

DEMOGRAPHICS (Please type or print)

STATE DENTAL LICENSE #: _____

Name:	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border-bottom: 1px solid black; text-align: center;">Last</td> <td style="width: 33%; border-bottom: 1px solid black; text-align: center;">First</td> <td style="width: 33%; border-bottom: 1px solid black; text-align: center;">MI</td> </tr> </table>	Last	First	MI
Last	First	MI		
Social Security Number:	_____ - _____ - _____			
Individual NPI:	_____ - _____ - _____			
Date of Birth:	____ / ____ / ____ Do you currently hold a DEA registration? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female			
Languages Spoken Fluently:	_____			
Home Address and Phone:	_____ (____) _____			

PRIMARY PRACTICE LOCATION

Primary Office:	_____
Street Address:	Group Name and Clinic Name (if different) _____
City/State/Zip:	_____ County: _____
Office Phone Number:	(____) _____ ER/After Hours Number: (____) _____
Fax Number:	(____) _____
Tax ID Number (TIN):	_____ - _____ - _____
Corporate NPI:	_____ - _____ - _____
Office Manager/Contact:	_____ Office Email: _____
If more than one location please attach a separate sheet with the above information.	

BILLING INFORMATION (If different from information given above)

Billing Name:	_____
Billing Address:	_____ County: _____
Office Manager/Contact:	_____
Billing Phone Number:	(____) _____
Billing Tax ID Number (TIN):	_____ - _____ - _____

GENERAL DENTISTRY EDUCATION

Institution _____	Grad Date _____	Degree _____
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SPECIALTY EDUCATION

Institution _____	Specialty _____	Grad Date _____	Degree _____
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For the above specialty, I am: Educationally Qualified (**attach copy of specialty certificate**)
 Board Certified * (**attach copy of certificate from Specialty Board**)
 *Date of Certification: _____ Expiration Date: _____

DISCLOSURE QUESTIONS

Please complete the Professional Liability Addendum in this application if any of the following questions are answered in the affirmative.

1. Yes No Is your dental license in the state in which you practice currently limited, suspended or revoked?
2. Yes No Has a professional entity (licensing board, Medicare/Medicaid, DEA, Hospital) ever stipulated, restricted, revoked, suspended or in any way limited you or your practice?
3. Yes No Have you ever had any malpractice (professional liability) claims or lawsuits brought against you (includes pending or dismissed claims or lawsuits, settlements or final judgments)?
4. Yes No Is your Professional Liability current with limits of \$1million/\$3 million?

PROFESSIONAL LIABILITY ADDENDUM

Professional Liability Carrier: _____ Policy Limits: _____

PL Expiration Date: _____ Policy Number: _____

COMPLETE ONLY IF you answered "YES" to any Disclosure Questions.
Attach separate sheet if necessary.

Malpractice Claim(s) / Board Action(s)

Date of Occurrence: _____ Settlement Amount/Fine Pd: _____

Name & Address of Insurance Carrier _____

Current Status of Claim/Action: _____ Date Claim/Action Resolved: _____

Details of Allegations / Details of Action (conditions, limitations, etc.) Attach copy of Board Action/Corrective Action:

DISCLOSURE QUESTIONS AND PROVIDER CONSENT

I certify that the information furnished on the DeCare Dental Networks, LLC (DDN) *Application for Contracting* is complete and accurate. I acknowledge that my eligibility to become a participating dentist is contingent upon the provision of complete and accurate information in this application. I agree to inform DDN within ten (10) days of notice of any material changes in such information, whether before or after entering into an agreement with DDN for the provision of dental services. I agree to notify DDN of any changes in malpractice coverage, including the insurance carrier and policy number within ten (10) days of the date any such changes occur. I certify that my office protocols for infection control are in compliance with current CDC/OSHA guidelines. I understand that my application may require DDN to review information related to me on file with other entities, including but not limited to, state licensing boards, specialty boards, professional societies, malpractice carriers, and the National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank administered by the U.S. Government. I hereby consent to and authorize the release of such information by any such entity that requires authorization. I authorize photocopies of this authorization to be used by DDN.

Signature _____ Date _____

Name _____

(please print or type)

DeCare Dental Networks, LLC maintains all information gathered as part of the credentialing/re-credentialing process in a confidential manner and will not communicate or reproduce any information obtained during the process. DDN strictly enforces the provisions designed to safeguard information and ensure confidentiality. DeCare Dental LLC's selection process insures that Credentialing decisions are not based on an applicant's race, ethnicity/nationality, gender, age, sexual orientation, or the types of patients or procedures in which the dentist specializes.