X-RAY CONSENT FORM

Patient Name _____

PLEASE ANSWER THE FOLLOWING QUESTIONS **(FEMALES ONLY)**

1. Are you pregnant or any chance you may be? Yes / No

2. Date of the start of your last period. _____

3. Are you on any type of birth control? Yes / No

4. Are you trying to get pregnant? Yes / No

Your signature indicates that you have read and answered all of the above questions accurately and accept all responsibility associated with exposure.

Patient Signature _____

X-rays are needed to properly diagnose your condition. By signing below, I consent to having the diagnostic x-rays performed.

Patient Signature _____

Doctor Signature _____

THIS FORM IS FOR EVERYONE; PLEASE SEE BOTTOM PORTION