PRIVACY PROTECTED

Plan Name:_____

Name:_____

License Number:_____ License State:____

Practice Name:_____

Street:_____

City:_____ State:____ Zip:_____

DATE OF BIRTH: __/__/__ DOCTOR SSN#: ___-__-____

DOCTOR PHONE#: ___-___-____ DOCTOR FAX#: ___-___-____

☐No ☐Yes ***FASTER*** Service Email:_____

PLEASE MARK YES OR NO AND INCLUDE A COPY OF THE DOCUMENT FOR EACH YES

☐No ☐Yes **Current Professional Liability Insurance Declaration Page, Include Copy**

☐No ☐Yes **Current State License, Include Copy**

☐No ☐Yes **State Drug Certificate, Include Copy**

☐No ☐Yes **SPECIALIST , Include Copy** →

☐No ☐Yes **DEA, Include Copy**

- ☐ Dental Public Health
- ☐ Oral Pathology
- ☐ Prosthodontist
- ☐ Periodontist
- ☐ Endodontist
- ☐ Oral Surgery
- ☐ Pedodontist
- ☐ Orthodontist

☐No ☐Yes **Change In Practice Address In Last 5 Years. If Yes, Include 5 Year Work History.**

School Name (Where Highest Degree Was Completed) _____ **STATE** ____ **Year Graduated** ____

☐No ☐Yes **Specialty Board Certified**

☐No ☐Yes **Hospital Privileges: Fill In Below**

ACTIVE Hospital Name _____ **CITY** _____

☐No ☐Yes **Have You Held Any Other Licenses In The Past 5 Years.(List State and License Number)**

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