

**Provider Application  
Dental Facility Information**  
(Use a separate form for each Location)

**Dental Facility:**

Name of Practice \_\_\_\_\_  
(As you want it to appear in our provider directory)

Street Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address, If Different \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Office Numbers:  
Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Legal Entity: Corporation \_\_\_\_\_ Partnership \_\_\_\_\_ Sole Proprietor \_\_\_\_\_ Tax I.D. Number \_\_\_\_\_

Principal Owner(s):	Dental License #
_____	_____
_____	_____

**Principal Contacts:**

Dentist \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Administrator \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

**Staffing:**

Office Staff (FTE's):  
Dentists \_\_\_\_\_ Hygienists \_\_\_\_\_ RDA's/DA's \_\_\_\_\_ Admin Staff \_\_\_\_\_

Associate Dentist(s) Name	Dental License #	Specialty	Hours/Week
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Complete an "Individual Dentist Information" form for each Owner and Associate)

**Availability/Capacity:**

Office Hours:  
Mon: \_\_\_\_\_ Tues: \_\_\_\_\_ Wed: \_\_\_\_\_ Thurs: \_\_\_\_\_ Fri: \_\_\_\_\_ Sat: \_\_\_\_\_ Sun: \_\_\_\_\_

# of Operatories: \_\_\_\_\_ Patient Base: \_\_\_\_\_ FFS/Indemnity \_\_\_\_\_ % Prepaid \_\_\_\_\_ % Denti-Cal \_\_\_\_\_ %

Other Managed Care Plans Accepted: \_\_\_\_\_

Appointment availability: New Patient \_\_\_\_\_ Routine \_\_\_\_\_ Hygiene \_\_\_\_\_ Emergency \_\_\_\_\_

Foreign Languages Spoken: \_\_\_\_\_

**Accessibility:**

Location:

Ground Floor: \_\_\_\_\_ 2<sup>nd</sup> or Higher: \_\_\_\_\_ Elevator: Yes \_\_\_ No \_\_\_ N/A \_\_\_

Free Parking: Yes \_\_\_ No \_\_\_ # of Parking Spaces: \_\_\_\_\_ On site restrooms: Yes \_\_\_ No \_\_\_

Handicap accessible:

Parking: Yes \_\_\_ No \_\_\_ Restrooms: Yes \_\_\_ No \_\_\_ Front Door: Yes \_\_\_ No \_\_\_  
Elevator: Yes \_\_\_ No \_\_\_ Operatories: Yes \_\_\_ No \_\_\_ X-Rays: Yes \_\_\_ No \_\_\_

Routine appointment intervals: \_\_\_\_\_ Average waiting time in office with appointment: \_\_\_\_\_

Appointments per dentist/day: \_\_\_\_\_ Describe broken appointment policy & follow up system:

\_\_\_\_\_

Are emergency services available 24 hours a day: Yes \_\_\_ No \_\_\_

Describe how you provide for emergency services in your absence: \_\_\_\_\_

\_\_\_\_\_

Specialists to whom your Practice refers patients:

Endodontist: Name: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Periodontist: Name: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Oral Surgeon: Name: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Pedodontist: Name: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_