

X-RAY CONSENT FORM

Patient: _____ Date: _____

During your examination, the doctor may feel that x-rays will be needed in order to diagnosis your condition. We would like to make you aware that x-rays may be required, in order, to administer treatment. In order to perform x-rays on any patient our office requires the patients consent for such tests to be performed.

Please Choose One:

_____ I understand that my doctor may need x-rays in order to diagnosis my condition and I give permission of all needed diagnostic tests.

_____ I understand that my condition may require my doctor to take x-rays to further diagnosis my symptoms. I choose not to have any x-rays at this time and release my doctor of all liabilities.

Patient: _____
Signature: _____ Date: _____

X-RAY CONSENT FORM FOR CHILD

During your examination, the doctor may feel that x-rays will be needed in order to diagnosis your childs condition. We would like to make you aware that x-rays may be required, in order, to administer treatment. In order to perform x-rays on any minor patient our office requires consent of the patients parent/guardian for such tests to be performed.

Please Choose One:

_____ I understand that the doctor may need x-rays in order to diagnosis my child's condition and I give permission of all needed diagnostic tests.

_____ I understand that my child's condition may require the doctor to take x-rays to further diagnosis their symptoms. I choose not to have any x-rays of my child at this time and release the doctor of all liabilities.

Signature of parent/guardian: _____

Date: _____