MILLER WHITMER
FAMILY CHIROPRACTIC

CONSENT TO X-RAY

I hereby authorize Miller-Whitmer Family Chiropractic and Wellness Center, Inc., and the corresponding Doctors (Miller and Whitmer) to take x-rays of myself (or said minor).

Dated this _____ day of _____ 20_____.

Printed Name: _____

Signature Patient: _____

Signature of Parent or Guardian (if minor): _____

CONSENT TO X-RAY

Date of onset of patient's last menstrual period (LMP): _____

I hereby authorize Miller-Whitmer Family Chiropractic and Wellness Center, Inc., and the corresponding Doctors (Miller and Whitmer) from any and all liability. I hereby affirm that I am not pregnant nor am I attempting to get pregnant as of this date. I have been informed adequately of the potential effects of radiation on a developing fetus. If a pregnancy test has been performed, I am also aware that this test is not 100% accurate and my yield false results.

Dated this _____ day of _____ 20_____.

Printed Name: _____

Signature Patient: _____

Signature of Parent or Guardian (if minor): _____