

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

6636



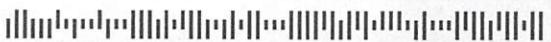
RETURN SERVICE REQUESTED

002957
0101
(925)837-8218

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.					
CHECK CARD USING FOR PAYMENT					
	<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. #		
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

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

607515(PC1)

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

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.

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

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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
()
 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

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

6636



RETURN SERVICE REQUESTED

002750
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"/>	DISCOVER
<input type="checkbox"/>	VISA	<input type="checkbox"/>	AMERICAN EXPRESS	<input type="checkbox"/>	AMERICAN EXPRESS
CARD NUMBER			SIGNATURE CODE (CVV)		
SIGNATURE			EXP. DATE		
STATEMENT DATE			ACCT. #		
01/27/2023					
			AMOUNT PAID		
			\$		



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STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT
607515(PC1)

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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

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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 <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> 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	