BIG IDEA FAMILY CHIROPRACTIC
3450 Acworth Due West Rd., NW ▪ Suite 330 ▪ Kennesaw, GA 30144
678-574-5227 ▪ fax 678-574-5223

CONSENT FOR TREATMENT
AND AUTHORIZATION TO PERFORM X-RAYS

Name _____ Date_____

I authorize Dr. Gomez, DC to perform a radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

Signed: _____

Witness: _____

To the best of my knowledge I am NOT pregnant and the above-named Doctor has my permission to x-ray me for diagnostic interpretation.

Signed: _____

Date of last menstrual cycle: _____