MAKE CHECKS PAYABLE TO:

TEST Creek Forest Dental
16815 Spring Creek
Forest Dr.
Spring NY 11111

Pay Online!
Scan code with your phone or visit
https://pay.vynetrellis.com/ab1c34de/f
Link expires 45 days after statement date.

SCAN ME

Paying by mail?
Provide your payment details on the back of this page.

ADDRESSEE:

TEST 1 PATIENT
9999 BROKEN ELM DR.
SPRING TX 77388

REMIT TO:

John Doe
1234 Abana Path
Suite 100
Gotham NY 45603-9351

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

STATEMENT

BALANCE FORWARD	$0.00

DATE	PATIENT	DESCRIPTION	CREDITS	CHARGES
01/01/0001	Test Patient	Balance Forward	-$0.00	$0.00
2/29/2025	Test Patient	CROWN-PORCELAIN FUSED TO HIGH NOBLE MET Tooth 30 /	-$0.00	$400.00
	Test Patient	Est Insurance Insurance Claim from February 29, 2024 was Submitted to Prim. Ins	-$0.00	$0.00
	Test Patient	Insurance Claim from February 29, 2025 was Submitted to Prim. Ins	-$0.00	$0.00
	Test Patient	Insurance Claim from February 29, 2025 was Submitted to Prim. Insura	-$0.00	$0.00
	Test Patient	Insurance Claim from February 29, 2025 was Submitted to Prim. Insuranc	-$0.00	$0.00
2/29/2025	Test Patient	LIMITED ORAL EVALUATION-PROBLEM FOCUSED / Est Insurance $10.00	-$0.00	$10.00

TOTAL CHARGES:	$410.00
ESTIMATED INSURANCE PAYMENT:	$300.00
BALANCE DUE:	**$110.00**

CURRENT	30 DAYS	60 DAYS	90 DAYS	EST. INSURANCE	ON CONTRACT	DUE DATE
$110.00	$0.00	$0.00	$0.00	$300.00	$0.00	03/07/2025

TEST Creek Forest Dental
(631)370-6911

16815 Spring Creek
Spring, NY 11111

IF PAYING BY CREDIT CARD, SELECT THE CARD BELOW AND FILL OUT DETAILS.

MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS ☐

CARD NUMBER	EXP. DATE	SIGNATURE

STATEMENT DATE	ACCT #	PAY THIS AMOUNT	SHOW AMOUNT PAID HERE $
03/07/2025	10527	$110.00	

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

YOUR NAME (Last, First, Middle Initial)			
ADDRESS			
CITY		STATE	ZIP
TELEPHONE	MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
EMPLOYER NAME	EMPLOYER TELEPHONE		
EMPLOYER ADDRESS	CITY	STATE	ZIP

YOUR PRIMARY INSURANCE COMPANY'S NAME		EFFECTIVE DATE
PRIMARY INSURANCE COMPANY'S ADDRESS		PHONE
CITY	STATE	ZIP
POLICY HOLDER'S ID #		GROUP PLAN #
SECONDARY INSURANCE COMPANY'S NAME		EFFECTIVE DATE
SECONDARY INSURANCE COMPANY'S ADDRESS		PHONE
CITY	STATE	ZIP
POLICY HOLDER'S ID #	GROUP PLAN #	