

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

6636



RETURN SERVICE REQUESTED

008062  
0101  
(925)837-8218

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.					
CHECK CARD USING FOR PAYMENT					
	<input type="checkbox"/>	MASTERCARD		<input type="checkbox"/>	DISCOVER
	<input type="checkbox"/>	VISA		<input type="checkbox"/>	AMERICAN EXPRESS
CARD NUMBER			SIGNATURE CODE (CVV)		
SIGNATURE			EXP. DATE		
STATEMENT DATE			ACCT. #		
07/27/2023					
			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
06/28/2023	Balance Forward		0.00	
* 07/10/2023	Periodic oral evaluation	Vincent	105.00	
* 07/10/2023	Prophylaxis-adult	Vincent	123.00	

\* 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
	228.00	0.00	0.00	0.00	228.00

MAKE CHECKS PAYABLE TO:

DONALD SCHMITT,

PAGE NUMBER: 1

133850.18284

v2.0.000

**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                     Separated  
                                   Single                             Divorced  
                                   Married                             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