DREEM DENTISTRY
REEM HAJ-ALI, DDS, MS

CONSENT TO DENTAL PHOTOGRAPHY

I, _____, give my consent to Dreem Dentistry, LLC and staff to take radiographs of dentition and/or photographs of the head and neck areas, including the profile, face, teeth, smile and intraoral features. I give my consent for photographs to be taken pre-treatment, during treatment, and post-treatment for the purposes of internal office use in dental records, treatment planning, marketing, including websites and social media sites.

I understand that my identity and personal information will be kept confidential. I hereby waive any right that I may have to inspect or approve the finished product(s) and advertising copy to which the photographs may be applied and do not expect compensation, financial or otherwise for the use of these photographs,

I hereby release, discharge, and agree to hold harmless Dreem Dentistry, LLC and all persons acting on behalf of Dreem Dentistry, LLC, from any and all claims, damages, actions and demands in any way arising out of or in connection with the use of such photographs, including but not limited to any claims for defamation or invasion of privacy.

For a photograph of me, I represent and certify that (a) I am of legal age OR (b) for a photograph of a minor child, I represent and certify that I am a parent or the legal guardian of that child. Further, I represent and certify that I am not under any legal disability and that I have read the foregoing carefully and fully understand the contents and meaning of this release.

Patient Name: _____ Date: _____

Signature of Patient/Guardian: _____ Date: _____

Witness Signature: _____ Date: _____

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