VO DENTISTRY
GEORGIA ORTHODONTIC CARE

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PHOTO RELEASE

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Patient's Name: ____

Patient's Address: ____

City/State/Zip: ____

Phone #: ____

Work #:____

Signing your name at the bottom means that you agree for VO DENTISTRY & GEORGIA ORTHODONTIC CARE to use your information.

Patient's Signature: ________________________
Date:

If under 18 years of age, Parent or Guardian Signature:_____________________
Date: