X-RAY CONSENT FORM

Patient Name:________________________________ Date:_________________________________.

During your examination, the doctor may feel that x-rays/pictures 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 treatment. In order to perform x-rays/pictures 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/pictures in order to diagnose my condition. I give my permission of all needed diagnostic tests and for such items to be used for purposes of research, education or publication in professional journals.
- ☐ 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-rays/pictures at this time and release my doctor of all liabilities.

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

With those factors in mind, I am advising my doctor that: (Please circle one)

I am pregnant   Yes   No   I don't know

I could be pregnant   Yes   No   I don't know

Patient Signature:____________________________________ Date:____________________________.

Witness Signature:___________________________________. Date:_____________________________.