



Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examination of myself which Eastpointe Chiropractic may consider necessary or advisable in the course of my examination and treatment.

Signed _____ Date _____

If Patient is a Minor

I am the parent or legal representative of _____ who is a minor, _____ years of age. I authorize the performance of diagnostic x-ray of this minor which Eastpointe Chiropractic may consider necessary or advisable.

Signed _____ Date _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant, and Eastpointe Chiropractic has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed _____ Date _____