Dental Photography Consent Form

I (patient's name) _____ authorise my dentist to take photographs of my jaws and teeth, before, during, and after treatment.

I consent to allow the photographs and or video to be used for the following:

- Dental Records and Research
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books.
- Marketing material, including websites and printed materials, patient education.

I understands if any such media is used, my name and other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the usage of this media.

[ ] Please tick here if you don't want your full face used for any of the above purposes.

Patient Signature: _____

Date: _____

Name of Dentist: _____

Dentist Signature: _____