

## CONSENT TO DENTAL PHOTOGRAPY

I, \_\_\_\_\_ (Patient), authorize

Drs. Patrovi and Kianpour, 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:

- To communicate with dental labs
- 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

Signature (Patient) \_\_\_\_\_

Date \_\_\_\_\_