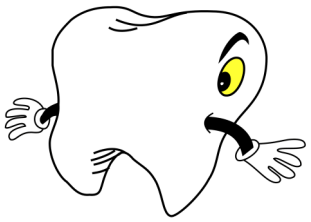
Specialist Provider Profile



(A separate profile is required for each provider)

Please type or print clearly - All information is required unless noted otherwise

Please note that we only require numbers and dates for License, Insurance and DEA

What is your name?_____ D.D.S. or D.M.D. Date of Birth_____/_____/_____

Emergency or Cell Phone Number: (_____)_____ What is your EMAIL address?_____

What Dental College did you graduate from?_____ In What Year?_____

What Dental School did you receive your specialty training?_____

Are you Board Certified? [] Yes [ ] No (if yes) What year were you certified?_____ In what State _____

What is your License Number?_____ State:_____ When does it expire?_____/_____/20_____

Who is your Professional Liability Insurance Carrier? _____

What is your Policy Number?_____ When does your policy expire?_____/_____/20_____

What is your D.E.A. Number?_____ When does it expire?_____/_____/20_____

What is the name of your practice? _____

Address:_____City:_____State:_____Zip:_____

Do you have any Dental Board problems that we should know about? [ ] Yes [ ] No (if yes; please use additional paper to explain)
NOTE: A yes answer to the above question DOES NOT automatically disqualify you from participation in our plan.

What is your area of Specialty? (Check all that apply)

[ ] Orthodontics	[ ] Pedodontics	[ ] Endodontics	[ ] Prosthodontics
[ ] Oral Surgery	[ ] T.M.J.	[ ] Periodontics	[ ] Implants