JACKSON
IMPLANTS & PERIODONTICS

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Consent Dental Photography

I, _____, authorize

Jackson Implants and Periodontics, to take photographs, and/or videos before, during and after treatment.

I consent to allow the photographs to be used for the following:

- ***Dental Records, Insurance***
- ***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.

____Check here if you do not want your photos used for any of the above purposes.

_____ _____

Patient signature Date

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