



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

Karl K. Wirtz, D.D.S., P.C.