White Rock Chiropractic

718 N. Buckner Blvd. Ste. 100

Dallas, Tx. 75218

Verification of Non-Pregnancy

NAME____ DATE______________________________________

I UNDERSTAND THAT IF I AM PREGNANT & HAVE X-RAYS TAKEN, I COULD EXPOSE MY UNBORN CHILD TO RADIATION WHICH COULD BE POTENTIALLY HARMFUL. WITH THIS IN MIND, I AM ADVISING MY DOCTOR THAT :

____ I AM PREGNANT

____ I COULD BE PREGNANT

____ I AM LATE WITH MY MENSTRUAL PERIOD

____ I AM TAKING BIRTH CONTROL PILLS

____ I HAVE AN IUD

____ I HAD MY TUBES TIED

____ I HAD A HYSTERECTOMY

____ I HAVE IRREGULAR PERIODS

____ MY LAST CYCLE BEGAN (DATE) ____________________________

WITH FULL UNDERSTANDING OF THE ABOVE, I BELIEVE THAT I AM NOT PREGNANT AND, THEREFORE, CONSENT TO ANY X-RAYS THAT THE DR. FEELS ARE NECESSARY TO TREAT ME.

PATIENT SIGNATURE ___________________________________

WITNESS ____