**FREEPORT FAMILY CHIROPRACTIC**

**40 Washington Street Freeport, FL 32439**

**Phone (850)835-9867 Fax (850)880-6089**

**X-RAY CONSENT FORM**

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

During your examination, the doctor may feel that x-rays will be needed in order to provide your treatment. In order to perform x-rays on any patient our office requires that patients consent for such tests to be performed.

**Please choose one of the following:**

\_\_\_\_ I understand that the doctor may need x-rays in order to administer my treatment and I give my permission to perform such tests.

\_\_\_\_ I understand that it may be necessary for the doctor to take x-rays to administer my care. I choose not to have any x-rays at this time and release the doctor of all liabilities. I also understand that the doctor has the right to refuse treatment to me if I choose this option.

**Consent To X-Ray A Minor:**

I am the parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who is a minor, \_\_\_\_years of age. I hereby authorize the performance of diagnostic x-rays of the minor named above. Freeport Family Chiropractic has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

**Females: Regarding Possibility of Pregnancy**

This is to certify that, to the best of my knowledge, I am **NOT** pregnant. The doctor and certified staff of Freeport Family Chiropractic have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES | NO | DON'T KNOW |
| I am pregnant |  |  |  |
| I could be pregnant |  |  |  |
| My menstrual period is late |  |  |  |
| I have an IUD |  |  |  |
| I have had a tubal ligation |  |  |  |
| I have had a hysterectomy |  |  |  |
| I have irregular menstrual periods |  |  |  |

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_