CONSENT FOR PHOTOGRAPHY

I, ____ (Patient), hereby consent for New Orleans Dental Center professionals to take photographs, and/or videos of my face, smile, jaws and/or teeth, before, during and after treatment.

I understand that the photographs may be used for any of the following:

- *Dental Records*
- *Dental Research*
- *Dental Education including lectures, seminars, demonstrations, professional publications, such as journals or books*
- *Marketing material, including websites and printed materials, patient education*

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 full face photo used for any of the above purposes.

____	______________________________
Patient's or Guardian's Signature	Witness

____

Date