



*Your Perfect Smile Cosmetic & Family  
Dentistry*

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## **Consent to Dental Photography**

Patient Name: \_\_\_\_\_

In connection with dental services, which I am receiving from Stacie L. Holt, DDS/Tracie L. DeVault, DDS, I agree and consent to allow photographs taken before, during, and after completion of my dental treatments to be used for dental records, patient counseling, or other purposes.

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Witnessed by: \_\_\_\_\_