CENTENNIAL CHIROPRACTIC

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Patient Consent to X-Ray

I ________________________________ authorize the performance of diagnostic x-ray examination of myself which the above doctor or his associates may consider necessary or advisable in the course of my examination and treatment.

Signed ___________________________
Date _____________________________

Consent to X-Ray a Minor

I ________________________________ authorize the performance of diagnostic x-ray examination on my child or ward which the above doctor or his associates may consider necessary or advisable in the course of examination and treatment.
Age of minor _________
Signed ___________________________
Date _____________________________

Verification of Not Pregnant

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor and his associates have my permission to perform diagnostic x-ray examination. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual period _________
Signed ____________________________
Date ______________________________