Mercer Island CHIROPRACTIC

X-RAY CONSENT

PATIENT CONSENT TO X-RAY
I authorize the performance of diagnostic x-ray examination of myself which Dr. Parton may consider necessary to accurately diagnose and analyze my spinal condition.

_____ _____
Patient Signature Date

CONSENT TO X-RAY A MINOR
I am the parent or legal guardian of _____, who is a minor. I authorize the performance of diagnostic x-rays of this child, which Dr. Parton may consider necessary to accurately diagnose and analyze _____ spinal condition.

_____ _____
Parent / Legal Guardian Signature Date

FEMALES: REGARDING POSSIBILITY OF PREGNANCY
This is to certify that, to the best of my knowledge, I am not pregnant, and Dr. Parton has my permission to perform diagnostic x-rays. I have been advised that certain advised that certain x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

_____ _____
Patient Signature Date

FEMALES: CONSENT TO X-RAYS DURING PREGANCY
This is to certify that I am or may be pregnant and that Dr. Parton has my permission to perform diagnostic x-rays involving my cervical spine, on the condition that lead shielding is utilized over the truck of my body. I have been advised that certain x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

_____ _____
Patient Signature Date