I (or my Child), ____________________, am (is) a patient of Gonzalez Dental Care and agree to the following:

I hereby consent for dental photographs to be taken of me (or child or person for whom I am a legal guardian). These photographs can include intra-oral and extra-oral as well as full facial photographs. I understand that the information may be used for any one or a combination of the following purposes:

1) Dental Teaching and Patient Education
2) Marketing Purposes
3) Dental Records.

By consenting to these Dental photographs, I understand that I will not receive payment from any party for the use of said photographs. Refusal to Consent to photographs may affect the Dental care I will receive **only in** that the diagnosis of my dental and oral health conditions may not be as thorough or complete without these photographs. If I have any questions or wish to withdraw my consent in the future, I may contact **Gonzalez Dental Care**.

By signing the form below, I confirm that this consent has been explained to me in terms, which I understand.

I hereby consent for the Dental photographs to be used as follows:

- **Within the office to educate other patients:** Yes    No    Thanks
- **In marketing efforts as examples of work done by Gonzalez Dental Care:** Yes    No    Thanks
- **For Dental Records:** Yes

Thank your for your help in educating others in the quality of benefits of our work.

**Patient Signature** ________________________________  **Date** ________________________________

**Witness Signature** ________________________________  **Date** ________________________________