MODERN SMILES CONSENT FOR DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize

Dr. Kasra Tajik and Dr. Shahira Saad, to take photographs and/or videos of my face, jaws, and teeth, before, during and after treatment.

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

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Patient education
- Marketing materials, including website and social media

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 shot used for any of the above purposes

Signature (Patient) _____

Date _____