VIET HO
PROSTHODONTIST

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CONSENT FOR DENTAL PHOTOGRPAHY

Patient Name: _____

Date of Birth: _____

I, _____ (Patient), authorize Dr. Viet Ho, to take photographs, and/or videos of my jaws 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 dental photographs used for any of the above purposes*

_____
Patient Signature

_____
Witness

_____
Date