

**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: _____ Tax I.D. Number: _____
(Corporation/Partnership/Sole Proprietor, Etc)

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

Principal Contacts:

Dentist: _____ Phone : _____

Administrator: _____ Phone : _____

Staffing:

Office Staff (# Of 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)

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, 2nd Floor, etc.)

Elevator: _____
(Yes/No/N/A)

Free Parking: _____ # of Parking Spaces: _____ On site restrooms: _____
(Yes / No) (Yes / No)

Handicap accessible (Yes / No):

Parking: _____ Restrooms: _____ Front Door: _____

Elevator: _____ Operatories: _____ X-Rays: _____

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: _____