Phone: (866) 801-9440
Fax: (866) 364-2915
info@betternight.com

Section 1: Patient Information (required)

Patient Name:

Referring Physician:

Address, City, State, Zip:

Address, City, State, Zip:

Date of Birth:

Phone:

Patient Email:

Fax:

Cell Phone:

1 D W L R Q D O 3 U R Y L G H U – G H Q W L 4 H U

Work Phone:

Section 2: Diagnostic Service

☐ Patient is being referred to BetterNight for assessment of sleep disorder.

Notes:

Practitioner Signature:

Date:

Patient Insurer Name:

Patient Insurer ID#: