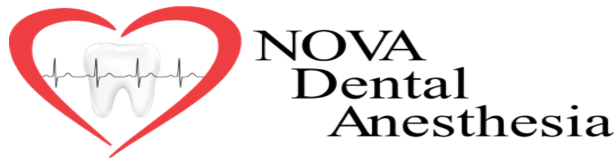

CONSENT TO DENTAL PHOTOGRAPHY

I, ____ (Patient), authorize NOVA DENTAL ANESTHESIA 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, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites and printed materials, patient education

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

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

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

Print Name (Patient): __________________________________ Date ____/____/________

Signature: ____Relation to patient:____________________
(Patient or Parent/Guardian if Patient is a minor)

Print Parent/Guardian Name if patient is a minor: ____