Excellence In Health Chiropractic & Rehab Clinic
Dr. William A. Ross, D.C.
2008 E. Northern Lights Blvd., Anchorage, AK 99508
Phone (907) 562-6325 Fax (907) 569-5078

Consent to X-Rays

Today's Date:_____

Name of patient:_____ Birthday:_____ _____

I give consent for X-Rays to be taken of me and / or my child. I will not hold Dr. Ross's office responsible for any occurrences having to do with the X-Rays that are taken at this clinic.

Signature: Patient / Guarantor _____

Guarantor print name _____

At this time I choose not to have X-Rays taken of me and / or my child, I understand that Dr. Ross is not liable for any occurrence pertaining to not taking X-Rays at this clinic.

Signature: Patient / Guarantor _____

Guarantor print name _____

WOMEN: I understand that if I am pregnant and have X-Rays taken which expose my lower torso to radiation it is possible to injure the fetus. I have been advised that the 10 days following the onset of menstrual period is generally considered being safe for X-Rays.

With the full understanding of the above, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time and I acknowledge consent in the event an X-Ray examination is to be performed.

Signature: Patient / Guarantor_____