



First Vu Imaging
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NEW CLIENT INFORMATION FORM

Client Name: _____
(First) (Middle) (Last)

Client's Date of Birth: _____ Baby's Due Date: _____

Spouse/ Partner's Name: _____
(First) Middle (Last)

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

Best Contact Phone Number: _____

Email Address: _____
(Your privacy is assured. Please list the email address for First Vu On Demand.)

Physician/ Midwife: _____ Phone Number: _____

Have you informed your physician/ midwife of you visit to our facility? Yes No

Have you had any problems with you current pregnancy? Yes No

If yes, please explain: _____

When was your last ultrasound? _____ Were the results normal? Yes No

If abnormal, please explain: _____

How did you hear about us? _____

Are you considering cord blood banking? Yes No

I verify the accuracy of the information above. I authorize First Vu Imaging to disclose medical information to my healthcare provider and/or First Vu Imaging's medical director if necessary. I agree that I am financially responsible for charges related to this ultrasound service.

Client Signature: _____ Date: _____

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