Asai DENTISTRY

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Photo Consent

I hereby authorize Dr. Rickland Asai, DMD or his designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of _____'s dental needs.

I hereby give Dr. Rickland Asai, DMD the absolute right and permission to use my photographs/slides for dental lab or insurance purposes.

Signature _____ Date_____

Parent/Responsible Party's Signature _____

Relationship to Patient _____