Consent to X-Ray

Patients Name: _____

I hereby authorize Dr. _____ and whomever he/she designates as his/her assistant's to take x-rays of myself (or said minor).

Dated this _____ day of _____ 20_____

Witness _____
Printed Name

_____
Signature

Patient _____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if patient is a minor)

Pregnancy Warning

Patient Name_____ Date_____

◊ I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.
◊ I have been advised that the 10 days following the onset of a menstrual period are generally considered to be safe for x-ray examination.

With those factors in mind, I am advising my doctor that:

I am pregnant:	Yes	No	Don't Know
I could be pregnant:	Yes	No	Don't Know
I have an IUD:	Yes	No	Don't Know
I have had a tubal ligation:	Yes	No	Don't Know
I am late with my menstrual period:	Yes	No	Don't Know
I am taking oral contraceptives:	Yes	No	Don't Know
I have had a hysterectomy:	Yes	No	Don't Know
I have irregular menstrual periods:	Yes	No	Don't Know

My last menstrual period began on: _____

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed now.

I hereby authorize the Doctor to examine and treat any condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-rays negatives will remain the property of this office.

Patient Signature Date

Guardian or Parent Signature Authorizing Care Date