The offices of Dr. David Shirazi

TMJ & Sleep Therapy Centre of CONEJO VALLEY & LOS ANGELES

BREATHE SLEEP HEAL LIVE

X-Ray Consent Form & Pregnancy Release

Patient's Name: _____

Patient's Date of Birth: _____

Please answer the following questions:

1. Are you pregnant or is there any chance you may be pregnant? Y/N
2. Day 1 of your last menstrual cycle: _____
3. Are you on any type of birth control? Y/N
4. Are you trying to get pregnant? Y/N

Your signature indicates that you have read, understood and accurately answered all of the above and accept all responsibility associated with exposure to yourself or your unborn child.

Signature of Patient (Parent if Patient is a Minor): _____

Date: _____

Witness: _____