www.babytimeultrasound.com
babytimeultrasound@yahoo.com

CLIENT/PATIENT REGISTRATION FORM

Full Name: ____ ____________
(Last) (First) (Middle) (D.O.B.)

Spouse Name: ____
(Last) (First) (Middle)

Address: ____________________ City: ______________ State: ________ Zip: ______

Home Phone: __________________ Work: ______________ Cell: ________________

Email Address: ____

PRENATAL CARE INFORMATION

Due Date: ________________________ Gestation Weeks (#): ____________________

Physician: ________________________ Physician's Phone #: ____________________

Have you informed your doctor of your visit to our facility? ____Yes ____No

Have you had any problems with your current pregnancy? ____Yes ____No

If yes, please explain: ____

How many ultrasounds have you had with current pregnancy?______________________

Date of last ultrasound? ____

Were the results normal? ____Yes ____No

If abnormal, please explain: ____

How did you hear about us? ____ Advertisement ____ Friend/Co-worker ____Internet ____ Other (please list below)

____

I verify accuracy of information above is true to my knowledge. I authorize BabyTime 3D/4D Ultrasound Studio, INC. to disclose any medical information to my health-care provider/physician if necessary. I agree to all financial responsibility of all charges related to this ultrasound.

Print Name:______________________________________

Client's/Patient Signature:______________________________ Date: ______________