Rocky Mount Periodontics and Implant Center
400 Peachtree Street
Rocky Mount, NC 27804
252-446-0400 252-977-2341 fax

CONSENT FOR PATIENT PHOTO

Date _____

Patient Name _____

I authorize Drs. Kim and Arrington, PA and their staff to take my photo for identification purposes. It will be retained in my file as a part of my dental records.

Patient signature _____