Robert E. Steele, D.D.S Briana A. Reinert, D.D.S.

FAMILY DENTISTRY

Informed Consent
X-rays & Photographs

I understand that photographs, x-rays and other records may be made during the course of my examination, treatment, and follow-up care. I give my permission for _____ (print patients name) to have x-rays and necessary photographs.

Patient Signature _____Date_____

Witness_____