



## Patient Consent to X-Rays/Photos

I authorize the performance of diagnostic x-rays/photos of myself which Coconut Kids Dentistry & Orthodontics / Braces by Grant may consider necessary or advisable in the course of my examination and treatment.	
Signed	Date
Printed Name	
If Patient is a Minor	
I am the parent or legal representative of	
	nostic x-ray/photos of this minor which Coconut Kids
Dentistry & Orthodontics / Braces by Grant may co examination and treatment.	onsider necessary or advisable in the course of the
Signed	Date
Females: Regarding the Possibility of Pregnancy	
This is to certify that, to the best of my knowledge, Orthodontics / Braces by Grant has my permission and treatment.	, I am not pregnant, and Coconut Kids Dentistry & to perform diagnostic x-rays during the examination
Signed	Date
Printed Name	

Note: If you require a copy of an x-ray, there is a duplication fee of \$55 each.