Consent to Dental Photography:

Name of Patient: _____

In conjunction with the dental services which I am receiving from Dr. Trevor Onishenko or Dr. Wade Foster, I agree and consent to allow photographs taken before, during, and after completion of my dental treatments, to be used for the dental records, education, public relations, patient counseling and or other purposes.

_____
Initial here

I further agree and consent that the photographs relating to my dental care may be published, either separately or in connection with each other in dental photo albums or for in office display purposes.

_____
Initial here

Date: _____

Patients Signature: _____

Witnessed by: _____