

Photography Consent Form

As part of our goal to provide you with comprehensive care, digital photographs may be taken as part of your exam. These can aid in diagnosis and your ability to be involved in your treatment plan.

A checkmark will indicate that you give your consent for your photographs to be used for the following:

_____ 1) Your printed treatment plan, including Cosmetic Imaging of a proposed “After” possibility.

_____ 2) Education of dental care providers (your name omitted)

_____ 3) Website, promotional video, newsletter, and/or other printed material (your name omitted)

_____ Full face

_____ Mouth only

_____ 4) Before and After Album for patient education (your name omitted)

_____ Full face

_____ Mouth only

_____ 5) Email to dental specialists who may be involved in your care (*May include x-rays)

_____ 6) Email to your personal email (please provide)

Sign _____

Date _____

Should you decide to change your mind about any of these choices, please ask to fill out an updated form. We appreciate your cooperation and want you to feel comfortable that your privacy will be respected.

Sincerely,
Marty W. Lindahl, DDS