



# Womb With a View Client Information Worksheet

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, Zip: \_\_\_\_\_

Phone: (Day) \_\_\_\_\_ (Eve.) \_\_\_\_\_ (Cell) \_\_\_\_\_

May we contact you with special offers and promotions \_\_\_\_\_ Email: \_\_\_\_\_

I am receiving prenatal care: Yes \_\_\_\_\_ No \_\_\_\_\_ Due Date: \_\_\_\_\_

Doctors name: \_\_\_\_\_ Doctors phone: \_\_\_\_\_

Doctors address: \_\_\_\_\_

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: \_\_\_\_\_

*(Please read and sign the back.)*

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FOR WOMB WITH A VIEW™ USE ONLY

GESTATION: \_\_\_\_\_ NO. OF FETUSES: \_\_\_\_\_ FHR: \_\_\_\_\_ GENDER: \_\_\_\_\_

Package: \_\_\_\_\_ Payment & Method: \_\_\_\_\_

Notes: \_\_\_\_\_

GESTATION: \_\_\_\_\_ NO. OF FETUSES: \_\_\_\_\_ FHR: \_\_\_\_\_ GENDER: \_\_\_\_\_

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Notes: \_\_\_\_\_

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