

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: _____

Specialty 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

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: _____