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CONSENT FOR RADIOLOGY

(To be completed on day of x-ray)

PLEASE READ THIS ENTIRE FORM.

I, _____, hereby give my consent for Hazeldean Family Chiropractic Clinic and Dr. _____ to take x-rays as needed to determine the status of my spine.

Anyone of childbearing age with internal reproductive organs (ovaries, uterus) must complete this section and check the appropriate category.

- Not applicable.
- I am presently using the birth control pill or an IUD as a form of birth control.
- I have started my menstrual period in the last 10 days.
Date: _____
- I have had a hysterectomy or tubal ligation.
- I am presently in menopause or post-menopause.

If applicable, this is to certify that, to the best of my knowledge, I am not pregnant at this time. I will assume all responsibility for any effects on a fetus potentially present.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

Patient signature: _____ Date: _____

Patient printed name: _____

Chiropractor signature: _____ Date: _____

Chiropractor printed name: _____

File #: _____