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Consent to X-Ray

Date: ____________________

Patient Name/DOB: ____________________________________

During your examination, the doctor may feel that x-rays will be necessary in order to diagnose your condition. In order to perform x-rays on any patient our office requires the patient's consent for such tests to be performed.

PLEASE CHOOSE ON OF THE FOLLOWING:

_____ I understand that my doctor may need x-rays in order to diagnose my condition and I give permission to have them performed. I give my permission for xrays today and all future doctor's visits with Dr. Lan Hua.

_____ I understand that my condition may require my doctor to take x-rays to further diagnose my symptoms. I choose not to have x-rays performed 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 can expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for x-ray exam.

PLEASE CHECK THE APPROPRIATE STATEMENT BELOW.

I AM PREGNANT

I AM UNSURE IF I AM PREGNANT BUT WOULD LIKE TO PROCEED WITH THE X-RAY

I AM NOT PREGNANT

SIGNATURE ____________________________ DATE ___________________