DentalBees
WE WORK HARD FOR YOUR SMILES

DENTAL PHOTOGRAPHY CONSENT FORM

I (patient's name) _____ authorise:

Dental Bees Staff to take photographs, and or video of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs and or video 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 understand if any such media is used, my name and other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the usage of this media.

☐ Please tick here if you do not want your full-face used for any of the above purposes.

Patient Signature: _____

Date: _____

Name of Practitioner: _____

Practitioner's Signature: _____