Provider Name:

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

Rep Name:

Section 1: Patient Information (required)

Patient Name:

Address, City, State, Zip:

Date of Birth:

Home Phone:

Cell Phone:

Email:

Referring Physician:

Address, City, State, Zip:

Phone:

Fax:

Email:

National Provider Identifier:

Section 2: Diagnostic Service

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

Notes:

Practitioner Signature:

Date:

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