BIRCH TREE
DENTISTRY
DR. BOUZ DDS

CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient Name), authorize Dr. Sviatoslav Bouz, DDS, and his team to take photographs, and/or videos before, during, and after my treatment, including images of my face, jaw, and teeth.

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

- Dental Records
- Dental Education
- Marketing materials (including website publications), printed materials, and patient education.

I further understand that if the photographs and/or videos are used, my name and 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 consent to use of full-face images for the purposes listed above.

Patient Signature: _____ Date: _____