



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 prior to the administration of treatment.

In order to perform x-rays on any patient, our office requires the patient's consent for such tests.

Please Choose One:

_____ I understand that my doctor may need x-rays in order to diagnose my condition and **I give permission** for the administration of these 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-rays at this time and release my doctor of all liabilities as a result of this choice.

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken which may 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 exams.

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

I am pregnant Yes No Do not know

I could be pregnant Yes No Do not 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 on _____

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 it is requested by my doctor.

Signature: _____

Date: _____