Sleep Disorders Center
FORT SANDERS REGIONAL MEDICAL CENTER

Date___________________

Patient Name____

Patient Phone____________________ Patient's DOB____________ Patient's SSN___________________

Patient Address_________________________________ City__________ State__________ Zip________

Insurance_______________________________________ ID#__________________ Group#___________

Insurance Phone_________________________ *(or copy of insurance card)*

Insured's Name____ Insured's DOB_____________________

Diagnosis____

(or reason for visit to the sleep center)

Comments____

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MD Name____ MD Phone__________________________

MD Fax____________________________

☐ Evaluate and treat patient at Fort Sanders Sleep Disorder Center

MD Signature ____

Thank you for choosing Fort Sanders Sleep Disorder Center, a nationally accredited lab by the American Academy of Sleep Medicine.

Your patient will be mailed an information packet with questionnaire for their completion prior to initial visit. For urgent situations, please call us at (865) 541-1375 to make alternate arrangements.

Fax to: (865) 541-1714

Fort Sanders Sleep Disorder Center
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0023-0102