Santa Monica Dental Arts
by Dr. Koshki

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IN-OFFICE IMAGES: GENERAL CONSENT FORM

I consent for dental photographs or images to be made of me or my dependent (or person for whom I am legal guardian). I understand that these images may be used for my dental record for purposes of: identification, insurance processing, referrals to other dental or medical professionals or labs, or in –office dental training.

***I understand that Dr. Koshki will ask for specific permission before posting or sharing my images to any publication, outside educational source or social media outlet. Further, I understand that neither Dr. Koshki nor his assigned will ever disclose my name or other identifying information along with such images, nor seek remuneration for their use.**

If I have any questions or wish to withdraw my consent in the future, I may contact Dr. Koshki or his Office Manager by phone, email or posted mail.

My signature below indicates that the information in this consent form has been explained to me, and I assent to the use of my images as outlined above.

_____ ___/___/___
Patient Name Date

_____ ___/___/___
Patient or Guardian Signature Date