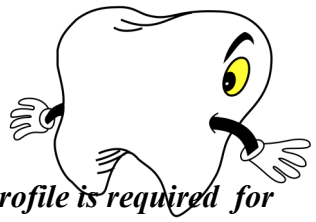
Specialist Center Profile



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

Please Note: If you have more than one (1) dental center, the two (2) page Center Profile is required for each center. Copies of these pages are permissible

Please Tell Us About Your Office

What is the name of your practice? _____

What is the physical address of the Office?_____

City:_____ State:_____ Zip Code:_____

What is the office phone number?(_____)_____-_____ Fax Number?(_____)_____-_____

What is the name of your office manager or appointment coordinator?_____

Office Manager's email address: _____

Do you have a Web Site? [ ] Yes [ ] No If yes please give us your web address: www._____

If you have a web site would you like a link from our dentist list to your web site? [ ] Yes [ ] No

Is your office in a Metropolitan Area (over 100,000 people) [ ] Yes [ ] No (If no) miles from a Metro Area? _____miles

Are languages other than English spoken in your office? [ ] Yes [ ] No (if yes, please specify) _____

Is the mailing address the same as the physical address? [ ] Yes [ ] No (If no, please give us the mailing address below).

Adress:_____City:_____State:_____Zip:_____

Please Tell Us About Your Operatories and Patient Capacity

How many operatories do you have?_____ How many assistants do you have?_____

Please Tell Us About Options and Special Equipment that you have

(please check all that apply to your office)

[ ] Nitrous Oxide	[ ] Ultra Sonic Cleaning	[ ] Laser	[ ] Electro Surge
[ ] IV Sedation	[ ] Oral Sedation	[ ] Prophy Jet	[ ] Denta Cam
[ ] K.C.P. 2000	[ ] Brite Smile/Zoom (etc.)	[ ] High Speed Endo	[ ] Digital X-Ray
[ ] Cavitron	[ ] Children Sedation	[ ] On site denture Lab	[ ] On site Crown & Bridge Lab
[ ] Panoramic x-ray	[ ] Diode Laser	[ ] CAD/CAM (Cerec)	[ ] 3D Imaging

[ ] Other (please explain):_____

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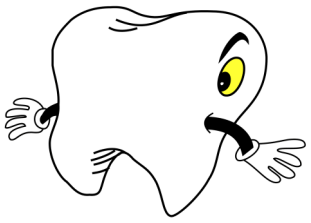


Page II

Please Tell Us What Days and Hours You are Open

Days Open: [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday

Office Hours: ____-____ ____-____ ____-____ ____-____ ____-____ ____-____ ____-____

Please Tell Us About Your Payment Policy

Please check the credit cards that you accept: [ ] Mastercard [ ] Visa [ ] American Express [ ] Discover

Do you accept any other credit cards? [ ] Yes [ ] No (if yes, please specify)_____

Please check any of the following other forms of payments that you make available to patients

[ ] Personal Checks [ ] Care Credit [ ] "In house" financing [ ] Payment plans available through a finance company

[ ] Other (please explain):_____

Equipment Sterilization and Infection Control

Do you sterilize your instruments in office? [ ] Yes [ ] No (if yes) Type: [ ] Autoclave [ ] Chemclave [ ] Statem [ ] Steam [ ] Cold [ ] Other

Do you sterilize your handpieces in office? [ ] Yes [ ] No (if yes) Type: [ ] Autoclave [ ] Chemclave [ ] Statem [ ] Steam [ ] Cold [ ] Other

Do you spore test your sterilization unit? [ ] Yes [ ] No (If yes) how often? [ ] Daily [ ] Weekly [ ] Monthly [ ] Other

If other or no is checked for any of these questions please explain:_____

Personal Sterilization and Infection Control that is Used in this Office

In the Operatory, Do you wear: Mask [ ] Yes [ ] No Gloves [ ] Yes [ ] No

Eye Protection [ ] Yes [ ] No [ ] As Needed Protective Clothing [ ] Yes [ ] No [ ] As Needed

Emergency Control Procedures

Is your office equipped with Oxygen [ ] Yes [ ] No Is your office equipped with a Blood Pressure Device [ ] Yes [ ] No

Is your office equipped with a Defibrillator [ ] Yes [ ] No Does your office have at Least 1 C.P.R. Certified Person [ ] Yes [ ] No

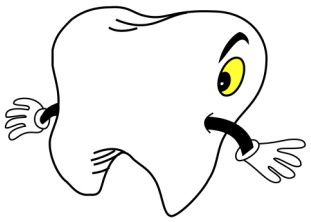
Compliance Procedures

Does your office Meet O.S.H.A. Standards [ ] Yes [ ] No Does your office Have a Written Infection Control Policy [ ] Yes [ ] No

Does your office Have a Written Hazard Control Policy [ ] Yes [ ] No Does your office have a written H.I.P.P.A. policy [ ] Yes [ ] No

Is your office able to accommodate patients with Disabilities (Special question for our disabled members) [ ] Yes [ ] No

Specialist Provider Profile



(A separate profile is required for each provider)

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

We only require numbers and expiration dates of the following items, we do not require copies of them.

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 the 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