SOCKET SCIENCE · TEMPLATE

Consent to clinical photographs and video recordings

Clinical photographs and videos help us plan and document your treatment. Some may also be useful for teaching, publication or information about our clinic. You decide which uses you agree to. Refusing any use will not affect your treatment.

Patient name: _____ Date of birth: _____

Clinic: _____ Clinician: _____

1. Images that may be taken

☐ Photographs inside the mouth
☐ Photographs of the face and smile
☐ Video recordings of treatment
☐ Radiographs and 3D scans

2. I agree that my images may be used for

1. My clinical record and treatment planning	☐ Yes	☐ No
2. Teaching dental professionals and students	☐ Yes	☐ No
3. Presentations at professional meetings	☐ Yes	☐ No
4. Publication in professional journals or books	☐ Yes	☐ No
5. The clinic website	☐ Yes	☐ No
6. The clinic social media accounts	☐ Yes	☐ No
7. Advertising of the clinic	☐ Yes	☐ No

3. Identification

☐ Images in which I may be identified (for example my full face) may be used
☐ Only images in which I cannot be identified may be used

4. Storage

Images are stored securely as part of your clinical record in line with data protection law. Names and identifying details are removed from images used outside your care whenever possible.

5. Withdrawing consent

You may withdraw consent at any time by telling the clinic in writing. We will stop new uses and remove images from our own website and social media. Material already printed or published by others may not be recallable.

6. If the patient is a child

Parent or guardian name: _____ Relationship to the patient: _____

☐ The child has been asked and agrees

_____ _____ _____

Patient · Signature / Date | Parent or guardian · Signature / Date | Clinician · Signature / Date

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