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Patient Consent for Dental Photography/Video

Patient Name: _____ Date: _____

I consent for dental photographs/videos to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my dental record, for purposes of dental teaching, or for publication in dental textbooks or journals as I have designated below. By consenting to these dental photographs/videos, I understand that I will not receive payment from any party. Refusal to consent to photographs/video may prevent Dr. Cullen from proceeding with care as the photographs/videos are used for diagnostic and treatment purposes. If I have any questions or wish to withdraw my consent in the future, I may contact Dr. Veasey B. Cullen, Jr. or his staff.

PLEASE SELECT ONE OF THE FOLLOWING OPTIONS:

- ○ I consent for these photographs/videos to be used in dental publications, including dental journals, textbooks, electronic publications and our office website*. I understand that the image may be seen by members of the general public, in addition to scientists and dental researchers that regularly use these publications in their professional education. Although these photographs/videos will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my dental record.

  *I also agree to allow my Full first name and the First letter of my last name to be used along with any testimonials that I provide to the office. Yes_____ No_____

- ○ I do not consent for these photographs/videos to be used in dental publications, including dental journals, textbooks, electronic publications and our office website.

By signing the form below, I confirm that this consent form has been explained to me in terms which I understand.

_____ _____

(Signature of Patient)
(*Signature of Parent/Guardian if minor*)

(Witness)