Consent to Dental Photography

I, _______________________, authorize Dr. Billings/Dr. Lisco to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to the photographs 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 and other identifying information will be kept confidential.

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

☐ Check this box if you DO NOT want your full-face shot used for any of the above purposes.

________________________________ ________________________________

Patient / Guardian Name Date

________________________________ ________________________________

Email Address Phone Number