ANDERSON
Dental Associates
FAMILY & COSMETIC DENTISTRY

PHOTOGRAPHY CONSENT

Patient Name:_____

I hereby authorize Anderson Dental Associates and staff to take photographs and/or videos of my face, jaws, mouth, and teeth. I understand that the photographs and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines). I further understand that if the photographs and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

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

_____ _____

Patient's (or Legal Guardian's) Signature Date

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