



X-Ray Patient Consent Form

Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examinations which may be considered necessary or advisable in the course of my evaluation and treatment in this office.

Signed _____ Date _____

If Patient is a Minor

I am the parent or legal representative of _____ who is a minor.
I authorize the performance of diagnostic x-ray of this minor as deemed necessary for evaluation or treatment.

Signed _____ Date _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed _____ Date _____