EASTSIDE
DENTAL MEDICINE
The Center for Advanced Cosmetic and Implant Dentistry

JYOTI P. SRIVASTAVA, MS, DDS
ROBERT G. CASTRACANE, DMD

Where skillful dentistry, health, beauty, and luxury converge

INFORMED CONSENT FOR DIGITAL IMAGES

I _____ understand that photographs, radiographs (digital/panoramic) and other records may be done during the course of my examination, treatment and follow-up care. I give my permission for such items to be used for purposes of research, education, 'before' and 'after' photos or publication in professional journals. I understand that my name and full face will not be published in any material in endeavor to maintain my anonymity.

Signature of Patient, Parent or Guardian **Date**

Witness **Date**

595 Madison Avenue, 27th Fl., New York, NY 10022 theteam@eastsidedentalmedicine.com www.eastsidedentalmedicine.com
T 212.758.9498 T 212.838.7676 F 212.838.3533