SWISS BIOLOGIC DENTISTRY
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PHOTOGRAPH AUTHORIZATION FORM

Patient Name: _____ DOB: _____

Use of Photographs for Medical and Diagnostic Purposes

initials

☐ I hereby give my consent for Swiss Biologic Dentistry to take photographs of my, or my child's teeth, jaw, and/or face for any and all diagnostic purposes or treatments. I understand that photographs may be necessary to fully perform the dental services you have requested from this office. Photographs used in this context shall only be used by those professionals and/or employees who provide care or necessary ancillary dental services. Any photos so used shall become a part of my, or my child's permanent patient record.

Additional Photograph Use Authorizations

This office uses photographs for both marketing and educational purposes. Being able to use real photographs of our work is important to educating patients about our procedures and outcomes. We believe it is better to show our actual results instead of just talking about them. We ask that you give us the following authorizations, but your treatment WILL IN NO WAY BE AFFECTED if you choose not to.

☐ I consent to the use of images in marketing materials to be used through various media, including but not limmited to print, online, and television advertising.

☐ I consent to the use of these images to promote the dental practice through the practice's website and other marketing material used in the office

☐ I consent to all of the above uses but prefer only photos of my jaw and teeth be used and not my whole face.

☐ By consenting to the use of these photographs as described above, I understand that I will not receive compensation, financial or otherwise, from Swiss Biologic Dentistry. I hereby release and discharge Swiss Biologic Dentistry from any and all claims and demands arising out of or in connection with the use of my photographs, or other information provided by me, including any and all claims for libel and invasion of privacy.

☐ I understand that Swiss Biologic Dentistry may not further disclose this health information without first obtaining a new written authorization from me. I understand that I may refuse to sign the additional authorization, and that my refusal to sign will not affect my ability to obtain treatment or payment, enrollment, and eligibility for benefits.

Patient or Parent/Guardian Signature: _____ Date: _____

Patient or Parent/Guardian Name: _____ Date: _____