Photography Consent Form

I, (print name) _____, hereby authorize Karl K. Wirtz, D.D.S. and Sunridge Dental Care to take photographs of my face, jaws, and teeth.

I understand that the photographs will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations to other patients, marketing efforts to include publications, websites and professional publications.

I further understand that if the photographs are used in any publications, marketing or websites as part of a demonstration or lecture, all reasonable attempts will be made to conceal my surname and / or identity.

_____ _____

Patient's Signature Date

Authorization to Use Testimonial Remarks

I, (print name) _____, hereby authorize Karl K. Wirtz, D.D.S. and Sunridge Dental Care to use the testimonial remarks that I have provided for use in publications, websites or as part of a demonstration, marketing or lecture.

I further authorize the use of my first name and my last name initial (e.g. Jane D.) to identify me as the source of this testimonial.

_____ _____

Patient's Signature Date

Authorization to Distribute Name and Number

I, (print name) _____, hereby authorize Karl K. Wirtz, D.D.S. and Sunridge Dental Care give my name and phone number as a reference or testimonial source for other patients who may have questions regarding similar types of care as I have experienced.

_____ _____ _____

Patient's Signature Phone # Date