DOUGLAS CHIROPRACTIC & MEDICAL CENTERS

PATIENT PREGNANCY DISCLAIMER

THIS CERTIFIES THAT CONCERN REGARDING PREGNANCY AND RADIATION EXPOSURE HAVE BEEN EXPLAINED TO MY SATISFACTION. I UNDERSTAND THE CLINICAL NECESSIFY OF HAVING X-RAYS TAKEN AT THE TIME AND GRANT PERMISSION FOR THIS PROCEDURE. IN DOING SO, I RELEASE THE DOCTORS/CLINIC FROM THE RESPONSIBILITY FOR POTENTIAL DAMAGE ARISING FROM THIS PROCEDURE.

AT THE PRESENT TIME
(PLEASE CHECK ONE)

_____ I AM SURE THAT I AM NOT PREGNANT.
_____ IT IS POSSIBLE THAT I COULD BE PREGNANT.
_____ I AM PREGNANT.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____