

C O M F O R T

C H I R O P R A C T I C

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PATIENT PREGNANCY DISCLAIMER

My signature below certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having x-rays taken at this time and grant permission for this procedure. In so doing, I release Dr. Orlasky from 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 may be pregnant.
- I am pregnant.

Signature of Patient

Date

Signature of Witness

Date