



MOHAMMAD IZADI, D.D.S.
SPECIALIST IN ORTHODONTICS*

SIGNATURE ON FILE

I hereby authorize my insurance company/s to make all insurance benefit payments directly to Mohammad Izadi, D.D.S., otherwise payable to me.

I also authorize the release to my insurance company/s any information including the diagnostic records and diagnosis of any treatment required to comply with applicable law and facilitate the billing and reimbursement for treatment provided.

Insurance Co.: _____ Group # _____

Insurance Co.: _____ Group # _____

Employed By: _____

Signature of Party #1 Date

Insurance Co.: _____ Group # _____

Insurance Co.: _____ Group # _____

Employed By: _____

Signature of Party #2 Date

see reverse side of this form 