**Dental X-Ray Consent Form**

Dental x-rays allow the orthodontist to diagnose and treat conditions that cannot be detected during a clinical examination.

There will be two x-rays taken today; a panoramic x-ray and a cephalometric x- ray these x-rays will guide the orthodontist to what is needed for the patient’s treatment.

Dental x-rays are a part of comprehensive oral treatment and necessary for diagnostic purposes.

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

Dental x-rays are safe as far as radiation is concerned the amount to which you are exposed to is minimal.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I **consent** to having necessary x-rays taken today for diagnostic purposes.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I **do not consent** to having x-rays taken today and I am aware that the doctor may not be able to properly diagnose treatment that is needed.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_