AUTHORIZATIONS:

(1) PARENT / GUARDIAN AUTHORIZATION FOR CHILD / MINOR:

THE INFORMATION THAT I HAVE GIVEN REGARDING MY CHILD'S MEDICAL STATUS IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS.

I AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES FOR MY MINOR / CHILD.

X _____ _____/_____/_____

Signature of Parent / Guardian Date

(2) INSURANCE ASSIGNMENT AND RELEASE:

I HEREBY AUTHORIZED AND REQUEST MY INSURANCE COMPANY TO PAY FARHAD AZIZZADEH, DDS, PC INSURANCE BENEFITS OTHERWISE PAYABLE TO ME AND ACKNOWLEDGE THAT I AM ULTIMATELY FINANCIALLY RESPONSIBLE FOR ANY DENTAL SERVICES I RECEIVE.

I AUTHORIZE FARHAD AZIZZADEH TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY NECESSARY TO SECURE PAYMENT OF BENEFITS.

I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. THE AUTHORIZATION WILL REMAIN IN FORCE UNTIL TERMINATED IN WRITING BY ME.

X _____ _____/_____/_____

Subscriber's or Authorized Person's Signature Date

(3) FINANCIAL AGREEMENT FOR PATIENT WITH DISCOUNT DENTAL PLAN OR NO INSURANCE

I UNDERSTAND THAT I'M FINANCIALLY RESPONSIBLE FOR ANY DENTAL SERVICES THAT I RECEIVE AT FARHAD AZIZZADEH, DDS, PC.

I UNDERSTAND THAT PAYMENT IS EXPECTED AS SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

X _____ _____/_____/_____

Subscriber's or Patient's Signature Date
(or Parent / Guardian if minor)