Havens Family DENTAL
Kyle R. Hickman DDS

I, _____
First Name **Last Name** **DOB**

consent to medical images and/or video being made of me or my child/dependent. I agree that duplicates may be made for the referring doctor.

I agree that the images may be:	**Yes**	**No**
Used for education and training	☐	☐
Can use face images	☐	☐
Can use mouth images only (base of nose to chin)	☐	☐
Used on office website (havensfamilydental.com)	☐	☐
Can use face images	☐	☐
Can use mouth images only (base of nose to chin)	☐	☐
Used on any office social media site (Havens Family Dental)	☐	☐
Can use face images	☐	☐
Can use mouth images only (base of nose to chin)	☐	☐
Used with my first name in a dental account specific to the case	☐	☐

By singing below, I confirm that I understand this consent form.

_____ _____
Signature of Patient/Parent or Guardian Date

_____ _____
Signature of Doctor/Staff Date

Kyle R. Hickman D.D.S.
1582 N. Waggoner Road
Suite B
Blacklick, OH 43004
phone 614-762-2737
fax 614-762-2168
www.havensfamilydental.com