



Billing Tax ID \_\_\_\_\_ Practice Name \_\_\_\_\_

Practice Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

Title  D.D.S.  D.M.D. Specialty:  Endodontist  Oral Surgeon  Orthodontist  Pedodontist  Periodontist  Prosthodontist

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Gender  Male  Female

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ License # \_\_\_\_\_ Rendering Provider NPI \_\_\_\_\_

Do you prescribe medications?  NO  YES Dental School Name \_\_\_\_\_ Year Graduated \_\_\_\_\_

DEA # \_\_\_\_\_

**SPECIALTY BOARD STATUS** Are you Board Certified?  NO  YES If No, are you or have you been Board Eligible?  NO  YES  
If Yes, Year of Board Certification \_\_\_\_\_ Expiration \_\_\_\_\_

**PROFESSIONAL WORK HISTORY**

Please list all present and previous dental work history within the past five (5) years. Please provide written explanation of any breaks in history greater than 6 months. Curriculum vitae accepted in lieu of completing the following table.

Hire Date (mm/yy)	Term Date (mm/yy)	Employer	Location Address	Reason for Leaving

**PROFESSIONAL LIABILITY INSURANCE** (Required coverage minimum: \$500,000 per incident, \$1,000,000 aggregate)  
Carrier \_\_\_\_\_ Limits \_\_\_\_\_ Effective Date \_\_\_\_\_ Term Date \_\_\_\_\_

**HOSPITAL ADMITTING PRIVILEGES:** Do you have hospital privileges?  NO  YES (please complete below)

Hospital Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**CONFIDENTIAL INFORMATION**

For any "Yes" response in this section, please provide a brief explanatory statement with your completed form.

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|---|--|
| 1. Within the past five years up to and including the present, have you been involved in any malpractice suit or arbitration, or has any settlement ever been paid by you or paid on your behalf? IF YES, please provide a narrative and status for each case.  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. Have you ever had any one of the following items denied, revoked, suspended, not renewed, placed on probation, subjected to disciplinary action, or otherwise limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items: |  |
| State license   | YES NO   |
| DEA, CDS, or other applicable narcotic registration   | YES NO   |
| Hospital or other health-care facility staff membership or privileges   | YES NO   |
| Medicaid or other government program participation  | YES NO   |
| HMO, PPO, or other managed care plan  | YES NO   |
| Employment as a health-care provider by a military service, hospital, HMO, or other health-care organization  | YES NO   |
| 3. Do you have any condition that, with or without accommodation, would make you unable to perform the essential functions within your area of practice or unable to perform such essential functions without health and safety of patients?  | YES NO   |
| 4. Within the past five years up to and including the present, have you used illegal drugs or have you had a chemical dependency or substance abuse problem?  | YES NO   |
| 5. Have you ever been convicted of a crime (other than a traffic offense), or are you currently under indictment for an alleged crime?  | YES NO   |

Please attach legible COPIES of the following: State Dental License (wallet-size only) Specialty Board Certificate (if applicable)  
DEA Certificate (if applicable) General Anesthesia License (if applicable)

**ATTESTATION**

I, the undersigned, hereby certify that the information provided on this application is truthful, correct and complete in all respects, and I further understand that the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as a participating dentist with the dental plan. The undersigned hereby agrees to notify the dental plan of any changes in the above information.

Dentist's Signature (no signature stamps) \_\_\_\_\_

Date \_\_\_\_\_