**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, 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 diagnose 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 diagnose my symptoms. I choose not to have any x-rays at this time and release my doctor of all liabilities.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALES ONLY:**

I understand that if I am pregnant and have x-rays taken which expose my 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 \_\_\_\_Don’t know

I could be pregnant \_\_\_\_Yes \_\_\_\_No \_\_\_\_Don’t know

My menstrual period is late \_\_\_\_Yes \_\_\_\_No \_\_\_\_Don’t know

I have irregular menstrual periods \_\_\_\_Yes \_\_\_\_No

* My last menstrual period began \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have an IUD \_\_\_\_Yes \_\_\_\_No

I have a tubal ligation \_\_\_\_Yes \_\_\_\_No

I have a hysterectomy \_\_\_\_Yes \_\_\_\_No

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 requested by doctor.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_