



*First Vu Imaging*  
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info@firstvuimaging.com  
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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: \_\_\_\_\_