Koenig Family Chiropractic

X-RAY CONSENT

***Who Signs*: MALES AND FEMALES**

The doctor has explained that the purposes of the x-rays about to be taken are to analyze the spine for vertebral subluxation and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-ray, I will be informed. I understand that I must then make a determination, to seek additional advice, diagnosis, or treatment for the "unusual finding" from a health care provider. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

_____ DOB: ____ /____ /____

Print Patient Name

_____ DATE: ____ /____ /____

Patient or Authorized person's Signature

CONSENT TO EVALUATE A MINOR CHILD

I, Parent/Legal Guardian, of child, hereby grant permission for my child to receive chiropractic examinations, spinal adjustments and x-rays.

_____ DOB: ____ /____ /____

Print Child's Name

_____ DATE: ____ /____ /____

Parent or Authorized person's Signature

PREGNANCY RELEASE

Who Signs*: FEMALES ONLY -> *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

□ The first day of my last menstrual cycle was on _____-_____-_____ Date

□ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ DOB: ____ /____ /____

Print Patient Name

_____ DATE: ____ /____ /____

Patient Signature