Armitage Oral Surgery
Oral & Maxillofacial Surgery

Consent to Dental Photography

I, _____ (Patient Name), authorize:

Armitage Oral Surgery, P.C. and any of their assignees to take photographs, and/or video of my face, mouth, teeth and jaws, before, during and after treatment.

I consent to allow the photographs or videos to be used for the following professional purposes:

- Dental records, dental research, dental education including lectures, seminars, demonstrations, professional publications such as journals or books.
- Social Media (Facebook, Instagram, Tik Tok, Google, Yelp, etc.), marketing material including websites and printed materials, patient education.

I further understand that if the photographs and/or video are used, my name and address will be kept confidential. I do not expect compensation, financial or otherwise, for the use of my photographs and or videos. I understand that the practice cannot condition the treatment I do or do not receive based on whether or not I sign this authorization.

Patient/Guardian Signature _____ Date_____