Teague Chiropractic Office
Dr. Albert Teague
100 W. National Rd.
Englewood, OH 45322

CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

Date ______________________________ Time ____________________ AM / PM

I have been informed by Dr. Albert Teague that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness).

I authorize Dr. Albert Teague to perform such radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

Signature: ______________________________________

Printed Name: ___________________________________

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: ______________________________________