DentalOptions

APPLICATION FOR PARTICIPATION
AS A
PREFERRED DENTIST

The undersigned hereby tenders this Application for acceptance by DentalOptions upon the terms and conditions set forth in the attached PROVIDER PARTICIPATION AGREEMENT.

The undersigned represents and warrants as follows:

1. I am licensed to practice Dentistry in the States of _______________, and my license is in good standing. My license number is _____________________.

2. I was first licensed to practice Dentistry on the ____ day of _______, ____, in the State of __________.

Dentist Name: ____

Corporate Name: ____

Street Address: ____

City: _____________________ State__________ Zipcode______

Phone: (______)_________________Tax ID # _________________

E-mail address: ________________________ NPI # ____________________

Signature: Dr. _____________________________ Date________________

Specialty: General Practice ____ Pedodontist ____ Periodontist _____ Orthodontist_____

Endodontist ____ Oral Surgeon _____ Prosthodontist _____ Denturist _____

Number of Co-Practitioners or Associates:____

Have you ever had your professional license suspended or revoked, or have you ever been placed on probation by any disciplinary board, or have you ever appeared before an ethics, disciplinary, or licensing board: ____

If so, Please explain:____

Have you now pending or have you ever been held liable, settled, or compromised a claim or lawsuit against you for alleged improper or negligent professional care: ___________________________

If so, please explain: ____

SERVICE INFORMATION:

Regular Office Hours:

Monday ________________________ Tuesday_______________Wednesday_____________

Thursday ________________________Friday_________________Saturday_______________

Are emergency services available 24 hours a day? _______________________________________

In your absence, how are emergency situations handled? __________________________________

Do you have an answering service? ____

What is the average office waiting time for patients with appointments? ______________________

How many dental hygienists do you employ? ____

Second languages spoken by you or your staff? ____

Do you have on-site laboratory facilities? ____

FACILITY INFORMATION:

Is your office accessible to the physically handicapped? __________________________________

What are your parking facilities?____

Is your office adjacent to a bus route? ____

What is the seating capacity of your reception room? _____________________________________

How many operatories are available in your office? _______________________________________

Are restrooms located within your office? ____

PATIENT CAPACITY INFORMATION:

How many active patients does your office serve? ____

How many new patients do you accept per month? _______________________________________

How many new patients can you accommodate?____

Do you have the capacity to expand facilities? ____

Number of patients currently treated each week?____

Maximum number of patients that could be treated weekly? _______________________________

ALL INFORMATION CONTAINED IN THIS QUESTIONAIRE IS CONFIDENTIAL AND WILL ONLY BE FOR THE AUTHORIZED USE OF DentalOptions.