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Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examination of myself which Eastpointe Chiropractic may consider necessary or advisable in the course of my examination and treatment.

Signed ____ Date ______________

If Patient is a Minor

I am the parent or legal representative of ______________________________________ who is a minor, _______ years of age. I authorize the performance of diagnostic x-ray of this minor which Eastpointe Chiropractic may consider necessary or advisable.

Signed ____ Date ______________

Females: Regarding Possibility of Pregnancy

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

Signed ____ Date ______________