**RICHMOND CHIROPRACTIC INC.**

Dr. Daniel P. Richmond, D.C.

9092 Talbert Ave. Suite 9

Fountain Valley, CA 92708

Office Phone: (714)593-4775

**X-RAY CONSENT FORM**

At Richmond Chiropractic, we try to minimize your exposure to X-rays. We use high speed film, only take necessary views, use collimation, and provide protective shields over reproductive organs. Please initial the appropriate spaces, sign the bottom and date it.

**Patient Consent to X-ray**

\_\_\_\_\_\_\_I authorize the performance of diagnostic X-ray examination of myself which Dr. Daniel Richmond may consider necessary or advisable in the course of my examination and treatment.

**Females: Regarding Possibility of Pregnancy**

\_\_\_\_\_\_\_This is to certify that, to the best of my knowledge, I am not pregnant, and Dr. Daniel Richmond 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.

**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 the minor which Dr. Daniel Richmond may consider necessary or advisable.

I understand that the X-rays taken shall remain in this office as medical records. However, should I like a copy of the prescribed X-rays, Richmond Chiropractic will provide a copy on a CD for a nominal fee of ($20 cash).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature (if patient is a minor)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature

**X-RAY INSTRUCTIONS**

Please remove: Any jewelry, bra, shoes, piercings, and clothing.

Put gown on with the opening in the back. Please leave on your underwear and socks. Crack the door slightly open when you are ready.