Sound Waves Alaska

Anchorage, AK

907.416.8727

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NEW CLIENT REGISTRATION FORM

Full Name:_____

(First) (Middle) (Last)

Spouse/Partner's Name:_____

(First) (Middle) (Last)

Address: _____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work:_____ Cell:_____

Email Address (your privacy is assured):_____

Due Date:_____ Physician:_____

Date of Birth:_____ 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 this current pregnancy? _____

When was your 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)

_____

I verify the accuracy of the information above. I authorize Sound Waves Alaska 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: _____