

CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (patient) authorize Callahan Dental 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:

- Dental Records
- Dental Research
- Dental Education including lectures, demonstrations, professional publications
- Marketing material, including websites and printed materials, patient education

I further understand that if the photographs and/or videos are used, my name or any other identifying information will be kept confidential.

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

Check here if you do not want your full face shot used for any of the above purposes.

Signature (patient) _____

Date: _____

Witness presented:

Signature _____

Date: _____