

Bruce E. Crowley, D.D.S.

Patient Identification Photograph Consent Form

Purpose: For dental records and identification

I understand that photographs may be taken of me and I understand these are printed images.

I understand and agree that the nature of use of these images are for: Dental Records Identification

I have been provided the opportunity to ask questions concerning patient identification photography and understand that refusal to consent will not affect my dental care.

I consent to my photograph being taken, and understand they can be used for clinical purposes and identification.

Patients Signature/Parent if minor _____ Date: _____

Patients Printed Name _____ Date of Birth: _____

I decline having my photo taken.

Patients Signature/Parent if minor _____ Date: _____

Patients Printed Name _____