CHOICE
Diagnostic Imaging

X-RAY

PLEASE PRINT. THANK YOU!

Patient: _____ Study: _____

DOB: _____ Weight: _____

Referring Physician: _____ CC: _____

What type of pain, symptoms or problems are you currently experiencing?

Please explain: _____

_____

_____

_____

Are you pregnant? YES NO

When was your last period/menstrual cycle? _____

I certify that I have read the above information and have answered all questions pertinent to this exam. I therefore consent to the performance of this exam.

_____ _____ _____

Patient Signature *(Guardian/Parent If A Minor)* Witness Date