



Masha Kogan, DDS

X-RAY AND PHOTO CONSENT FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

I, the responsible party listed below, hereby give my permission to allow you to record, take or obtain photographs and/or X-rays of me relating to any dental or medical circumstances. This consent I have granted is extended for an undefined period of time.

I acknowledge that I am over the age of eighteen (18) years old and have read and understand the contents of this consent.

Patient/Guardian Name (Print)

Signature

Date