PIERCE & RYAN DENTISTRY

Consent to Dental Photography

I, _____ authorize Pierce & Ryan Dentistry, to take photographs and/or videos of my face, jaw 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.

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

_____ _____

Patient or Guardian Signature Date

Name of Parent or Guardian if Patient is under the age of 18: _____