

Anthony B. Sims DDS., PC

Consent Form

Your Name \_\_\_\_\_ Date \_\_\_\_\_

Name of Patient \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Patient's Relationship to You \_\_\_\_\_

I \_\_\_\_\_ Authorize & Consent for Dr. Anthony B. Sims and his staff to perform an examination and treatment. I authorize Dr. Sims to take photographs & video for study, educational and diagnostic purposes, including Website.

\_\_\_\_\_  
Patient (Guardian) Signature