

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 QUESTIONNAIRE IS CONFIDENTIAL AND WILL ONLY BE FOR THE AUTHORIZED USE OF DentalOptions.