

Please type or print clearly. Each dentist must complete a separate form. Dentists must submit separate form for each location where they practice.

PROVIDER INFORMATION

PERSONAL Title D.D.S. D.M.D. **Specialty:** Orthodontist Pedodontist Periodontist Oral Surgery Endodontist Today's Date _____

Last Name _____ First Name _____ Middle Initial _____ Gender Male Female

Date of Birth _____ Social Security # _____ License # _____ License Expiration _____

Dental School Name _____ Year Graduated _____ DEA# _____ DEA Expiration _____

Professional Work History _____

BOARD STATUS Are you Board Certified? No Yes If no, are you or have you been Board Eligible? No Yes
 Year of Board Certification (if applicable) _____ Are you an ADA Member? No Yes

PROFESSIONAL LIABILITY INSURANCE FOR LAST 5 YEARS (use a separate sheet if necessary). **IMPORTANT:** Please attach a copy of current malpractice insurance cover page(s) showing name and address of carrier, doctor's name, expiration date, and limits of liability.

Current Carrier	Policy #	Limits	Exp. Date
Previous Carrier	Policy #	Limits	Exp. Date

HOSPITAL ADMITTING PRIVILEGES: Do you have hospital privileges? No Yes (please complete below)

Hospital Name	Address	Phone
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PRACTICE INFORMATION

Practice Name	Phone	Fax
Address	City	State Zip Code
Mailing Address (if different from above)	City	State Zip Code
Principal Owner(s)	Principal Contact(s)	
Legal Entity (check one) <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor	Tax ID Number (TIN) or Employer ID Number (EIN)	

FACILITY DETAIL

Facility Location (check one): Professional Building Stand-alone Building Shopping Center

Number of Accessible Parking Spaces:	Handicap Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No	Near Public Transit? <input type="checkbox"/> Yes <input type="checkbox"/> No
Waiting Room Capacity:	Patient Education Materials Available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Drinking Fountain? <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of Operatories:	Expansion Capability? <input type="checkbox"/> Yes <input type="checkbox"/> No	Credit Cards Accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of Standard X-Ray Machine:	Panorex? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Laboratory Capabilities (check all that apply): Pouring Models Minor Repairs Fabricate Dentures Fabricate Crowns

Facility uses computer(s) for (check all that apply): Practice Management Appointment Scheduling Insurance Billing (EDI) Accounts Receivable Computers not used

EMERGENCY CARE

Emergency Telephone Number (including area code): _____ How is 24-hour coverage provided? _____

CAPACITY/AVAILABILITY

Office Staff (indicate in FTE's):	Dentists:	Hygienists:	Assistants:	Receptionists:	Operatories:		
Office Hours:	Mon:	Tues:	Wed:	Thurs:	Fri:	Sat:	Sun:
Total Maximum Capacity (number of patients):			At what percentage of your Total Maximum Capacity are you operating?				
Foreign Languages Spoken (list in order of fluency):							
Access/Appointment Availability:	Initial: _____ (wks)	Routine: _____ (wks)	Hygiene: _____ (wks)	Emergency: _____ (hrs)			
Average Waiting Time in Office with Appointment:			Appointments per dentist per day:				
Does office have a broken appointment or no show appointment policy? (describe):							

CONFIDENTIAL INFORMATION

NOTE: Any "YES" answer to the following questions requires that you supply a brief explanatory statement. Please use a separate sheet as necessary.

- Are you now or have you ever been involved in any malpractice suit or arbitration, or has any settlement ever been paid by you or paid on your behalf? YES NO
 If YES, please explain for each suit, arbitration, or settlement (whether open or closed) all details including dates of incidents, filings, settlements; underlying circumstances; your role and legal status (defendant, co-defendant, other); subsequent events (including patient outcome); professional liability insurer involved; amounts paid, current status, and total numbers. Total Numbers
- Has your professional liability insurance ever been denied, suspended, canceled, or not renewed? YES NO
- 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? YES NO
 - 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
 - Professional organization membership 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
- Do you have any physical or mental impairment or condition that, with or without accommodation, would make you unable to perform the essential functions of a practitioner in your area of practice or unable to perform such essential functions without a direct threat to the health and safety of others? YES NO
- Considering the essential functions of a practitioner in your area of practice, are you suffering from any communicable health condition that could pose a significant health and safety risk to your patients? YES NO
- Within the past five years up to and including the present, have you ever had a chemical dependency or substance abuse problem that might adversely affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? YES NO
- 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
- Have you ever been subject to any peer-review type of action? YES NO

NOTE: Any "NO" answer to the following questions requires that you supply a brief explanatory statement. Please use a separate sheet as necessary.

- Does your office utilize proper infection control and barrier techniques? YES NO
- Does your office comply with OSHA requirements? YES NO
- Does your office have 24-hour emergency service or otherwise conscientiously make arrangements for emergency care, such as an answering service or machine with your home phone number, for your patients of record? YES NO

REQUIRED SUBMISSIONS

Attach READABLE COPIES of the following: State Dental License (wallet size only) DEA Certificate Professional Liability Insurance Declarations Page Resume
 Specialty Certificate (if applicable) X-Ray Certificate CPR Certificate General Anesthesia License (if applicable) Board Certification (if applicable) RDA License (if applicable)

I authorize Access Dental to consult with professional liability carriers, and other persons or entities to obtain information concerning my professional qualifications, including competence, ethics and other qualifications. I, the undersigned, hereby certify that the information requested by Access Dental 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 Access Dental of any changes in the above information.

Dentist's Signature (no signature stamps)

Date

ASSOCIATE DENTIST INFORMATION

PERSONAL Title D.D.S. D.M.D. **Specialty:** Orthodontist Pedodontist Periodontist Oral Surgery Endodontist Today's Date _____

Last Name _____ First Name _____ Middle Initial _____ Gender Male Female

Date of Birth _____ Social Security # _____ License # _____ License Expiration _____

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- Has your professional liability insurance ever been denied, suspended, canceled, or not renewed? YES NO
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FACILITY SELF ASSESSMENT QUESTIONNAIRE

Name of Office: _____ Date: _____
Office Number: _____ Telephone # _____

FACILITY AND EQUIPMENT

- | | N/A | YES | NO |
|--|--------------------------|--------------------------|--------------------------|
| 1. Treatment rooms clean, neat, and free from dirt. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Amalgamators covered to prevent spillage of mercury. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Spill kit available if using bulk mercury. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Prescription drugs dispensed on facility are documented, and securely locked. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Needles, syringes, & prescription pads stored securely. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Well-maintained eyewash station with hot water disconnected. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Nitrous oxide if provided, includes a scavenger system. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

ADMINISTRATION AND ACCESSIBILITY

- | | | | |
|---|--|--------------------------|--------------------------|
| 1. Emergency same-day appointments when necessary. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. New patient appointments available within 3 weeks. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Documentation of two attempts to follow-up on broken appointments. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Waiting in office under 30 minutes from appointment time. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Availability of evening and after hours appointments. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Recall program in place. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Sufficient staff for a timely delivery of care. | | <input type="checkbox"/> | <input type="checkbox"/> |

STERILIZATION AND INFECTION CONTROL

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 1. Use autoclave, vented chemiclave; dry heat or chemical sterilization. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Weekly spore testing documented. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Staff use of gloves, masks, eyewear, and protective attire. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Sterile gloves used when doing surgical procedures. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Staff washes hands before treating each patient. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Staff wears new gloves for each patient. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Face shields and protective eyewear disinfected after each patient. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Gowns are changed when soiled with blood or other body fluids. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Protective attire is removed on leaving work areas. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Impervious barriers are used on impossible to clean and disinfect areas. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Hard surfaces in operatories disinfected between patients & at end of the day. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Staff is knowledgeable in sterilization procedures, heat vs. disinfectant. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Nitro gloves or a higher-grade utility gloves are used when cleaning instruments. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Color changes on instrument bags indicating proper sterilization. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Sterile coolant is used during surgical procedures. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Dental hand pieces flushed, bagged and sterilized between patients. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Disposable objects designed for single use are not resterilized and reused. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Cold sterilization solutions are labeled with name, dilution and expiration date. | | <input type="checkbox"/> | <input type="checkbox"/> |

STERILIZATION AND INFECTION CONTROL con't

- | | N/A | YES | NO |
|---|--------------------------|--------------------------|--------------------------|
| 19. Needles are recapped using scoop technique or mechanical device. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Anti- retraction valves installed in the dental units. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Hand pieces and waterlines flushed for 30 seconds between patients. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Sharps are deposited in a rigid leak-proof container. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Infectious waste disposed of according to state and local regulations. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Fixer and developer disposed of properly. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Scrap amalgam stored in plastic screw type container using a suitable liquid. | | <input type="checkbox"/> | <input type="checkbox"/> |

LABORATORY

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 1. Splash shield used in laboratory. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Ragweels, burs, and instruments sterilized between cases. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Lathe-pan lining and pumice changed between cases. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Proper infection control for impressions, dentures, and equipment. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

RADIOLOGY

- | | | | |
|--|--|--------------------------|--------------------------|
| 1. Equipment registered and certificate available. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Intact lead apron with a thyroid collar used during procedures. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Only licensed operators use the equipment. | | <input type="checkbox"/> | <input type="checkbox"/> |

EMERGENCY PROCEDURES

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 1. Emergency kit available, no expired items, labeled with an inventory of medications. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Staff involved in direct patient care aware of location & content of emergency kit. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Portable emergency oxygen, tank full, with positive pressure valve or ambu bag. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Emergency evacuation routes posted. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Doors are marked NO EXIT if not an egress and possibility of confusion exists. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Fire extinguishers have certificates attached and are checked and current. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. First aid kit available and complete. | | <input type="checkbox"/> | <input type="checkbox"/> |

OSHA GENERAL SAFETY STANDARDS

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| 1. Chemicals inventoried / MSDS COLLECTED. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Secondary containers labeled. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Hepatitis B Vaccinations offered and documented. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Exposure control and post-exposure plan available. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Written emergency evacuation plan exists. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Contaminated laundry stored and laundered appropriately. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Training documented in office manual. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Required posters displayed. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Form 300 available and posted in April. (N/A ONLY FOR UNDER 11 STAFF MEMBERS) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Notes: _____

Dentist Signature _____

Date _____