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X-Ray Pregnant Consent Form

Patient Name:

Patient DOB: ____/____/____

Are you pregnant or any chance you may be: ____ YES ____ NO

____ To the best of my knowledge I am not pregnant or believe there is any possibility that I may be pregnant.

____ I further understand that if I have any doubts, x-rays should not and will not be performed.

Signature: _____ Date: _____

Witness: _____ Date: _____

*The exam your doctor has ordered uses Ionizing radiation which can have a severe health effect during pregnancy to an unborn baby. The possibility of severe health effects depends on the gestational age of the unborn baby at the time of exposure and the amount of radiation it is exposed to. Unborn babies are particularly sensitive to radiation during their early development, between weeks 2 and 15 of pregnancy. Such consequences can include stunted growth, deformities, abnormal brain function, or cancer that may develop sometime later in life. You should contact your doctor if you believe you may be pregnant to discuss possible side effects and the risks and benefits of the procedure. If you feel that you may be pregnant, please inform the doctor before your exam.