Inner Reflections
3D/4D Ultrasound Studio

Client Information

Name: _____ Date of Birth: _____

Address: _____ City, Zip: _____

Phone: (Day) _____ (Eve.)_____ (Cell) _____

Email: _____

I am receiving prenatal care and over 18 years: Yes ____No_____

OB/GYN Doctor's Name: _____ OB/GYN Doctor's Phone: _____

OB/GYN Doctor's Address: _____ City, Zip: _____

How many weeks are you today _____

Date of last ultrasound ordered by MD - OB/GYN: _____ Due Date_____

By signing below I acknowledge and understand this ultrasound scan has not been ordered by my current OB/GYN physician however he/she has been made aware of my appt. for 3D/4D scan and has no objections in my obtaining one. I further understand that this ultrasound will not to be used to replace or substitute current physician care and in no way is the scan used for any diagnostic purposes. 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 furthermore been informed by Inner Reflections that they follow FDA recommendations for frequency (sound waves) and length of scan which has found no detrimental effects in more than 35 years of case studies. I further understand that receipt of services by Inner Reflections is contingent upon my execution of the Inner Reflections Waiver and Release.

May we contact you by email with special offers and promotions? _____

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

FOR INNER REFLECTIONS STAFF USE ONLY
WEEKS: _____ 1#_____ 2#_____ 3#_____
GENDER_____ FHR: _____
Package: _____ Payment & Method _____
Notes: _____

WEEKS: _____ 1#_____ 2#_____ 3#_____
GENDER_____ FHR: _____
Package: _____ Payment & Method _____
Notes: _____