Dentist Application

Dental Office Profile

Please Include a Copy of:

- ☐ License
- ☐ DEA Certificate
- ☐ Current Certificate of Malpractice Insurance
- ☐ Specialty Training in Board Certificate and/or Post Graduate Training (If Specialist)
- ☐ W-9 Form with Tax Identification Number and Legal Name as Registered with the IRS

Send completed application with attachments via email to
providerapps@DominionNational.com

251 18th Street South, Suite 900
Arlington, VA 22202
888.471.3631 (toll free)
DominionNational.com

DENTIST INFORMATION

Last Name: _____ Suffix: _____
First Name: _____ Middle Name: _____

Date of Birth: _____ State(s) of License: _____ License Number(s): _____
DMD or DDS: _____ Personal Social Security Number: _____
Your DOB is required. We cannot accept your form without this entry.
Individual NPI (Type I):_____ Medicaid ID (PROMISE ID in Pennsylvania): _____
☐ Yes ☐ No Do you have hospital privileges? If yes, complete the following:
Hospital Name: _____ Phone: _____
Address: _____ City: _____ State: _____
☐ Yes ☐ No Do you prescribe drugs? If yes, attach copy of DEA certificate ☐ Attach*
☐ Yes ☐ No Are you an ADA member?
☐ Yes ☐ No Are you a licensed specialist? Specialty: _____
☐ Yes ☐ No Are you a Board Certified Specialist?
Dental School: _____ Phone: _____ Graduation Year: _____
Speciality Training Institute: _____ Phone: _____ Graduation Year: _____

MALPRACTICE COVERAGE

Please include current certificate of Malpractice insurance ☐ Attach*

Insurance Carrier or Producer/Agent: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Amount: $_____ per occurrence $_____ aggregate

PRIMARY LOCATION

Practice Name: _____ Practice Phone Number: _____
Start Date at this Practice: / / Practice Fax Number: _____

Street Address (no P.O. Box): _____ City: _____ State: _____ Zip: _____
☐ **Check here if mailing address is the same as street address** Wheelchair Access ☐ Yes ☐ No
Mailing Address: _____ City: _____ State: _____ Zip: _____
Tax ID # (TID) or Employer ID # (EID): _____ Primary Contact Email: _____
Practice NPI (Type II) - if applicable: _____ Primary Website:_____
Number of Operatories: _____ Languages spoken other than English: _____
Office Hours: (e.g. 8:00 - 5:00)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

ADDITIONAL LOCATION

Practice Name: _____ Practice Phone Number: _____
Start Date at this Practice: / / Practice Fax Number: _____

Street Address (no P.O. Box): _____ City: _____ State: _____ Zip: _____
☐ **Check here if mailing address is the same as street address** Wheelchair Access ☐ Yes ☐ No
Mailing Address: _____ City: _____ State: _____ Zip: _____
Tax ID # (TID) or Employer ID # (EID): _____ Primary Contact Email: _____
Practice NPI (Type II) - if applicable: _____ Primary Website:_____
Number of Operatories: _____ Languages spoken other than English: _____
Office Hours: (e.g. 8:00 - 5:00)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

* Click to attach an electronic document

WORK HISTORY

REQUIRED: List all current and previous dentistry-related work and school experience for the **last five years.** Include residency or fellowship, as applicable. CV/Resume accepted. Gaps over six months require an explanation on the back of this application.

	Previous Practice Name, Experience, Residency, etc.	Location (City and State)	Start Date (MM/YY)	End Date (MM/YY)
1.				
2.				
3.				

CONFIDENTIAL QUESTIONS

REQUIRED: Please explain any "Yes" response to questions 1-8 or "No" response to questions 9-11 on the back of this application.

☐ Yes ☐ No 1. In the past ten years, have you been involved in any malpractice suit or arbitration, or has any settlement been paid by you or on your behalf?

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; and current status.

☐ Yes ☐ No 2. Has your professional liability insurance ever been denied, suspended, cancelled, or not renewed?

3. Have you ever had any 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?

Please mark "Yes" or "No" to the following items

☐ Yes ☐ No State license
☐ Yes ☐ No DEA, CDS, or other applicable narcotic registration
☐ Yes ☐ No Hospital or health-care facility staff membership or privileges
☐ Yes ☐ No Professional organization membership
☐ Yes ☐ No Medicaid or any 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 4. 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 5. 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 6. 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 essential functions of a practitioner in your area of practice.

☐ Yes ☐ No 7. 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 8. Have you ever been subject to any peer-review type of action?

☐ Yes ☐ No 9. Does your office utilize proper infection control and barrier techniques?

☐ Yes ☐ No 10. Does your office comply with OSHA requirements?

☐ Yes ☐ No 11. 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?

QUESTION EXPLANATIONS

Use this space, and/or a separate sheet of paper to explain:
1 Work place history gaps over six months
2 Any “Yes” response to confidential questions 1-8 from the previous page
3 Any “No” response to questions 9-11 from the previous page

AUTHORIZATION & RELEASES

REQUIRED

Any additional information you would like to have included in this application, please detail on your practice’s letterhead and attach. ☐ **Attach an electronic document**

I authorize Dominion Dental Services, Inc. and its applicable affiliates (“Dominion National”) and its clients to whom information on this form may be released, their parent organizations, affiliates, subsidiaries, successors, employees, and vendors selected to perform credentialing services to obtain information from others including State licensing authorities, certification boards, professional liability insurance carriers (including claim histories and loss reports), hospitals, substance abuse programs, and health-care-related employers about my qualification, including without limitation my professional competence and conduct.

I consent to the release to Dominion and its credentialing vendor of any kind and all information that may be relevant to an evaluation of my qualifications, including information about disciplinary action and information that might otherwise be considered confidential or privileged. I release Dominion, its credentialing vendor, and any persons or entities providing information to Dominion and its credentialing vendor, or evaluating the information received or provided on this form, from any and all liability, providing their acts were in good faith and without malice.

I understand I have the burden of providing adequate information to Dominion to demonstrate my qualifications. I understand and agree that any mistreatment or material omission on this form may constitute grounds for rejection of my application or dismissal as a member or participating provider with Dominion. I understand and agree that it is my obligation to immediately notify Dominion if any material changes occur in the information I have provided on this form. I understand that statements written on this form will be considered statements made by me, even if prepared by an employee, agent, or representative.

I attest that the information contained on this form is correct and complete.

DENTIST’S NAME: _____

DENTIST’S SIGNATURE: _____ DATE: _____

SUBMIT