The Ultrasound Zone
3D/4D Ultrasound Studio
618-288-3315

Boy_____

Girl_____

ELECTIVE ULTRASOUND REGISTRATION FORM

Full Name: _____

Date of Birth: _____ Cell Phone: _____ Zip Code_____

Email Address: _____

Due Date: _____ Do you wish to know the sex of the baby? YES ☐ NO ☐

How far along: _____weeks Number of Babies in the pregnancy: _____

Physician Name: _____ Physician Phone #: _____

I verify the accuracy of the information above. I authorize **The Ultrasound Zone** to disclose medical information to my healthcare provider if necessary. I understand that I am financially responsible for charges related to this ultrasound.

Patient Signature: _____ Date: _____