

Doctor Profile

- DMD General Practitioner
 DDS Specialist _____

Last Name First Name M.I. _____
(Please Specify)

Home Address

City County State Zip

Home Telephone Number Cellular Phone Number (if applicable)

Marital Status Spouse Name (if applicable)

Sex: Male Female _____
Social Security Number Date of Birth

State of Birth Country of Birth (if outside of U.S) NPI Number (if applicable)

Practicing Hand: Left Right
Check One (optional):
 White Black (not of Hispanic origin) Hispanic American Indian
 Asian Canadian Other _____

Emergency Information:

Contact Name Relationship

Address

City State Zip Phone Number

Educational Background:

Undergraduate University Month & Year of Graduation

Dental School Month & Year of Graduation

Specialty Training Month & Year of Graduation

Internships, Residency or Post-Graduate Programs Month & Year of Completion
(Please indicate by circling)

Dental Licensure: *(please include copies of the following)*

_____	_____	_____
State of Licensure	License Number	Expiration Date
_____	_____	_____
State of Controlled Substance	CSR Number	Expiration Date
_____	_____	_____
DEA	DEA Number	Expiration Date

Work History

For the last five years, please provide us with the name and address of each location where you have practiced. Please include the month and year for the Start and End Dates.

Practice Name	Location (City and State)	Start Date	End Date

List any Professional Organization of which you are members (ADA, State Dental Society, etc)

List any awards, achievements or accomplishments which would be of interest to prospective patients

List your personal interest or hobbies

List below any community involvement you are currently or have participated in

What do you enjoy most about practicing dentistry?

List any insurance plans you are already credentialed with

List any foreign languages spoken: _____

Malpractice Coverage: (please include a copy of declaration page)

Current Carrier

Carrier's Phone Number

Policy Number

Amounts of Coverage

Dates of Coverage

Please list any previous malpractice insurance carriers below:

Previous Carrier	Policy Number	Start Date	End Date

Please answer the following questions:

1. Do you have hospital privileges? Yes No

If yes, please complete the following:

Hospital Name: _____ Phone Number: _____

Address: _____ City _____ State _____

2. Do you prescribe drugs? Yes No
 3. Are you an ADA member? Yes No
 4. Do you have Specialty Training? Yes No

Specialty: _____

5. Are you board certified? Yes No
 6. Are you board eligible? Yes No

Please answer the following questions, if you answer "yes" to any of the following, please explain below:

1. Have you ever been cited for violations of your state's dental practice act? Yes No
 2. Have you ever been cited for violations in other state in which you have practiced? Yes No
 3. Have you ever been cited by the Drug Enforcement Administration for narcotics or other controlled substance violations? Yes No
 4. Have you ever committed any act or acts which would render you morally or professionally unqualified to render services Yes No

Please answer the following questions, if you answer “no” to any of the following, please explain below:

1. Do you follow all proper emergency protocol as recommended by the ADA, Centers for Disease Control, OSHA, and all other governing local, State and federal authorities? Yes No

2. Do you follow all proper sterilization protocol and barrier techniques as Recommended by the ADA, Centers for Disease Control, OSHA, and all Other Governing local, state and federal authorities? Yes No

3. Do you follow all proper radiation and chemical protocol as recommended By the ADA, Centers for Disease Control, OSHA, and all other governing Local, state and federal authorities? Yes No

I hereby acknowledge that the above completed information is true and factual.

Signature

Date

Print Name