ACADEMY OF OSSEOINTEGRATION
Certification in Implant Dentistry

Patient Consent & Statement of Authenticity

I, _____, attest to being the patient represented in the attached case presentation template titled _____

_____

I can verify that Dr. _____ was the providing clinician for all of the relevant treatment indicated and that the case presented is a true representation of the work undertaken by the applicant.

I consent to all materials including clinical photographs (including any full-face photographs), radiographs and any relevant medical, dental and/or social history being included in this case presentation and understand that it may be reviewed by other clinicians on behalf of the Academy of Osseointegration.

I agree to full disclosure of my contact details as stipulated below and agree to be prepared to receive an unsolicited communication from the Academy of Osseointegration or its representative in order to further verify the veracity of this application, should it be deemed necessary.

PATIENT CONTACT DETAILS:

Address: _____

_____

Telephone: _____ Email: _____

PATIENT SIGNATURE:

Print name: _____ Signature: _____

Witnessing name: _____ **Signature:** _____

Witness address: _____ City:_____ State: _____

This form must be legally authenticated. Please indicate which authentication method you are using:

Notary Public ☐

Signed Affidavit ☐

Other method: _____