CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient) , authorize

Dr. _____ (Dentist), to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following (*delete any that are not applicable)

**Dental records, dental research, dental education including lectures, seminars, demonstrations, professional publications such as journals or books*

**Marketing material, including websites and printed materials, patient education *FULL FACE/ *MOUTH*

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential, (other than if Full Face photographs are used)

I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature (Dentist) _____

Signature (Patient) _____

Date _____