

CLIENT INFORMATION WORKSHEET

NAME: _____

ADDRESS: _____ E-MAIL (S) _____

CITY, ZIP: _____

PHONE: (DAY): _____ (EVE.) _____ (CELL): _____

I AM RECEIVING PRENATAL CARE: YES _____ NO _____

DOCTORS NAME: _____

DOCTORS ADDRESS: _____

DOCTORS PHONE: _____ DUE DATE: _____

IF KAISER, KAISER PATIENT NUMBER: _____

DATE OF LAST ULTRASOUND BY MD _____

I understand this has not been ordered by my physician. I understand that this ultrasound is not to be used to replace physician care. I have been informed that the federal Food and Drug Administration has determined that the use of medical ultrasound equipment for other than medical purposes, without a physician's prescription, is an unapproved use. I have been informed that Womb With a View™ follows FDA recommendations for frequency (sound waves) and length of scan which has found no detrimental effects in 40 years of case studies.

I have read and understand the above: Signature: _____ Date: _____

FOR WOMB WITH A VIEW™ USE ONLY

GESTATION: _____

NO. OF FETUSES: _____

FHR: _____

GENDER: _____