MANAGED DENTALGUARD
DENTIST PROFILE

Personal Information:

Dentist's Name | Address | Date of Birth

License # | Social Security # | Do you bill under this #? | Provide all other TIN #'s under which you bill

Degrees | Dental School | Year of graduation

☐ DDS ☐ DMD ☐ Other_____

If licensed in other states, give state & license # | Do you prescribe controlled substances? | If yes, attach a copy of your federal DEA certificate and state certificate where applicable.

Are you a : | Dental Specialty | Number of years in practice

☐General Dentist ☐Specialty Care Dentist

Name of program and institution where ADA accredited specialty training was received. | Date Graduated

Have you completed a residency? | Name of institution | Date Completed

Are you on the faculty or staff of a teaching institution? | Name of institution | Position

Other professional positions | NPI Number

Memberships:

List current professional memberships

☐ADA ☐ State Dental Society ☐ Local Dental Society ☐ Other_____

Professional Liability Insurance:

Carrier | Policy Number | Liability Limits | Expiration Date

Practice History:

If you answer "YES" to any of the following questions, please provide a detailed explanation, including without limitation (information provided will be kept confidential):

- The incident(s) on which the action(s) were based, including pertinent dates;
- How the matter was resolved, including any conditions or stipulations and whether they have been met and/or are still pending;
- List any payments and whether the payments were a result of settlement or judgement, include pertinent dates;
- Describe in detail the specific clinical steps and/or processes you instituted to prevent the recurrence of this situation; and
- List any continuing education courses you attended relating to this situation, include dates.

	Yes	No
1. A. Do you have any pending malpractice, arbitration, or State Board issues?	☐	☐
B. Has any malpractice claim, settlement, judgement, or arbitration ever been paid by you or paid on your behalf?	☐	☐
C. Have you ever been subject to any discipline or findings (e.g., letters of guidance, censure, admonition) by a State Board of Dental Examiners?	☐	☐

		Yes	No
2.	Has your professional liability insurance ever been denied, suspended, canceled, or not renewed?	☐	☐
3.	A. Do you now have, or within the last five years had, any physical condition, mental condition, substance or chemical dependency condition that does or has interfered with your ability to practice dentistry with or without accommodation?	☐	☐
	B. Are you now or have you within the last two years received treatment or been advised to receive treatment for alcohol or other substance or chemical dependency?	☐	☐
4.	Have you ever had any of the following items voluntarily or involuntarily denied, revoked, suspended, terminated, not renewed, placed under probation, subjected to disciplinary action, sanction, or otherwise limited or curtailed:		
	A. State Dental License	☐	☐
	B. DEA certificate or other narcotic registration	☐	☐
	C. Hospital or other health care facility staff membership or privileges	☐	☐
	D. Professional organization membership	☐	☐
	E. Medicare, Medicaid, or other government program participation	☐	☐
	F. Dental Managed Care, PPO, or other dental or health plan participation	☐	☐
5.	Have any items in #4 above been voluntarily relinquished?	☐	☐
6.	Do any items in #4 have any action pending?	☐	☐
7.	If you have ever been employed as a dentist or other provider by a military service, hospital, HMO, or any other health care organization, was your employment ever terminated by the employer?	☐	☐
8.	Have you ever been convicted of a crime (other than a traffic offense), or are you currently under investigation or Indictment for an alleged crime?	☐	☐

Please explain all "YES" answers here. Use additional sheets, if necessary.

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Work history (at least five years) related to dentistry (If self employed, please indicate):

Name _____ Location _____ Dates _____

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I certify that all information in this Profile is complete and accurate to the best of my knowledge, and I agree to notify MDG in writing of any changes within ten (10) business days. I consent to the release of information provided on this form and on my *Office Profile* to third parties who provide utilization and credentialing services to MDG. I also hereby give permission for MDG, or its assignees, to obtain information about my professional credentials and qualifications from others, including certification boards, state licensing authorities, National Practitioner Data Bank, professional liability insurance carriers, and employers.

Signature of Dentist_____ Date_____