CONSENT TO DENTAL PHOTOGRAPHY

I authorize Dr. Julie Combs, DDS, to take photographs and/or videos of my face, jaw, and teeth before, during, and after treatment.

I consent to allow the photographs and/or videos to be used for the following:

- Dental records
- Dental research
- Dental education, including the following: lectures, seminars, demonstrations, and professional publications such as journals or books
- Marketing material, including websites and printed materials

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 is you do not want a full face shot used for any of the above purposes

_____ _____

Signature of Patient, Parent, or Guardian Date

_____

Printed Name of Patient, Parent, or Guardian

Greenfield Periodontics LLC
Julie L. Combs, DDS MS
120 W McKenzie Rd, Suite J • Greenfield, IN 46140
(317)477-3000 Phone • (317)477-3002 Fax