PATIENT NAME: ______________________________ **Date:**______________________

Consent to Diagnostic Records

I hereby give permission to GLK Orthodontics and qualified staff to take diagnostic records for the purpose of planning orthodontic treatment. These records can include photographs, radiographs, and study models.

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Signature of Patient/Legal Guardian

Consent to Use Records

I hereby give my permission for the use of orthodontic records (made in the process of examination, treatment, and retention) for purposes of professional consultations, board examinations, research, education, or publication in professional journals.

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Signature of Patient/Legal Guardian

Consent to Use Photo

I hereby authorize GLK Orthodontics to use my photo or my child's photo on their website, on the bulletin board, on an office presentation and/or for any promotional material(i.e. brochure).

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Signature of Patient/Legal Guardian

Insurance Payment Authorization

I hereby authorize payment to GLK Orthodontics for the group insurance benefits otherwise payable to me for services provided to my child or me by GLK Orthodontics. I am also aware if an insurance check is sent to me, I need to pay it to GLK Orthodontics.

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Signature of Patient/Legal Guardian