Elective Ultrasound Registration Form:

Today's Date: ___________________________________

Full Name: _____________________________________

Date of Birth: __/__/___

Spouse's /Partner's Name______________________________

Address: _______________________________________

City: ___________________ **State:** _____ **Zip:** _______

Home Phone: _______________ **Cell Phone:** _______________

Email Address:__________________________@_________

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Pregnancy Information:

Estimated Due Date: ___/____/_____

Do You Know the Gender of your Baby? ____**Yes** _____**No**

If yes, ________**Boy** _________**Girl**

For customization reasons please provide baby's name (if you have one):

____

Gestational Age Today: ____**Weeks** ____**Days**

Are you having Twins or Triplets? _______

OB Physician ____________________ **Phone #**____________

Does your doctor know you are getting an ELECTIVE Sonogram?

Yes_____ **NO**______

I verify the accuracy of the information above. I authorize Picture Me Baby, 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 sonogram, and that there are no refunds offered.

Patient Signature______________________

Print name____________________________

How did you find our services?

___ **Internet Search: What search engine?** ___________________

___ **Referral from a former client: Who**______________________

___ **Other:** _______________________________