MANAGED DENTALGUARD
OFFICE PROFILE

General Information:

Name of Principal Dentist(s)/Owner(s) | Degree | State License Number/Expiration Date

Practice Name (if any) | Office Telephone ( ) | Emergency Telephone ( ) | Fax # ( ) | Email Address

Street Address | City | State | Zip Code | County

Social Security Number | Tax Identification Number | Which number(s) will you receive payments under?

Is your office applying as a: | Dental Specialty(ies)

☐ General Dentist ☐ Specialty Care Dentist

How long have you practiced at this location? | NPI Number:

Personnel:

Does this practice have an office manager? | Name | How long at this practice?

Please complete for each hygienist: | License # | FT or PT (# days/wk) | CPR current? (Y/N)

Name

License # | FT or PT (# days/wk) | CPR current? (Y/N)

Name

License # | FT or PT (# days/wk) | CPR current? (Y/N)

Name

# of other staff:

Assistants: | Receptionists: | Lab Technicians:

Please list all dentists practicing at this location who will participate in the MDG program.
Check box if this dentist should be listed in our directory.

Name | License # | Full or Part time (if part time, days of the week)

☐

Name | License # | Full or Part time (if part time, days of the week)

☐

Name | License # | Full or Part time (if part time, days of the week)

☐

Name | License # | Full or Part time (if part time, days of the week)

☐

Practice Administration:

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

How does this office handle requests for emergency appointments, both during & after hours? | Emergency Phone #

Please list credit cards accepted for payment of dental services:

Please list foreign languages spoken in this office:

Patient Care

Please indicate the services routinely provided in this office by all dentists who will participate in MDG:

ENDODONTICS:	Yes	No	ORAL SURGERY:	Yes	No
Anterior root canal treatment	☐	☐	Erupted tooth surgical removal	☐	☐
Bicuspid root canal treatment	☐	☐	Soft tissue impaction removal	☐	☐
1st molar root canal treatment	☐	☐	Partial bony impaction removal	☐	☐
2nd molar root canal treatment	☐	☐	Full bony impaction removal	☐	☐
RESTORATIVE:			PERIODONTICS:		
Amalgam restorations	☐	☐	Case type II, III scaling/root planing	☐	☐
Composite restorations	☐	☐	Case type IV, V scaling/root planing	☐	☐
PEDIATRIC DENTISTRY:					
Routine care for children under age 6	☐	☐			

You may also add comments about your referral patterns. If you provide us with the name of the specialists you normally refer to, we will make every effort to include those dentists in our network.

Will this office accept new patients from MDG? How many?

Is this practice equipped to handle handicapped patients? ☐Yes ☐No

What is the average time, in weeks, for the following types of appointments:

Initial? Hygiene? Routine Treatment?

What is the average waiting time, in hours, for an emergency appointment?

What is the usual in-office wait time, in minutes, for a scheduled appointment?

Facility:

How far is the office from public transportation?

Is parking available? Is it free?

Do you have an existing:

Office Policy Manual? Staff training program? In-house quality assessment program?

How many operatories are available?

Does your office use a recall system?

How many intraoral x-ray units?

Panoramic units?

Are the x-ray units currently state certified?

Is the office equipped with:

Nitrous Oxide? IV Sedation? Plumbed Oxygen? Portable Oxygen?

Do you have an onsite laboratory?

Describe the methods and procedures used in sterilization. (Be sure to include the frequency of biological spore testing.)

I certify that all information in this Profile is complete and accurate to the best of my knowledge.

Signature of Dentist_____ Date_____