



Elective Ultrasound Registration Form

Personal Information:

Name: _____

Partners/FOB Name: _____

Date of Birth: ____/____/____ Estimated Due Date: ____/____/____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____(cell) Email address: _____

Pregnancy Information:

Date of LMP: ____/____/____

Who is your prenatal care provider or OB/GYN? _____

OB Physician phone #: _____

Singleton or Twins (circle one)

Do you know the gender of the baby? Y or N (circle one)

Do you want to know the gender of the baby? Y or N (circle one)

Have you had any complications with this pregnancy or any previous pregnancies in the past?
Y or N If yes please explain: _____

How did you hear about us?

Internet Search Facebook Friend/Family Doctor Other _____

I have notified my physician that I have chosen to obtain an elective 3D/4D fetal ultrasound from Expecting Miracles, LLC. I understand this has not been ordered by my physician. I understand that this ultrasound will not be reviewed by a physician and does not replace my medical ultrasound. I have been informed that the federal FDA has determined that the use of medical ultrasound equipment for other than medical purposes, without a physicians' prescription, is an unapproved use.

Signature

Date