**Baby Expressions 3D/4D Ultrasound**
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# Client Registration Form

Full Name: _____
(First) (Middle) (Last)

Spouse/Partner's Name _____
(First) (Middle) (Last)

Address: _____ City: _____State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Due Date: _____ Health Provider (Doctor/Midwife): _____

Mom's Date of Birth: _____ Clinic (Dr's Office): _____

Have you had any problems with your current pregnancy? Yes ☐ No ☐

If yes, please explain: _____

When was your last ultrasound? _____

Were the results normal? Yes ☐ No ☐

If abnormal, please explain: _____

How did you hear about us? Repeat Customer ☐ Friend/Family ☐ Google ☐ Brochure ☐

Doctor ☐ Facebook ☐ Other (please list) _____

If Friend/Family please list name: _____

I verify the accuracy of the information above. I authorize Baby Expressions 3D/4D Ultrasound to disclose medical information to my healthcare provider if necessary. I agree that I am financially responsible for charges related to this ultrasound.

Client's Signature: _____ Date: _____