro/4bwx | Vincent | 45.00 | |
| * 01/05/2023 | Bitewings-four films | Vincent | 116.00 | |
| * 01/05/2023 | Periodic oral evaluation | Vincent | 70.00 | |
| * 01/05/2023 | Prophylaxis-adult | Vincent | 123.00 | |
| 01/18/2023 | Dental Ins Pmt-(01/06/2023)-Metlife | Vincent | | -350.10 |
| 01/19/2023 | Credit Card Payment -Thank You | Nikolai | | -25.50 |

*Dental Insurance has been billed.

PARENTS OR GUARDIANS ARE RESPONSIBLE FOR ANY BALANCE OR CO-PAYMENTS NOT MET BY THEIR INSURANCE

15

| CURRENT BALANCE | OVER 30 DAYS | OVER 60 DAYS | OVER 90 DAYS | TOTAL BALANCE |
|---|---|---|---|---|
| 48.90 | 0.00 | 0.00 | 0.00 | 48.90 |

**MAKE CHECKS PAYABLE TO:**
DONALD SCHMITT,
**PAGE NUMBER: 1**
**133850.18284**
**v2.0.000**

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## IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE.

### ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY STATE ZIP

TELEPHONE
( )

MARITAL STATUS
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER'S NAME PHONE

EMPLOYER'S ADDRESS

CITY STATE ZIP

### ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

PRIMARY INSURANCE COMPANY'S ADDRESS PHONE

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

SECONDARY INSURANCE COMPANY'S ADDRESS PHONE

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

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