The Hub Dental Practice

CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient)
authorize the 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 you wish to exclude)

• Dental Records

• Dental Research

• Dental Education including lectures, seminars, demonstrations, professional publications such as journals/books

• Marketing material, including websites and printed materials, patient education.

I further understand that if the photographs and/or videos are used,

My name and my age and other identifying information will be kept confidential.

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

NOTE: Please be assured that your full face will not be shot, and if shot, the area above the nose will be blocked out.

(Consent for Use of your photographs)

Name _____ Date of Birth ____//____//_____

Signature _____ Date ____//____//_____