PACIFIC CREST
ORAL SURGERY & DENTAL IMPLANTS

PATIENT CONSENT FOR PHOTOGRAPHY & ELECTRONIC COMMUNICATIONS

Patient Name: _____
Date of Birth:_____
Date:_____

CLINICAL PHOTOGRAPHY RELEASES:

I understand that photographs, digital images, and video recordings may be taken of my teeth, smile, and face during the course of my treatment.
[ ] YES, I consent to the use of my clinical images for dental research, educational presentations, and peer-reviewed dental publications. My name and identity will remain strictly confidential. My photos will not be used on social media platforms or any website galleries.
[ ] NO, I do NOT consent to the use of my photographs for any purpose other than my private internal clinical record.

TEXT MESSAGE & EMAIL COMMUNICATIONS (HIPAA ACKNOWLEDGMENT):

Our practice offers automated text messages and emails for appointment reminders, scheduling updates, billing statements, and treatment plans. Standard email and text messages are not fully encrypted, which means there is a small risk that information could be intercepted by an unauthorized third party.

By checking **YES** below, you accept this risk and authorize our office to communicate with you via these unencrypted channels.
Appointment Reminders & Account Updates
[ ] YES, I consent to receive automated text messages and emails regarding appointments, scheduling, and account updates at the contact info provided below.
[ ] NO, I do NOT consent to receive text or email updates for my appointments.
Marketing & Promotions
[ ] YES, I consent to receive emails or texts regarding office newsletters, promotions, or special events.
[ ] NO, I do NOT consent to receive marketing communications.

Mobile Phone Number: _____
Email Address: _____
Revocation: I understand that I am not required to sign this form to receive dental treatment. I have the right to revoke or modify this consent at any time by submitting a written request to the front office staff.
Signature of Patient or Legal Guardian:
X_____
Relationship to Patient (if minor): _____