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CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize Dr. Kevin Prush, to take photographs, and/or videos of my face, 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

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.

Patient Signature_____

Date_____