



Consent to Dental Photography

I hereby consent to photographs of my face, jaws, and teeth being taken before, during, or after treatment by Dr. John Oettinger or a member of his team. I understand that Dr. Oettinger is involved in many study groups and teaching endeavors. Therefore I understand that, in addition to being included as part of my dental record, the photographs may be used for purposes of collaboration with dental colleagues not involved in my care, presentations, teaching, publication in dental textbooks or journals, demonstrations to other patients in Dr. Oettinger's practice, or on Dr. Oettinger's website and social media platforms. In most cases only photographs of my teeth and surrounding tissues will be utilized, however some full face photographs may be used. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. By consenting to these photographs I understand that I will not receive payment from any party.

I authorize the use of these images: (Please initial indicating YES or NO below)

_____ YES _____ NO For in-office demonstration only, to prospective or current patients of the practice

_____ YES _____ NO On the website, social media platforms, or in-print advertisements

_____ YES _____ NO For presentations, teaching, and/or collaboration with other dental colleagues not involved in my care

_____ YES _____ NO For use in publications such as dental textbooks or journals

I understand that withholding consent to share photographs will not affect the care I receive. Photographs may still be obtained and used only for the purposes of diagnosis and treatment, and will be disclosed in accordance with the notice of privacy practices as with all other personal health information. If I wish to withdraw my consent in the future, I may do so with a written request.

Patient Name

Patient Signature

Date