ASH
Chiropractic & Wellness

Patient name: _____ Date:_____

X-RAY CONSENT

During your examination, the doctor may feel that x-rays are necessary in order to diagnose your condition and/or administer treatment. By signing below, I consent to having diagnostic x-rays performed, which the doctor determines is clinically necessary. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and the patient. I understand and agree that all services rendered to me will be charged to me and I'm responsible for timely payment of such services.

Patient's Signature: _____ Date: _____

FOR 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 am aware that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams.

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

I am pregnant. ○ Yes ○ No

I could be pregnant. ○Yes ○ No

I am late with my menstrual period. ○ Yes ○ No

I am taking contraceptives. ○ Yes ○ No

I have a tubal litigation. ○ Yes ○ No

I have had a hysterectomy. ○ Yes ○ No

I have irregular menstrual periods. ○ Yes ○ No

My last menstrual period began on _____

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

Name: _____ Signature: _____