



CLIENT INFORMATION

DATE:

Full Name: _____

Date of Birth: _____

Spouse's/Partner's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____

Email Address: _____

Pregnancy Information

Estimated Due Date: _____ Gestational age today: _____ weeks

Twins or Triplets? ___Yes ___No Do you want to know the gender? ___Yes ___No

OB Physician: _____ Office Phone: _____

OB Office Address: _____

When was your last ultrasound for this pregnancy? _____

Was it a normal ultrasound? ___Yes ___No

What, if any, problems have you had with this pregnancy? _____

By signing my name below, I verify the accuracy of the information above. I authorize Baby In Me 3D Ultrasound, LLC to disclose medical information to my healthcare provider if necessary. I understand that I am financially responsible for all charges related to this elective ultrasound, and that there are no refunds offered. I have fully read and signed the Elective U/S Acknowledgement, Waiver, Release of Liability and Hold Harmless form.

Print Name: _____

Date: _____

Signature: _____