

I. SITE OFFICE INFORMATION

PRACTICE NAME			ISSUE CAPITATION CHECK TO: <input type="checkbox"/> Doctor <input type="checkbox"/> Practice PRACTICE TYPE <input type="checkbox"/> General Dentist <input type="checkbox"/> Specialist <input type="checkbox"/> Multi-Disciplinary		
ADDRESS		SUITE #			
CITY	STATE	ZIP			
OFFICE TELEPHONE #	OFFICE FAX #	E-MAIL ADDRESS			
OWNER DENTIST	SS#	TIN	OFFICE MANAGER		
NPI# FACILITY/ SITE					

II. STAFFING

Indicate the names of all Dentists practicing in this office:

NPI # (DENTIST)	SS or TIN #	FIRST NAME	LAST NAME	SPECIALTY	LICENSE #	YEAR GRADUATED

III. PATIENT MANAGEMENT

Please Indicate Languages Spoken:

- English Chinese Russian Vietnamese Other (specify) _____
 Spanish Japanese French Tagalog

Please indicate number of new patients/month the Practice can accept without adding additional Dentists:

- Less than 50 51 -100 100+

Please indicate how long a patient must wait for an appointment:

- | | | |
|---|---|---|
| New Patient Exam (Days): | Hygiene Appointment (Days): | Routine Treatment (Days): |
| <input type="checkbox"/> 0-7 <input type="checkbox"/> 22-28
<input type="checkbox"/> 8-21 <input type="checkbox"/> 28+ | <input type="checkbox"/> 0-7 <input type="checkbox"/> 22-28
<input type="checkbox"/> 8-21 <input type="checkbox"/> 28+ | <input type="checkbox"/> 0-7 <input type="checkbox"/> 22-28
<input type="checkbox"/> 8-21 <input type="checkbox"/> 28+ |

Are emergency services available 24 hours per day, 365 days per year? Yes No

Do emergency services include the provision of clinical treatment where such treatment is required? Yes No

Indicate type of emergency provisions available in your practice:

- Associate coverage Answering Service Answering machine w/pager Other _____

Please indicate method used in recalling patients on a regular basis:

- Letter/Postcard Telephone Manual Telephone Automatic None Other _____

IV. EQUIPMENT MANAGEMENT

Is office equipped with:

X-ray Units Nitrous Oxide Portable Oxygen

Are x-ray controls permanently mounted to the walls?

Yes No

Does radiation equipment meet State inspection/safety requirements?

Yes No

Are x-ray units currently state certified?

Yes No

If yes, indicate:

CERTIFICATION #	EXPIRATION DATE
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V. COMPUTERIZATION

Do you submit claims electronically? Yes No

Do you have Internet access? Yes No

VI. FACILITY

Type of parking available

Please indicate the number of:

Private Lot

Square feet in practice:

<1000 1000-2499 2500-5000 >5000

Municipal Lot

Seats in reception area:

1-2 3-10 11-20 21+

Street

Equipped operatories:

1 2 3 4 5 6 7 8 or more

Please indicate days and hours of operation:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
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VII. INTERNAL POLICIES

Health education materials are available. Yes No

Emergency medical kit is routinely updated. Yes No

Post Op instructions are written. Yes No

Emergency phone numbers are by each phone. Yes No

Financial arrangements are routinely made. Yes No

New patients sign complete medical form. Yes No

Treatment plans are routinely presented to patients. Yes No

Medical conditions are flagged. Yes No

Informed Consent Forms are routinely used. Yes No

Medical histories are updated regularly. Yes No

Patient's records are in the treatment room. Yes No

X-rays are taken at initial exam. Yes No

Patients are escorted to and from operatory. Yes No

Doctors and assistants are trained in CPR. Yes No

Lead aprons are routinely used. Yes No

VIII. DOCUMENTATION

Please attach copies of the following documents for each provider listed in Section II of this form.

1. Dental License

2. Specialist License (where applicable)

3. DEA Certificate

4. Informed Consent For Treatment Forms and policy

5. Proof of Professional Liability Insurance

6. CPR

Please provide the following:

Dental License #

Specialist License #

DEA Certificate #

Medicare Opt Out? Yes No Denti-Cal Approved? Yes No

PROFESSIONAL LIABILITY INSURANCE COMPANY

PROFESSIONAL LIABILITY POLICY #

PROFESSIONAL LIABILITY (EACH CLAIM)

PROFESSIONAL LIABILITY (AGGREGATE CLAIM)

Signature of Owner Dentist

Date