ELECTIVE ULTRASOUND PHYSICIAN CONSENT

PATIENT INFORMATION

Name: _____ _____

(First) (Last)

Address: _____

(Street) (City) (State) (Zip Code)

Phone Number: (_____)_____

Email: _____

Date of Birth: ____/____/____ **Due Date**: ____/____/____ **# of Weeks Pregnant**: _____

PHYSICIAN CONSENT

I hereby confirm that _____("Patient") is authorized to have a 3D/4D ultrasound at Taguchi Women's Clinic, PLLC. I am Patient's attending physician and confirm that Patient is currently receiving pre-natal care under my direction.

Physician Name: _____ **Physician Phone Number**: _____

Physician Signature: _____