X-RAY CONSENT FORM

Patient: _____ Date: _____

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. We would like to make you aware that x-rays may be required in order to administer your treatment. To perform x-rays on any patient our office requires the patients consent for such tests to be performed.

Please choose one:

_____ I understand that my doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests.

_____ I understand that my condition may require my doctor to take x-rays to further diagnose my symptoms. I choose not to have any x-ray at this time and release my doctor of all liabilities.

Signature: _____ Date: _____

FEMALES ONLY:

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 ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exam.

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

I am pregnant	_____ Yes	_____ No	_____ I don't know
I could be pregnant	_____ Yes	_____ No	_____ I don't know
My menstrual period is late	_____ Yes	_____ No	_____ I don't know
I have an IUD	_____ Yes	_____ No	
I have had a tubal ligation	_____ Yes	_____ No	
I have had a hysterectomy	_____ Yes	_____ No	
I have irregular menstrual periods	_____ Yes	_____ No	
My last menstrual period began	_____		
I have begun menopause	_____ Yes	_____ No	

With full understanding of the above and believing that I am not currently at risk. I wish to have an x-ray examination performed today if requested by my doctor.

Signature: _____ Date: _____