Intraoral Photography Consent Form

I hereby consent to the taking of intraoral photographs for the purpose of documentation, diagnosis, treatment planning, and/or educational use as determined by my dental care provider.

I understand that these photographs may be used in my dental records and may be shared with other dental professionals as required for my treatment. I understand that my identity will remain confidential if photographs are used for professional education or publications.

Patient Name

Date of Birth

Date

Signature

☐ I acknowledge that I have read and understand the above information. All my questions have been answered to my satisfaction.