



Provider Relations
 4061 Powder Mill Road
 Suite 325
 Calverton, Maryland 20705-3149
 (301) 937-4447 Washington Area
 (800) 879-0288 Toll Free
 (301) 937-0245 Fax Number
 www.dentaquest.com

PARTICIPATING DENTIST APPLICATION

GENERAL INFORMATION

Dentist full name: _____			
FIRST NAME	MIDDLE INITIAL	LAST NAME	
Please check each box that is applicable:			
<input type="checkbox"/> D.D.S.	<input type="checkbox"/> OWNER	<input type="checkbox"/> GENERAL DENTIST	
<input type="checkbox"/> D.M.D.	<input type="checkbox"/> ASSOCIATE	<input type="checkbox"/> SPECIALIST - Please Specify:	
Trade Name: <i>(If applicable)</i> _____			Tax ID Number: _____
Business Address: Street and Suite Number: _____			
City: _____	County: _____	State: _____	Zip Code: _____
Business Phone Number: () _____		Fax Number: () _____	
Twenty-four hour emergency phone number: () _____			
How long in practice at present location? _____			
Are you currently practicing at another location? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you want to participate at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list name/address/telephone number of each location. Attach additional sheet if necessary:			
1.) _____			
2.) _____			
3.) _____			

PERSONAL INFORMATION

Home Address: _____			
City: _____	County: _____	State: _____	Zip Code: _____
Home Phone Number: () _____	Date of Birth: _____	Social Security Number: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Please indicate State and License Number for each State you are/were licensed in: _____			
Federal DEA License Number: _____			
Malpractice Carrier: _____	Policy Number: _____	Amount of liability: _____	
How long with this carrier: _____	If coverage has been less than 5 years, please list previous carrier: _____		

EDUCATION AND WORK HISTORY

Dental school attended:		Year graduated:	Degree:
Specialty training school attended:		Year and certificate granted:	
Are you Board Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of eligibility:	Are you Board Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, list date of certification:	
Residency Program: <input type="checkbox"/> Yes <input type="checkbox"/> No	Type/Location:	Date and certificate granted:	
Military experience: <input type="checkbox"/> Yes <input type="checkbox"/> No	Branch:	Years served:	
Are you affiliated with any Hospitals? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list:			
Are you affiliated with any Professional Associations? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list:			
List any positions of responsibility held in a Local, State or National Dental Association or in the ADA:			
Are you a participant in any other closed panel or prepaid dental program? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list:			
Please list all of the Continuing Education Courses taken in the last two years:			
<i>Course Name</i>	<i>Where/Given By</i>	<i>#CE Credits</i>	<i>Mo/Year</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Please attach a curriculum vitae or resume - or - supply a work history since graduation from Dental School in the space below:			

PLEASE SIGN AND RETURN THIS APPLICATION

By signing this Application, I do hereby acknowledge that all information provided is accurate and all questions have been answered truthfully.

By submission of this Application, I do hereby acknowledge my intent to enter into a Participating Dentist Agreement with DentaQuest subject to approval by the DentaQuest Credentials Committee and subject to my acceptance of the terms of that Agreement.

Signature: _____ Date: _____

Printed Name: _____

If you have any questions, please do not hesitate to contact DentaQuest at (301) 937-4447 or 1-800-879-0288.

CONFIDENTIAL INFORMATION

If you answer yes to any of the questions contained in this section, please explain completely.
Attach a separate sheet if you need additional space.

1. (a.) **Has any State Licensing or Disciplinary Board, or a comparable body in the Armed Service, denied your application for licensure, reinstatement, or renewal to practice dentistry?**
 No Yes - Please explain:

 - (b.) **Has any State Licensing or Disciplinary Board, or a comparable body in the Armed Service, taken any action against your dental license, including but not limited to monetary fine, sanction, reprimand, probation, suspension, or revocation?**
 No Yes - Please explain:

 - (c.) **Have you ever surrendered or failed to renew a dental license in any State?**
 No Yes - Please explain:
2. **Has your DEA Registration (Narcotics Number) ever been sanctioned, reprimanded, limited, suspended or revoked?**
 No Yes - Please explain:
3. **Has your request for specific clinical privileges ever been denied or granted with stated limitations, or have your hospital privileges ever been restricted, suspended, revoked, or not renewed?**
 No Yes - Please explain:
4. **Have you ever been denied acceptance or renewal thereof, or been subject to disciplinary action by any dental organization?**
 No Yes - Please explain:
5. **Have you ever been denied acceptance or renewal thereof, or been subject to disciplinary action by Medicare, Medicaid, or any government program participation?**
 No Yes - Please explain:
6. **Are you currently having any medical, physical, and/or psychiatric problem(s) which would adversely affect your ability to practice dentistry?**
 No Yes - Please explain:
7. **Do you have a history of substance abuse or a health condition that would affect your ability to practice dentistry?**
 No Yes - Please explain:
8. **Have you ever been named as a defendant or co-defendant in a malpractice action or claim?**
 No Yes - Please explain:
9. **Has any malpractice carrier ever made an out-of-court settlement or paid a judgment of professional liability claim on your behalf?**
 No Yes - Please explain:
10. **Has your malpractice coverage ever been denied or canceled?**
 No Yes - Please explain:
11. **Have you ever had a felony conviction or are you currently under indictment for any crime?**
 No Yes - Please explain:



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CREDENTIALS VERIFICATION RELEASE FORM

I acknowledge and agree that DentaQuest has a valid interest in verifying information concerning my professional competence, in determining whether to enter into an Agreement with me for the provision of Dental Services to members of of its dental plans.

Accordingly:

- (i) I represent and warrant to DentaQuest that the information contained in the foregoing Application is true and complete to the best of my knowledge and belief, and I agree to inform DentaQuest promptly if any material change in such information occurs, whether before or after my entering into an Agreement with DentaQuest for the provision of Dental Services;
- (ii) I am fully aware of the established OSHA guidelines regarding dental office procedures. To the best of my knowledge, my practice complies in all respects to those guidelines.
- (iii) I authorize DentaQuest to consult with educational institutions, hospital administrators, malpractice carriers, and other persons to obtain and verify information concerning my professional competence, character, and moral and ethical qualifications, and I release DentaQuest and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my Application; and
- (iv) I consent to the release by any person to DentaQuest of all information that may reasonably be relevant to an evaluation of my professional competency, character, moral and ethical qualifications, including any information relating to any disciplinary action, suspension, or curtailment of dental privileges; and I hereby release any such person providing information free from any and all liability for doing so.

Dentist's Signature

Date

Dentist's Name (Printed)

Address

()

Telephone Number