



MINOR X-RAY CONSENT FORM

NOTE: During the minor's routine examination, the doctor may feel that x-rays are needed in order to diagnose a condition. We would like to make you aware that x-rays may be required, and in order to administer them only a legal guardian may sign off on this consent form.

FOR MINOR PATIENTS ONLY:

First Name of Minor: _____

Last Name of Minor: _____

Age: _____ Date of Birth: ____/____/____

Full Name of Guardian (Print Please):

Relation to Minor: _____

Guardian's Phone Number: () _____ - _____

For Female Minors Only: I understand that if the minor is pregnant and has x-rays taken, this may expose the lower torso to radiation and it is possible to injure the fetus. I have also been advised that the ten (10) days following onset of a menstrual cycle are generally considered to be safe for x-ray exams.

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

Is Pregnant Could Be Pregnant Other concern: _____

I, _____ (guardian) acknowledge the need for x-ray imaging in order to diagnose and hereby affirm that I am legally bound to the minor patient and have complete authority to give permission for the minor to be x-rayed by Dr. Vatisas, DC. and/or imaging staff at Atlanta Health Connection Chiropractic.

Guardian Signature: _____ Date: ____/____/____

AHCC Witness: _____ Date: ____/____/____